Early Intervention Services: The role of psychiatrists and partnership working with the voluntary and community sector

Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO)

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Abbreviations

AO	Assertive Outreach
BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behaviour Therapy
CDW	Community Development Workers
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CSW	Community Support Workers
DoH	Department of Health
DUP	Duration of Untreated Psychosis
EDIT	Early Development and Intervention Team
EI	Early Intervention
EIS	Early Intervention Service
FEP	First Episode Psychosis
GMC	General Medical Council
HA	Health Authority
HAZ	Health Action Zone
ISP	Information Sharing Protocol
MH PIG	Mental Health Policy Implementation Guide
LEO	Lambeth Early Onset Team
MDT	Multidisciplinary Team
MHT	Mental Health Trust
NSGNWW	National Steering Group for NWW
NICE	National Institute for Health and Clinical Excellence
NIMHE	National Institute of Mental Health in England
NWW	New Ways of Working
NHS	National Health Service
NSF	National Service Framework
ODPM	Office of the Deputy Prime Minister

OT	Occupational Therapist
PCG	Primary Care Group
PCT	Primary Care Trust
RCT	Randomised Controlled Trial
RCP	Royal College of Psychiatrists
RMO	Responsible Medical Officer
SCT	Social Care Trust
SDO	NHS Service Delivery and Organisation R&D Programme
SHA	Strategic Health Authority
STR	Support, Time and Recovery
SW	Social Worker
UK	United Kingdom
VCS	Voluntary and Community Sector

Acknowledgements

Executive summary

Background

Key Government objectives in reforming mental health care are to re-define the role of psychiatrists, implement the development of Early Intervention Services (EISs) across the United Kingdom (UK), and encourage partnership working between mental health services and the Voluntary and Community Sector (VCS).

Very few established EISs have dedicated Consultant Psychiatrist medical input, and in those that do this is usually on a part-time basis. The EDEN Study (see Service Delivery and Organisation (SDO) Final Report, SDO/42/2003) found that only five of the 14 EISs in the West Midlands had dedicated Consultant Psychiatrist input, and usually provided this on a part-time basis. These five teams all felt the role of the psychiatrist was valuable and important from a clinical perspective and helped to establish the team's credibility within the wider mental health community.

The other seven active EISs managed issues of medical responsibility, assessment and prescribing through input from a variety of 'patch-based'[1] consultants. This, however, frequently created logistical difficulties, such as taking clients to outpatient clinics for reviews rather than being seen at the EIS base, delays in assessments (with concerns about impact on Duration of Untreated Psychosis) (DUP), and created tensions where the psychiatrists did not share the values and psychosocial approach of the EIS.

The dedicated EIS psychiatrists all had a particular interest in EI but described feeling isolated at times and felt that their consultant colleagues were reluctant to apply for dedicated consultant posts since EI was "too specialist". Furthermore, all were trained as adult rather than child psychiatrists and therefore experienced particular difficulties working with young people aged 14-18 and managing the interface with Child and Adolescent Mental Health Services (CAMHS).

In exploring relationships between EIS teams and local VCS organisations in the EDEN Study, only three of the 14 services had clear links with voluntary groups. The three with formal links were the largest and longest established services. Other teams worked with the VCS on an ad hoc basis. However, partnership working with the VCS was seen as valuable in broadening the focus of the service.

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[1] 'Patch-based' psychiatrists are those consultants who provide medical advice and cover for EIS but who do so on an ad hoc, informal basis for their geographical locality rather than having a paid session dedicated to the EIS.

Aims and objectives

The aims of this study were two-fold: firstly to explore interprofessional role relations between psychiatrists and non-medical EIS team members, and secondly to explore aspects of partnership working between EISs and the VCS and examples of good practice in this context. The specific objectives of the project were:

- to explore interprofessional role relations between psychiatrists and non-medical team members and identify challenges created by and constructive approaches to New Ways of Working (NWW)

- to inform ongoing national work in re-defining the roles of psychiatrists within the context of EISs that may be generalisable to other parts of the mental health system

- to understand the barriers and facilitators to partnership working between health and the VCS within the context of EISs

- to identify examples of good practice in partnership working between EISs and the VCS which are generalisable beyond the specific setting to other parts of the mental health system.

Methods

Qualitative research methods were used to explore interprofessional role relations between Consultant Psychiatrists and EIS non-medical team members and identify challenges created by and constructive approaches to NWW for psychiatrists. Focus groups and semi-structured interviews were used to collect data from psychiatrists and EIS team members. Semi-structured interviews were also used to collect data from Primary Care Trust (PCT) ccommissioners and from VCS professionals to explore aspects of partnership working. All interviews were audiotaped and fully transcribed. Members of the research team independently read the verbatim transcripts and jointly agreed the coding frameworks. The interview transcripts were analysed using a constant comparison approach.

Findings

Importance of multidisciplinary team working in EISs

Most EIS team members described their teams as multidisciplinary. All team members were committed to a team approach, with the quality of care dependent on team flexibility. Dedicated psychiatrists were more

knowledgeable about EIS aims, objectives and day-to-day working practices. Psychiatrists and EIS team members viewed the level and flow of funding of EISs as problematic, which complicated effective workforce planning and provision of services. (see the EDEN Study report for further details).

Roles and responsibilities of EIS team members

Although EIS team members brought different skills to the team, there was an acknowledgement that responsibilities, such as joint assessments and multidisciplinary care planning, were shared. EIS teams described a consensus style of team decision-making. This was a potential area of conflict between EIS teams and psychiatrists. There was a degree of role blurring within teams. Despite the acknowledged commitment to a team approach, EIS team members did not always view the accompanying genericism positively. Innovative ways of working were in early stages of development. Support, Time and Recovery (STR) Workers and Community Development Workers (CDWs) had recently been introduced and appeared to provide one solution to time-consuming tasks that other non-medical team members felt were not a good use of their professional skills or time.

Roles for Consultant Psychiatrists within an EIS context

The roles and responsibilities of psychiatrists and differences between leadership and management were often unclear. However, there was a consensus that diagnostic expertise and prescribing were key responsibilities of psychiatrists. The other roles identified were: medical and risk assessments, attending medical reviews, championing of services, Responsible Medical Officer (RMO) responsibilities, facilitating and supporting others, negotiation and coping with crises. It was evident that psychiatrists saw themselves as natural leaders, which caused tension within some EISs.

Strengths and weaknesses of dedicated EIS medical input

There were advantages and disadvantages of dedicated medical input to EISs. Some psychiatrists had positive attitudes towards EISs, and were described as 'team players', with a willingness to fit into the EIS team. EIS teams without dedicated psychiatrists experienced more difficulties accessing inpatient beds, a lack of a shared approach, challenges to continuity of care, and logistical difficulties with service users having to attend traditional outpatient clinics.

Value of EISs

There was some scepticism from patch-based psychiatrists about the value of EISs, involving issues about opportunity costs, deskilling of psychiatrists, diversion of funding from Community Mental Health Teams (CMHTs) to EISs, and whether EISs add any value over CMHTs. It was also suggested that if CMHTs were better resourced, separate EISs would not be needed.

Value and nature of VCS partnerships

Despite identifying the benefits of partnership working with the VCS, EISs had found it difficult to identify VCS organisations to provide services to individuals with first episode psychosis (FEP), mainly due to limited time for development work and raising awareness of EISs in the local community. Most partnerships were informal in nature and links were easier to develop with larger national voluntary organisations or where priorities and principles were shared.

Facilitators and potential barriers to partnership working (EIS perspective)

The study found that many EISs were having problems with developing partnerships. These included: lack of resources, lack of time, and lack of mutual understanding and communication difficulties. Solutions to some of these problems involved finding the time and resources to engage in community development work to raise the profile of EISs and to find out about the voluntary and community provision in the local community.

Facilitators and potential barriers to partnership working (VCS perspective)

Despite the VCS enthusiasm for partnership working, the findings highlighted challenges in the day-to-day practice (service planning, retention of staff, lack of time and money) and concerns about maintaining autonomy in relation to partnership working. Additional barriers to partnership working included lack of time to take up networking opportunities to raise awareness of the VCS, short-term contracts, and burdensome paperwork related to accountability.

According to the VCS, they added value to service provision, worked in a similar way to EISs (client-centred, flexible and responsive), and demonstrated their value through self-evaluation and external monitoring. Most of the partnerships were informal and ad hoc. However, this form of partnership seemed to be suited to the requirements of EISs. More formal partnership arrangements were not needed for EISs and the VCS to work effectively together in providing seamless services to service users. This was because EIS clients only accounted for a small proportion of referrals to the VCS, therefore, formalising partnership working arrangements would be too time consuming, particularly since EISs had limited development time.

PCT Commissioner interview findings

Understanding of partnership working between EISs and the VCS

There was inconsistency between some commissioners' interpretation and understanding of the guidance on wider non-statutory agency involvement, as outlined in the Mental Health Policy Implementation Guide (MH PIG) (Department of Health 2001).

Level of commitment to partnership working

There was variability in the commitment of commissioners to the MH PIG (Department of Health 2001) guidance in relation to partnership working. It appeared that the PCT commissioners had limited contact with the VCS and focused mainly on the accountability issues of contract monitoring and performance monitoring of VCS service provision. Furthermore, contacts between the PCT and the VCS were mainly with the larger and more established organisations from the VCS.

Perceived barriers to partnership working

A few PTC commissioners viewed duplication of services and the slowing down of service planning and development as barriers to partnership working with the VCS.

Examples of good practice in partnership working between EISs and the VCS

Sustainable funding

One VCS organisation had been successful in negotiating a five-year service level agreement through the local commissioners. This would provide support for infrastructure development, and reduce the problem of employment instability. Short-term contracts made planning for the future difficult, affecting staff recruitment and retention. Therefore, funding on a more secure basis enabled the development of the VCS organisation.

Shared aims and objectives

The presence and mutual recognition of a shared ethos between VCS organisations and EIS teams, reflected in mutual understanding of philosophy and the importance of providing services within mental health, underpinned the development of partnership working. The VCS professionals perceived EISs to be non-traditional and approachable, characteristics generally associated with the VCS. This perception possibly explains their motivation to work with EISs.

Communication

Good communication between partners is an essential requirement for effective partnership working. The way the partnership was managed provides a good practice example. There was good communication between VCS organisations and EIS teams. In particular, there was good communication about the important issues of risk assessment and service user confidentiality.

Opportunities for joint training

Training within the VCS organisations and training opportunities provided by EISs were valued by both sectors, in particular for the opportunity to network. Joint training increases opportunities to facilitate good working

relationships and understanding of each other's perspective and organisational limitations.

Co-location and integration

In a few instances, EIS teams and VCS organisations shared either the same building, or VCS personnel were integrated within the EIS team. Physical co-location and VCS personnel within EIS teams could lead to facilitating partnership working, shared ethos, good communication, networking and training opportunities, enhanced service choice and reduced fragmentation.

Implications

Local action

There were a number of implications for local action and policy.

- The consequences of patch-based psychiatrists providing mental health care to service users in EISs in traditional outpatient clinics is not necessarily an inexpensive option for commissioners.

- Roles and responsibilities of EIS team members and psychiatrists should be defined, particularly within the context of current debates over the issue of genericism versus specialism.

- There needs to be increased communication with the wider mental health community to raise awareness of the value of EISs (see also the EDEN Study report).

- Appropriate information about VCS services and opportunities to network need to be made available.

- Partnership cannot be based on only a small number of interpersonal relationships, since this is not enough to sustain the partnership.

Wider policy

- Clarification of the difference between leaders and managers is required.

- There are policy tensions between NWW encouraging medical leadership and the development of nurse prescribing and nurse leaders.

- There are policy tensions between the biopsychosocial approach of EISs and the biomedical approach of many psychiatrists.

Local action and wider policy

- VCS organisations need long-term funding to enable effective planning of services, which would facilitate effective partnership working.

- Appropriate levels of accountability are needed to resolve the issue of smaller VCS organisations becoming burdened with the associated paperwork.

- The importance of information sharing protocols, which allow multiple agencies to share confidential information, needs to be acknowledged.

- The value of the VCS in providing client-centred, flexible and responsive services needs to be communicated to the wider mental health community.

- There needs to be recognition that smaller organisations are more responsive to local needs but that they are also vulnerable and less able to make an impact on strategic decision making.

1 Introduction

1.1 New ways of working within mental health

Early Intervention (EI) in first episode psychosis (FEP) is an increasingly accepted paradigm, supported by an expanding evidence base that demonstrates a delay in treatment (duration of untreated psychosis, or DUP) is associated with poorer short-term outcome and a slower recovery (Drake et al. 2000). EI is also strongly supported by users and carers as a more appropriate way to treat young people with FEP (Lauber & Rossler 2003;O'Toole et al. 2004). Underpinning policy imperatives include the National Service Framework for Mental Health (Department of Health 1999a), The National Plan for the National Health Service (NHS) (Department of Health 2000) and, most recently, The NHS Improvement Plan, which states that *"a key priority will be to ensure better availability of EI and prevention services"* (Department of Health 2004c) and The National Service Framework for Mental Health – Five Years On (Department of Health 2004d).

The EDEN Study, funded by the Service Delivery and Organisation (SDO) R&D Programme in November 2002, evaluated the development and impact of Early Intervention Services (EISs) in the West Midlands. The study team recruited each of the 14 EISs in the region into the project and has been actively collecting data since March 2004. Each EIS represented a case study site and 50 semi-structured interviews with service users and carers and 162 semi-structured interviews with EIS professionals and members have been completed and analysed to date. Demographic data on patients incepted into the services were collected.

This current study (EDEN Plus) builds on the main EDEN Study, adding value by exploring two key issues that clearly emerged from the case study data and which have particular current policy significance:

1. interprofessional working within EISs with a particular focus on roles and responsibilities of team members and on New Ways of Working (NWW) for psychiatrists; and

2. barriers and facilitators to partnership working between EISs and the voluntary and community sector.

1.2 Monitoring the study

A Steering Committee was set up to monitor the progress of the EDEN Plus Study. The membership included:

Chair of Steering Committee (Dr Lynda Tait) – Research Fellow

Principal Investigator (Professor Helen Lester) – Chair in Primary Care

Professor Max Birchwood – Director, EI Service

Ms Sonal Shah – Project Officer

Dr Jonathan Tritter – Research Director, Warwick Business School

Ms Roslyn Hope – Director, NIMHE National Workforce Programme

Dr Jo Smith – NIMHE/Rethink Joint National EI Programme Lead

Mr Roger Telphia – Chief Executive, Future Health and Social Care

1.3 Report structure

The EDEN Plus Study builds on the main EDEN Study by exploring two key issues that emerged from the case study data. Section 2 describes the importance and development of EISs and Consultant Psychiatrists' roles within multidisciplinary teams (MDTs).

Inter-agency collaboration has been a theme in community care policies for decades. Section 3 reviews the literature on the current policy framework for promoting partnership working in UK mental health services and the VCS. This provides a policy context within which to interpret the findings of the study.

In Section 4, the aims and objectives, methods, participants, and procedures used to collect data are described, followed by an account of the data analysis. In Section 5 the findings are reported.

Section 6 presents a discussion of the findings in the context of the research and policy literature. Section 7 outlines the main implications for practice and wider policy issues, including suggestions for future research. Finally, Section 8 sets out our proposed dissemination strategy and conference presentations. Appendices can be found in Section 9.

2 Early Intervention Services and the role of the Consultant Psychiatrist

2.1 Aim

In this section, we present a brief summary of the background literature on key Government initiatives, in collaboration with professional bodies, aimed at implementing change in mental health care working practices in relation to re-defining the role of psychiatrists. This is followed by a review of the research and policy literature on the importance and development of EISs to provide the research context for the EDEN Plus Study. We also present a summary of the research and policy backgrounds in relation to multidisciplinary working and interprofessional practice within specialist mental health services.

2.2 Background

In the context of this study, EI and detection of FEP refers to *early* as possible contact following the onset of psychotic symptoms, and *intervention* refers to 'optimal, intensive, phase-specific intervention' for individuals with FEP (Edwards & McGorry 2002).

Key Government objectives in reforming mental health care are to redefine the role of psychiatrists, implement the development of EISs across the UK, and encourage partnership working between mental health services and the voluntary and community sector (VCS). In redefining the role of psychiatrists, the Department of Health, in conjunction with professional bodies, organised two conferences in 2003 to discuss issues of concern to psychiatrists who have felt 'overburdened' by the numerous, and often conflicting, roles and tasks expected of them. This has been exacerbated by increasingly unmanageable workloads in the context of significant changes taking place within mental health services. Since then, issues of concern to psychiatrists raised by the Department of Health's consultation process and joint guidance for Best Practice have been published in a range of documents including: *New Roles for Psychiatrists* (Department of Health 2004b), *Joint Guidance on the employment of Consultant Psychiatrists* (Care Services Improvement Partnership 2005), and *NWW for psychiatrists: Enhancing effective, person-centred services through NWW in multidisciplinary and multi-agency contexts* (Care Services Improvement Partnership et al. 2005a).

In line with the original brief from the SDO (SDO/42/2003), the EDEN Study evaluated the implementation and impact of EISs in the West Midlands. The EDEN Study findings emphasised the importance of the role of the psychiatrist within EISs and the disadvantages experienced when an EIS did not have dedicated medical input. In addition, models of partnership working that were described by EIS teams highlighted the importance of strengthening partnership working between EISs and the VCS. Based on

this work, additional funding was made available by the SDO, providing the opportunity to explore these two key areas: barriers and facilitators to partnership working between EISs and the VCS, and interprofessional working within EISs with a particular focus on roles and responsibilities of team members and on new NWW for psychiatrists.

2.3 **Importance of Early Intervention**

There are two important clinical reasons for intervening early in the development of a FEP. Firstly, there is accumulating evidence of the association between long DUP, on average 1-2 years between onset of psychosis symptoms and initiation of treatment (Larsen et al. 2001), and poorer short-term outcome and slower recovery (Drake, Haley, Akhtar, & Lewis 2000;Harrigan, McGorry, & Krstev 2003;Loebel et al. 1992;Norman & Malla 2001). Although other studies have failed to find an association (Craig et al. 2000;Ho et al. 2003), the conflicting findings may reflect the fact that DUP is difficult to define and measure. There is a lack of consensus about which psychosis symptoms should be used to define the onset of psychosis and difficulty in accurately pinpointing the date of onset from the service user and carer responses. Although incontrovertible evidence for the value of EI is unavailable at present, there are ethical concerns and research evidence that during this untreated period, irreversible social and psychological damage may occur (Edwards & McGorry 2002;Lincoln & McGorry 1995;Melle et al. 2006).

Secondly, the first three years after the onset of psychosis represent a critical period where the 'blueprint' for long-term trajectories is laid down (Birchwood, Todd, & Jackson 1998;Harrison et al. 2001). This is a period of high risk of relapse, where drug non-compliance is common and linked to a cycle of relapse (Robinson et al. 1999). Individuals, their families and friends are almost always profoundly affected by the experience of psychosis. Moreover, FEP commonly occurs during adolescence, which means it has the potential to derail social, educational and employment goals at a critical life stage (Jackson et al. 1999). Early detection and effective treatment of FEP is therefore of major importance.

Traditional treatment approaches that were developed to respond to the needs of people who have been treated with long-term psychosis are unsuitable for young people experiencing a FEP (Edwards & McGorry 2002;Malla & Norman 2001). Young people with a FEP face the same developmental challenges as those without mental health problems. However, experiencing a FEP during this 'critical' developmental stage predictably disrupts independent living skills, social relationships, educational progress, and current and future employment prospects (Birchwood et al. 1998). Furthermore, the experience of psychosis symptoms and the adverse events that may occur as a result of psychiatric inpatient treatment, such as involuntary admission, seclusion and restraint procedures, are so psychologically distressing that the FEP can be viewed as a traumatic life event for young people (McGorry et al. 1991;Shaw et al. 2002). Young people are also more likely to reject 'paternalistic' approaches

to medical treatment (Malla & Norman 2001). Thus, treatment setting and clinical management of FEP are of critical importance in a first episode as these distressing personal experiences can account for negative attitudes and beliefs about psychosis and its treatment (McGorry et al. 1991). They also influence how the young person engages with mental health services, and adapts to the challenges of mental illness (Tait, Birchwood, & Trower 2004). Without effective service engagement at an early stage, or where services are inappropriate or insensitively delivered, the opportunity for the young person recovering from a FEP to develop positive attitudes towards services and treatment may be lost (Tait, Birchwood, & Trower 2002).

2.4 Policy background and context: introduction of specialist services

EISs offer specialised, multi-disciplinary mental health care to young people experiencing a FEP and have been set up in Europe, Canada, New Zealand, Australia and the United States of America. This paradigm of care is supported by a series of underpinning policy documents, including: *Modernising Mental Health Services* (Department of Health 1998) and *The National Service Framework for Mental Health* (Department of Health 1999a). These key DH documents set out the principles and investment plans to direct the development and re-organisation of mental health services, including EISs. Perhaps the most important policy directive of relevance to EISs is *The National Plan for the NHS* (Department of Health 2000) which supported and accelerated the development of 50 EISs in England to meet the special needs of FEP patients and their families, and to improve the early detection and treatment of FEP.

The research evidence base to support current policy comes from a recent randomised controlled trial (RCT) comparison of the outcomes of specialist services ('early onset' team) with those of an existing CMHT service. In Lambeth (London), the effectiveness of a new EIS (the Lambeth Early Onset (LEO) team), established in January 2000, was evaluated in an RCT (Craig et al. 2004;Garety et al. 2006). Eligible service users were aged between 16-40 years, living in the catchment area of Lambeth, and presented with a FEP. The LEO team comprised ten multidisciplinary team members operating on an assertive outreach (AO) model of service delivery. Evidence-based treatment included low dose atypical antipsychotic medication, vocational strategies, cognitive behaviour therapy and family therapy. The control group received standard care as delivered by a CMHT.

Findings indicated that after 18 months, service users treated by the early onset team were more likely to have maintained contact with services and had fewer readmissions to hospital compared to service users receiving standard care (Craig, et al. 2004). The intervention at 18 months was associated with better quality of life, social and vocational functioning, adherence to medication and satisfaction with services (Garety et al. 2006).

Further evidence that EI for psychosis is effective comes from the OPUS trial, a RCT conducted between January 1998 to December 2000 (Petersen

et al. 2005). Eligible service users were aged between 18-45 years with clinical diagnoses of FEP, all of whom were randomised either to integrated or standard treatment. The MDT delivering the intervention followed an AO model. Evidence-based treatment included low dose atypical antipsychotic medication, social skills and coping skills training, problem solving and conflict resolution skills. Psychoeducational family therapy was also offered. The control group received standard treatment, which also involved low dose atypical antipsychotic medication. Petersen and colleagues (2005) found that at one-year follow up, the service users receiving the integrated treatment had better adherence to medication, fewer were homeless or unemployed, had drug or alcohol misuse problems, and had better social outcomes.

Although these are promising results for the effectiveness of EI compared to standard mental health treatment, another RCT study evaluating a new service in South London failed to find significant differences between service users in clinical and social improvements (Kuipers et al. 2003). Although the evidence base is more than enough to support the rationale for the concept of EI, further studies evaluating the components of EISs are needed to provide the evidence base for their effectiveness over other generic mental health services.

2.5 Specialised or generic services?

The implementation of EISs staffed by a dedicated team and run separately to generic mental health services has been challenged by those who argue that these new dedicated services could be integrated within generic mental health teams (Pelosi & Birchwood 2003). Critics of separate specialised services suggest that generic mental health services are able to provide effective clinical care for people with severe mental illness but that specialised services are 'diverting resources' from those teams (Pelosi & Birchwood 2003). Consultant Psychiatrists have also expressed concern that the implementation of specialist mental health teams would have a negative impact on other mental health services where specialist services were attracting 'good staff' away from generic mental health services (Harrison & Traill 2004;Pelosi & Birchwood 2003).

Ethical concerns and service users' positive views on specialist care support the rationale for the provision of specialist EISs. There are few other areas of health care where severely ill young people would be treated in adult wards by non-specialist teams. Moreover, national policy directives emphasise the importance of providing services adapted to the priorities and wishes of service users (Department of Health 1999a;Department of Health 2000). Furthermore, research evidence suggests that service users prefer the care provided by specialist services for FEP compared to what they have experienced before as either inpatients or outpatients, or care provided by standard mental health services (O'Toole et al. 2004). This was due to specialist services delivering care that conformed to NICE guidance on the management of schizophrenia (National Institute for Clinical Excellence (NICE) 2002), which included involving service users in

treatment decisions, flexibility of appointment times, and 24-hour access to resources and support, community treatment, high nurse to patient ratio, and service users feeling listened to and understood. In addition, carers in Switzerland held positive attitudes towards early diagnosis and specialised services for early detection of psychosis (Lauber & Rossler 2003). These positive attitudes were due to having the opportunity to cope with the difficulties associated with the illness earlier.

2.6 Models of service development in the UK

The recent Department of Health guidance document, the *Mental Health Policy Implementation Guide* (MH PIG) (Department of Health 2001) specifies the key strategic, organisational and policy objectives in establishing EIS teams. This document also provides details of a service model specification, allowing for local variation. A useful framework for classifying EIS models that has been adopted in the UK includes:

- stand-alone model

- hub-and-spokes model

2.6.1 Stand-alone

- MDT, including health and social work professionals

- independent first episode team:may or may not be consultant-led; if not consultant-led, has links with consultant, staff grade or registrar

- manages cases from inception up to three years (recommended by National Service Framework for Mental Health) (Department of Health 1999a)

2.6.2 **Hub-and-spokes**

- variation on stand-alone version

- multidisciplinary

- first episode psychosis care provided by specialists ('hub') who provide advice, consultation and therapeutic interventions

- mainstream mental health services (the 'spokes') hold primary responsibility for service users' care under the Care Programme Approach (CPA) and receive specialist input from 'hub'.

2.7 Current policy framework for promoting interprofessional working within mental health services

Interprofessional working within mental health services has been a policy goal of UK Government since the 1970s. This policy acknowledges the interconnected and diverse patient needs in the fields of mental health, social services, housing and education, with the aim of making service delivery more efficient and effective. Specific policy guidance in the form of the National Service Framework for Mental Health (Department of Health 1999a) has advocated that service delivery should be multi-agency in nature.

More recently, the Health Act (Department of Health 1999b) introduced legislation creating a Duty of Partnership on health and local authorities to encourage more flexible and innovative ways of working. Combining resources into pooled budgets that are available to both health and local authorities facilitates the commissioning and provision of services.

2.8 What makes an effective multidisciplinary mental health team?

Despite the rhetoric of evidence-based policy and practice, there has been limited empirical research on the negative or positive implications of interprofessional working. Previous work, largely focused on CMHTs, suggests that interprofessional working cannot be achieved through legislation alone and has, in fact, rarely been achieved in practice (Onyett 1999).

Key themes from research on the threats to effective interprofessional working within the setting of CMHTs include (Peck & Norman 1999):

- loss of faith by mental health professionals in the system within which they work

- their strong adherence to uni-professional cultures

- absence of a strong philosophy of community mental health services which is shared by all groups

- mistrust of managerial solutions to the problems of interprofessional working.

Findings from a study exploring interprofessional role relations within CMHTs suggest that psychiatrists were resistant to organisational changes related to the working practices and team approach of CMHTs (Peck & Norman 1999). Power and status issues were also issues of concern to psychiatrists. They did not agree with 'peer equality of status' and 'democratic decision making' and their professional identity did not involve a 'team identity' within CMHTs (Peck & Norman 1999). However, effective team working within CMHTs requires teams to make joint decisions where

different professions have equal status (Burns 2004). These findings expose some of the cultural and professional differences that exist between the mental health professions.

A study exploring the factors that either facilitated or hindered effective teamwork in multidisciplinary mental health teams in Australia and New Zealand identified role confusion and role conflict, including leadership role, differing understandings of responsibility and accountability, and interprofessional misperceptions as obstacles to effective teamwork (Herrman et al. 2002). Research on the perceived roles and functions of psychiatrists, from the perspective of medical and non-medical team members, in multidisciplinary mental health teams in Australia identified similar obstacles to effective teamwork (Tan 2001). Team and leadership roles were unclear, and professional cultural differences between medical and non-medical staff contributed to role confusion (Tan 2001).

It is important to remember that current working practices and staff assumptions must be taken into account in developing NWW and providing services in ways that differ from traditional practice. To adapt to NWW, teams need to reflect on the factors that make a team effective and consider obstacles and barriers that limit effective interprofessional relationships and teamwork.

2.9 Multidisciplinary and interprofessional working: EIS context

The implementation of community based mental health services has led to the development of MDTs to assess and treat patients in the community. The implementation of specialist EISs and their multidisciplinary approach to FEP care has similarly required the development of interprofessional working within mental health between professionals from different backgrounds and between mental health, social work, housing, education, users and carers, and the VCS (see Section 3.5: Partnership working in mental health).

2.10   New ways of working

Confusion exists as to the limits of the role of the Consultant Psychiatrist. Documents from the General Medical Council (GMC) and the Royal College of Psychiatrists (RCP) have provided guidance on this issue and there are legal roles and responsibilities set down in the Mental Health Act (1983). Interim guidance from the National Steering Group, *NWW for psychiatrists in a multidisciplinary and a multi-agency context* (National Institute for Mental Health in England et al. 2004), highlighted the need to redefine the roles and responsibilities of psychiatrists and pilot NWW within MDTs that promote more flexibility in responding to local need and encourage a better use of psychiatry expertise. The final report from the National Steering Group (Care Services Improvement Partnership et al. 2005b), co-chaired by the National Institute for Mental Health in England (NIMHE) and the RCP, was published in October 2005. This Best Practice Guidance provides the

framework for mental health services to help them develop NWW for psychiatrists that both support the delivery of person centred care and provide a satisfying and sustainable professional role.

The objectives of NWW are as follows:

- to tailor the role of consultants and all mental health professionals to the new values and service configuration which were described in the National Service Framework (Department of Health 1999a) and NHS Plan (Department of Health 2000), and which aim to address modern day expectations of service users

- to eliminate overworking of Consultant Psychiatrists, reduce their caseloads and allow them greater focus on more complex and higher risk cases

- to respond to the increasing aspirations and ability of non medical mental health professionals for autonomy in clinical decision making and responsibility for patients

- to build MDTs that can provide patients with the widest possible range of skills in assessment and care programme provision

- to ensure all professionals have the continuous support from and surveillance by other professionals that safe practice requires

- to eliminate current confusion over the responsibilities that Consultant Psychiatrists hold.

NWW requires a significant culture change within mental health services. In essence, it suggests that psychiatrists use their skills, knowledge and experience to the best effect by concentrating on service users with the most complex needs, acting as a consultant to MDTs and promoting distributed responsibility and leadership across teams. Examples in the Best Practice Guidance given include:

- moving towards more specialist goals for consultants rather than more traditional generic roles

- an increased number of non-medical personnel able to prescribe

- an increased focus on nurse-led clinics

- consultants to have a more consultative role in the context of new MDTs

- consultants to learn about medical leadership in clinical teams and how to work effectively with leaders from other disciplines

- working towards a model of distributed responsibility

- consultant as the medical lead/champion

- mental health nurses to operate as consultant advisors and advocates

- consultants to act as the experts in mental health and work with the MDT to ensure a comprehensive expert assessment of need

- consultants to act as a full contributor to multidisciplinary processes through a disciplinary relevant contribution whilst at the same time respecting the complementary contributions of other disciplines

- consultants to represent the MDT at tribunals and other legal forums.

There are significant opportunities for innovative NWW and developing a comprehensive service approach within the multidisciplinary EIS teams. The aim of the EIS teams is to provide needs-led mental health services that are local and community based, easily accessible, flexible, non-stigmatising and youth and culturally sensitive. Pursuing these general service principles and policy imperatives on partnership working necessitates a multi-agency as well as a multidisciplinary focus.

3 Partnership working between EISs and the voluntary and community sector

3.1 Aim

The aim of this section is to review the research context and policy background on inter-agency collaboration within mental health that focuses on the development of partnership working between mental health and the VCS.

3.2 Definitions of voluntary organisations

The VCS is diverse, and to highlight this we felt it was important to include as many organisations as possible. We used a broad definition of the VCS in the UK. Kendall & Knapp (1997) stated that any organisations included had to fulfil the following four criteria:

1. **Formal organisation** – this would include organisations with a formal charter or set of rules, and would rule out all informal activities that occur in the community

2. **Independent of government or self-governing** – an organisation should not be under the control of government or any for-profit organisation

3. **Non-profit distributing** – any profits must be put back into the organisation

4. **Voluntary** – there has to be some element of voluntarism, whether as part of the workforce or the Board of Trustees

3.3 Defining partnerships

There are a number of key differences between the voluntary and the community sector. The voluntary sector is seen as a service provider for which assistance in providing services is available whereas the more varied community sector relies on local support from local communities. Both formal and informal partnerships exist across the health and social care sectors. We have defined formal partnerships as those partnerships where formal agreements have been entered into, on both strategic and operational levels, documenting the type of partnership, how it will be managed, and procedures by which agreed aims are achieved. For the purpose of this study, informal partnerships are those where an EIS has established links with the mental health and non-health related VCS in order to take advantage of the opportunities presented by those organisations through which service user needs can be met more fully than EIS resources permit.

The nature and make-up of partnerships vary greatly (for more information, see Forbes, Hayes, & Reason 1998). Therefore, it was important to gain

insight into experiences of both formal and informal partnership working. Collaboration has been defined as:

'Any situation in which people are working across organisational boundaries towards some positive end.'

(Huxham & Vangen 2005)

Therefore, any contact that involved at least two organisations working on behalf of a service user was considered, for the purpose of this study, to represent partnership working.

3.4 Current policy framework for promoting inter-agency partnerships

The role of the VCS working in partnership with other agencies has been a political priority for over a decade (Aldridge 2005). Health Action Zones (HAZ) were introduced in 1997 to reduce health inequalities locally by encouraging the NHS, local Government, the VCS, and the local community to work together in partnership (Department of Health 1997). HAZs offer further opportunities to address determinants of health, for example, housing, employment, income and mental health problems. The *Health Act* (Department of Health 1999b) flexibilities encouraged integrated working between health and social care through pooled budgets and lead commissioning.

The Cross Cutting Review of the Role of the Voluntary and Community Sector in Service Delivery (HM Treasury 2002) allocated significant investment to support the VCS, including the £125 million *futurebuilders* fund (HM Treasury 2003) to encourage VCS participation in public service delivery. In addition, the Compact (Home Office 1998) was introduced to govern relations between the state and the VCS. This was followed by the Strategic Agreement between the Department of Health, NHS and the VCS (Department of Health 2004a), which applied the Compact's principles in the context of the NHS. The 2004 Spending Review (HM Treasury 2004) highlighted the Government's continuing commitment to devolve public services to enable communities to make local decisions based on local need and to encourage joined-up working.

3.5 Partnership working in mental health

Integrated services within a mental health context are of importance as service users often require a number of different services that statutory mental health services cannot provide in isolation (Sainsbury Centre for Mental Health 2000). Partnership working is also considered to be beneficial for service users and their carers, who can often experience fragmented services, a lack of continuity and conflicting information in situations where local agencies fail to collaborate effectively. This has been described in terms of being 'left in limbo', with users and carers feeling that they are failing to make progress through the health care system (Preston et al. 1999).

The VCS has an important part to play in providing exit routes out of mainstream mental health services (ODPM 2004). In addition, the VCS provides useful information and the provision of services to service users, for example, information on benefits, advocacy, help with access to housing, providing financial advice and employment opportunities. As mentioned above (Section 3.4), a range of policies support partnership working between social care and mental health, and effective partnerships are key to delivering Standard One of the National Framework for Mental Health (Department of Health 1999a). This states that Health and Social Services should:

- promote mental health for all, working with individuals and communities

- combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

VCS organisations also have a valuable role to play in combating social exclusion by providing new opportunities and meaningful involvement for service users in their local area. Developing interpersonal relationships with key people in local VCS organisations is important in helping to change attitudes towards people with mental health problems and enabling service users to access employment, vocational, sporting, social and leisure activities in the community (Repper & Perkins 2003). However, engagement with VCS organisations on behalf of service users can present mental health professionals with dilemmas concerning the disclosure of a person's mental health problems. For example, it might be appealing for mental health professionals to deliberately withhold information about mental health problems to avoid any subsequent problems from doing so (Repper & Perkins 2003).

Previous work also suggests that the VCS is valued by service users (Milne et al. 2004) because not only are they seen as separate from the statutory sector, but they also fulfil an 'honest broker' role and can advocate for their clients. Partnership working between the VCS and statutory services is also a way for service user views to be heard (Unwin & Molyneux 2005).

3.6 Barriers and facilitators to partnership working

Previous work on partnership working has focused on partnerships between health and social care (Peck, Gulliver, & Towell 2002), and between local government and the VCS (Cemlyn, Fahmy, & Gordon 2005) rather than health and the VCS.

In a literature review of partnership working, a number of barriers and facilitators to partnership working were identified (Wildridge et al. 2004). Barriers included cultural difference between organisations and lack of role clarity. Facilitators included developing trust between partners and having clear lines of communication. Research on identifying criteria to evaluate partnerships suggests that shared local priorities and service objectives

serve to define the nature of partnerships and how the partners work to achieve those objectives (Glendinning 2002).

In the context of health and social care, having individual organisational goals that overlapped were considered to be facilitators and the main barriers were organisational change as a result of Governmental pressures (Rummery & Coleman 2003). In the context of interprofessional working in CMHTs, individuals may have been protective of their professional identity (Larkin & Callaghan 2005). They found that despite having clearly defined roles, there was a perception that roles were not understood within the team. Limited time and money were identified as the main barriers to partnership working between local government and the VCS, but it was suggested that mutual understanding of each other's roles and responsibilities may facilitate partnership working (Harris, Cairns, & Hutchinson 2004).

The importance of time and resources, enabling staff at all levels to work across boundaries, and the VCS to become equal partners to negotiate change have all been recognised as important factors for effective partnership working in HAZ (Matka, Barnes, & Sullivan 2002). Recognising the need for a partnership in the first place and information sharing are also key aspects of effective partnership working (Asthana, Richardson, & Halliday 2002). For example, previous research on barriers that potentially hinder the development of effective partnerships has found that acknowledgement of the benefit of a partnership is key to the successful development of that partnership (Rummery & Coleman 2003;Wilson & Charlton 1997). A study of the collaboration between statutory and voluntary organisations, in a group of staff and service users of voluntary organisations and NHS mental health professionals, found that effective collaboration with statutory services could be promoted by health professionals recognising the importance of the contribution that voluntary organisations can make (Milne et al. 2004). Furthermore, increasing mutual awareness was suggested as way to strengthen links between the two sectors (Milne et al. 2004).

Developing partnerships may be complicated, however, by time constraints. Time was found to be a crucial factor in allowing relationships to develop and to understand each partner's constraints, objectives and agenda (Wilson & Charlton 1997). Barriers and facilitators to partnership working between health and the VCS from the perspective of Health Board officials were examined in a qualitative study (Coid, Williams, & Crombie 2003). The most common difficulties arose from funding regimes. Funding would sometimes only be offered for 12 months, hence the VCS was unable to plan ahead. The Health Board officials also noted the diversity of the voluntary organisations and suggested that monitoring of financial procedures to ensure accountability should reflect the size of the VCS. Above all, reviewing the research on partnership working appears to suggest that there are fewer challenges to introducing policies than there are challenges related to interprofessional behaviour and organisational cultures.

4 Methods

4.1 Methodology

This section presents a detailed description of the study design and the methods adopted to conduct the study. The section is divided into a description of the aims and objectives of the study, and ethical approval, followed by a description of the study design and data collection methods. The section ends with a discussion of the data analysis approach.

4.2 Aims and objectives

The aim of this study was to explore aspects of partnership and interprofessional working within the context of EISs that emerged from the EDEN Study data analysis, that add value by contributing to broader national debates on NWW in mental health. As there is a lack of evidence pertinent to interprofessional working within EISs, we used an exploratory approach to examine how Consultant Psychiatrists and EIS team members interpret and carry out their respective roles and responsibilities and work in collaboration with each other and with the VCS. The specific objectives of the study were:

1. to explore interprofessional role relations between psychiatrists and non-medical team members and identify challenges created by and constructive approaches to NWW

2. to inform ongoing national work in re-defining the roles of psychiatrists within the context of EIS that may be generalisable to other parts of the mental health system

3. to understand the barriers and facilitators to partnership working between health and the VCS within the context of EISs

4. to identify examples of good practice in partnership working between EISs and the VCS that are generalisable beyond the specific setting to other parts of the mental health system.

4.3 Ethics

This study builds on previous research conducted in the Department of Primary Care and General Practice, University of Birmingham on evaluating the development and impact of EISs in the West Midlands (EDEN Study). Ethics approval was granted by the South West Multi-centre Research Ethics Committee for a substantial amendment to the EDEN Study (MREC/03/6/54). All tapes and transcripts were stored in a locked filing cabinet at the University of Birmingham.

4.4 Study design

Qualitative research methods were used to explore interprofessional role relations between Consultant Psychiatrists and EIS non-medical team members and identify challenges created by and constructive approaches to NWW for psychiatrists. Two data collection methods were used: focus groups and semi-structured interviews. Nine focus groups were conducted with ten EISs out of 12 eligible EISs (see Section 4.5.2: Participants and focus groups) and three focus groups were conducted with Consultant Psychiatrists (one dedicated to EIS and two patch-based) during 2005/2006. Focus groups have been widely used to examine people's experience of the health service (Morgan 1997). The dynamic interaction of the group can provide insights into attitudes, perceptions and opinions, and dissent between participants can clarify beliefs and tap into underlying assumptions (Kitzinger 1994).

In-depth, semi-structured interviews were conducted with Consultant Psychiatrists who were unable to attend one of the three focus groups. This method of data collection was useful in exploring views that might otherwise have been lost in a focus group and in allowing greater in-depth questioning in areas that were highlighted as important in the group setting. It also provided an opportunity to include those psychiatrists who preferred not to take part in a group (Michell 1999). Semi-structured interviews were also carried out with VCS professionals nominated by EIS team members and with Strategic Health Authority (SHA) Mental Health Leads, Primary Care Trust (PCT) Commissioners for Mental Health Services, Mental Health Trust (MHT) Executives and Social Care Trust (SCT) Executives. Further details about the focus groups and semi-structured interviews are presented in Sections 4.5.2 and 4.5.3.

4.5 Data collection

4.5.1 Topic guide issues

Focus groups were held with EIS team members to explore interprofessional role relations between psychiatrists and non-medical team members and to identify challenges created by and constructive approaches to developing NWW. Questions focused on the following issues: roles and responsibilities of team members; management and leadership; characteristics of a good EIS team; partnership working with the voluntary sector, and any other issues EIS team members viewed as important.

Focus groups were held with Consultant Psychiatrists to explore roles and responsibilities, professional identity, working practices and approaches to NWW in EISs. Questions focused on the following issues: defining EISs; roles and responsibilities of psychiatrists in EISs; differences in professional history, culture and language; accountability; management and leadership, and views on key contributions psychiatrists make to EISs.

In-depth interviews were held with Consultant Psychiatrists to explore their views on the same issues discussed in the focus groups held with Consultant Psychiatrists.

In-depth interviews were held with VCS professionals to explore barriers and facilitators to partnership working between health and the VCS within the context of EISs and to identify examples of good practice in partnership working between EISs and the VCS. Questions focused on the following issues: partnership objectives; training; communication; referral pathways; confidentiality; risk assessment; accountability, and policy issues.

In-depth interviews were held with SHA Mental Health Leads, PCT Commissioners of Adult Mental Health Services and CAMHS, SHA Mental Health Leads and SCT Executives (Social Service Directors) to explore funding relationships and contracts between health and the VCS.

The topic guide questions (See Appendix 1: Topic guides) were developed from a priori themes from the EDEN Study data, a literature review, and issues that emerged as the study progressed.

4.5.2 Participants and focus groups

At the time of the study, there were few EISs with dedicated Consultant Psychiatrists working within the team; the majority of EISs used the services of patch-based psychiatrists. It was therefore decided to purposively select two groups of Consultant Psychiatrists: one consisted of dedicated Consultant Psychiatrists and the other involved patch-based Consultant Psychiatrists in order to maximise the potential for comparison and the richness of the data (Kitzinger & Barbour 1999).

We contacted all seventy-two Consultant Psychiatrists working in the West Midlands in 2005 by letter, including detailed information sheets, to inform them about the study and invite participation. This list of 72 psychiatrists was generated from NHS Mental Health Trust information, supplemented by local knowledge. Of these, 39 agreed to participate (78%), 11 refused, and 22 did not respond to the letter or could not be contacted by a follow-up telephone call. Twenty-two were available on the dates of the focus groups, and 14 of these (nine men and five women) attended one of the three focus groups conducted between June and July 2005. The focus groups were conducted during the evening at a hotel located near to the psychiatrists' workplace.

Because the EIS teams varied in size, EIS teams were eligible for inclusion in the study if they were operational and comprised more than two team members. Teams that were not yet operational or consisted only of two team members were excluded. Of the 12 eligible EIS teams in the West Midlands, 11 agreed to participate. Once invited, 10 of the 11 EIS teams attended one of a series of nine focus groups (two teams were combined into one focus group). After agreeing to take part, one EIS team declined to participate due to time constraints. Seven focus groups took place between September 2005 and December 2005, and two took place during April 2006. All were conducted at EIS premises.

On arrival, participants at each of the EISs and psychiatrist focus groups were briefly introduced to the study and topics of interest and asked to sign consent forms and to complete a brief demographic form. The demographic questionnaire included questions on profession, age, gender, year of qualification and key responsibilities in the EIS team. One researcher was responsible for moderating the focus group while the other researcher took detailed field notes of the order of speakers, nonverbal behaviour, observed group interactions, and operated the equipment. An interview guide with a set of predetermined questions and issues to be explored was used (see Appendix 1: Topic guides). Each focus group lasted approximately one hour, was audiotaped with permission and subsequently transcribed verbatim, with all names removed. At the end of each of the focus groups, participants were given the opportunity to add any further comments that had not been covered during the interview.

4.5.3 Participants and in-depth interviews

Semi-structured, face-to-face interviews were conducted with Consultant Psychiatrists (*n*=16), VCS professionals (*n*=47) and with SHA Mental Health Leads, PCT Commissioners, MHT Executives and SCT Executives (*n*=42). EIS teams across the West Midlands were asked to provide a list of VCS organisations they referred clients to. A total of 68 voluntary organisations were nominated: four were from statutory organisations, 10 did not respond, four did not wish to participate, two subsequently changed their minds and decided not to participate, and one organisation no longer existed. Of the VCS professionals contacted, 47 agreed to participate (89%). Participants were interviewed at their workplace. Demographic data on the type of organisation, number of referrals and number of staff, were collected from the VCS professionals (see Table 4).

Sixty-two SHA Mental Health Leads, PCT Commissioners for Mental Health Services, MHT and SCT Executives were approached for semi-structured face-to-face interviews either directly or as contacts from other people between March 2005 and November 2005. Twenty individuals declined to participate. A total of 42 semi-structured interviews were conducted (response rate of 68%). Aspects of those interviews are also described in the EDEN Study report.

Prior to starting, the participants were briefly introduced to the study and topics of interest and were then asked to sign consent forms and provide brief demographic information about the VCS organisation, including type of organisation, the number of referrals per year, the number of paid staff, the minimum level of training, funding, and other partnerships. Each interview lasted approximately one hour, was audiotaped with permission and subsequently transcribed verbatim, with identifying information removed. An interview topic guide with a set of predetermined questions and issues to be explored was used including type of partnership with EISs, training, confidentiality, communication, referral pathways, risk, accountability and government policy (See Appendix 1: Topic guides). At the end of all interviews, participants were given the opportunity to add any further

comments they felt were important but had not been covered in the interview. This procedure was followed for the semi-structured interviews conducted with the SHA Mental Health Leads, PCT Commissioners, MHT and SCT Executives.

4.6 Data analysis

Five verbatim transcripts of each of the focus groups with psychiatrists and EIS team members and five semi-structured interviews with psychiatrists were read independently by LT and HR, and a preliminary coding frame for the analysis was jointly agreed. LT coded all the transcripts, and LT and HL independently read the documents and negotiated the final categories. SS coded all the VCS transcripts with an independent researcher. In addition, SS and HL read 10 verbatim transcripts concerning semi-structured interviews with VCS professionals and developed a coding frame for the analysis. SS and HL independently read the transcripts, and disagreements during this process were discussed until a consensus was achieved. We analysed data collaboratively to determine the reliability of themes and establish the 'trustworthiness' of the findings (Glaser & Strauss 1967). Coded transcripts were then entered into the NVivo software package (QSR International) to further enhance the trustworthiness of the findings and aid data manipulation.

A constant comparison approach was used to interpret the data. Key concepts and categories were identified by using an open coding method from deconstructing each interview sentence by sentence (Glaser & Strauss 1967). Key categories were then compared across interviews and reintegrated into common themes. 'Sensitive moments' within focus group interactions that indicated difficult but important issues were sought (Barbour & Kitzinger 1999). Deviant cases were actively sought throughout the analysis and emerging ideas and themes modified in response (Silverman 1997).

5 Findings

5.1 Aims

We report on the findings of a qualitative study of EIS team members and Consultant Psychiatrists' views on NWW for psychiatrists in EISs, and VCS professionals' and PCT Commissioners' views on partnership working between EISs and the VCS. The aim of this study is to explore aspects of partnership and interprofessional working within the context of EISs and to draw out implications for the wider mental health system.

5.2 Findings

The findings corresponding to the emerging themes are presented in two sections: a) focus group and semi-structured interview data from EIS teams and Consultant Psychiatrists concerning NWW for psychiatrists within EISs, and b) a further section on focus group data from EIS teams and semi-structured interview data from VCS professionals, SHA Mental Health Leads, PCT Commissioners for mental health services, MHT and SCT Executives exploring experiences of partnership working with EIS teams.

We have used representative quotes to illustrate key themes. However, to preserve anonymity of participants we have not identified individuals by their initials or workplace location when reporting data. Instead, names of participants have been replaced with professional discipline, gender and an identification number for psychiatrists and EIS team members. Professional discipline and interview number identified PCT Commissioners, and interview number and VCS category identified VCS interviewees. Within the quotations, information has been added for clarification within square brackets and ellipsis points (…) indicate words or passages omitted from the verbatim quotations.

5.3 Interprofessional working within EISs

Five major themes that contribute to understanding interprofessional working within EISs and NWW for Consultant Psychiatrists are presented in Table 2. The analysis is presented as five major themes, supported by extracts from focus groups and semi-structured interviews.

5.3.1 EIS and Consultant Psychiatrist participants

Demographic details of EIS team members and Consultant Psychiatrists are reported in Table 1.

5.3.2 Early Intervention Service focus groups

The nine EIS focus groups involved 60 team members. The participants consisted of Community Psychiatric Nurses (CPN) (n=34); Psychologists

(n=12); Support, Time and Recovery (STR) Workers (n=4); Occupational Therapists (OT) (n=3); Youth Workers (n=2); Social workers (SW) (n=2); Community Support Worker (CSW) (n=1); seconded Personal Adviser, Connexions[2] (n=1), and Team Secretary (n=1). There were more female (n=36) than male participants (n=24). Participants were aged between 21 and 60 (mean 37.8, SD 9.1) years. Mean numbers of years qualified was 10.8 (SD 7.11) (range 0-28) years (see Table 1).

5.3.3 Consultant psychiatrist focus groups and semi-structured interviews

Of the 14 Consultant Psychiatrists attending one of three focus groups and 16 Consultant Psychiatrists participating in semi-structured interviews, 19 were males and 11 women. The average age of all the Consultant Psychiatrists was 47.8 (SD 6.9). The psychiatrists had an average of 19.5 (SD 8.3) (range 2-33) years service in the NHS (see Table 1).

Table 1. Participant demographic details

Demographic details	EIS team members (*n* = 60)	Consultant Psychiatrists (*n* = 30)
Gender		
Females	36 (60.0)	11 (36.7)
Males	24 (40.0)	19 (63.3)
Age range (years)		
21-30	15 (25.0)	0
31-40	22 (36.7)	4 (14.3)
41-50	18 (30.0)	17 (60.7)
51-60	5 (8.3)	5 (17.9)
61+	0	2 (7.1)
Missing data	0	2
Years qualified		
0-7 years	15 (34.1)	3 (11.5)

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[2] Connexions is a Government support service for young people aged 13 to 19, or up to age 25 for young adults with disabilities. Connexions co-ordinates all the support services young people may need, which may range from careers advice through to specialist drug or homeless services.

8-14 years	16 (36.4)	3 (11.5)
15-21 years	9 (20.5)	11 (42.4)
22-28 years	4 (9.0)	5 (19.2)
29-35 years	0	4 (15.4)
Missing data	16	4

Table 2.   Main themes on interprofessional working and NWW for psychiatrists in EISs

- Importance of multidisciplinary team working in EIS

- Roles and responsibilities of EIS team members

- Roles for Consultant Psychiatrists within an EIS context

- Strengths and weaknesses of dedicated medical input

- Value of EIS

5.3.4 The importance of multidisciplinary team working in EISs

EIS team members across most of the focus groups, with the exception of the smaller teams, described the composition of the teams as multidisciplinary, comprising the following core health and social care disciplines: Consultant and Staff Grade Psychiatrists (dedicated or patch-based medical input), CPNs, psychologists, OTs, SWs, CSWs, Youth Workers, and STR Workers. However, as reported in Section 5.2.1, CPNs formed the largest staff group in our sample, which reflects a typical skill mix of CMHTs (Burns 2004). A typical smaller team consisted of nurses and a psychologist. Each of the EIS teams was managed on a day-to-day basis by a team leader, all of whom came from a nursing background.

The importance of MDT working and, as a consequence of it, interdisciplinary working, was emphasised by all EIS team members. With the exception of clinical psychologists, the majority of the team members described undertaking roles related to the CPA. EIS team members described working as care co-ordinators, responsible for ensuring that service users' care plans were up-to-date and that the care needs of service users were being met by those who were responsible for delivering services. The complexity of mental health, the need to provide comprehensive care and the necessity for cooperation between team members made it difficult for one team member to solve all aspects of a problem or to provide all the support service users required. The quality of care provided therefore depended on the flexible collaboration between team members inside and outside the EIS team. Team members described operating a team approach,

where different aspects of care were provided by different team members for the benefit of service users:

'*We work very closely as a team, like a team approach. So everybody knows everybody else's clients and in that way we work very closely with the clients and it seems to function very well. Working with that sort of philosophy, that team approach, it's quite good as well for issues around engagement. It works very well'*. [CPN, M, 26].

'*…that's just generally how I prefer to work* [in a multidisciplinary way] *so I think that's how clients get the better service'*. [CPN, F, 20].

Decision-making within the EIS teams was shared and this was the preferred way of working. There was some tension concerning psychiatrists making decisions that team members were used to making as a team. Some of the strategic issues were said to be the remit of the Consultant Psychologist, but clinical issues were said to be the team's responsibility:

'*The decisions that we make sometimes are that more consensual…Working in our team has been advantageous as it's allowed us to taste some of that and it's nice. We like to make the decisions, and it would be quite entertaining if the psychiatrists were to join us in the future, but whether that individual would feel the taste as quite as nice? Advise us a little bit more about timing and accountability, a bit more.'* [CPN, M, 8].

Impact of funding arrangements

The dedicated consultants and a few patch-based consultants from the focus group interviews were critical of the funding arrangements of EISs. Several dedicated Consultant Psychiatrists referred to the concept of 'tokenism' arising as a consequence of the current (Labour) Government NHS policy focus on targets, highlighting the gap between policy pledges and implementing policy on the ground:

'*So it's quite a good multidisciplinary approach* [describing EIS composition] *but to the target numbers, nothing like the numbers we need to do decent case working. As far as I'm aware, there's still other EI teams that consist of one person and it's apparently tick the boxes for targets to be met, so the PCTs know that realistically no productive work can be done. So there's quite a lot of, I think, tokenism in EI and teams have been set up without proper resources, or thinking even where medics fit in…'*. [Dedicated Psychiatrist, F, 4].

The skill mix of professional disciplines working in many of the EIS teams was said to be constrained by the team budgets set at PCT Commissioner level. Professionals could not always choose the skills mix of team members or plan for the future in a logical and informed way because of the piecemeal and limited nature of the staff budget available to them. For example:

'*…sort of developing the skill mix of the team here along with commissioners, trying to sort of debate and discuss with commissioners how money is best spent and what sort of needs, the needs of EI as*

opposed to the needs of the skill mix of assertive outreach or crisis home treatment. Sometimes this message doesn't get across'. [CPN, F, 23].

And:

'*…the nature of how our funding has come in, which is it's been absolutely piecemeal, you know, one post or two posts at a time, with a huge pressure to get cases driven by targets and therefore a huge pressure to appoint case managers and case management capacity. We have two case managers, we then got a maximum caseload with the case manager; we had to push and then we got two more posts released and then it's just like that all the time and so whenever there's been money, it's never, we never had the luxury of a big package of money that you could decide, like, well, how do we split that? It's just been one or two posts and always at a time when we've reached a place where we're up to capacity'.* [Clinical Psychologist, F, 7].

Teams appeared to have evolved either as funding had been authorised or through pragmatic decisions. For example, one team suggested the reason CPNs formed the largest staff discipline within their team is that, due to the nursing background and professional training of CPNs, they were perceived to be skilled in managing both the acute medical and potential risk issues that can arise when delivering community mental health services:

'*We certainly went for qualified case managers because we're a small team and the anxiety in the team as a whole was managing people who were poorly. We wanted people who felt quite confident, reminding us that people at times could be quite unwell in the community and so a logical thing would be to go for CPNs because that actually is something that's very familiar to them. We felt we would be judged on how well we could do that, and indeed it impacted on admission rates and if you're trying to home treat you wanted people who were comfortable with dealing with that, and the risk and all those other things that go along with that. So yes, we did specifically target recruitment of qualified members of staff and particularly G-grade nurses…'.* [Clinical Psychologist, F, 7].

These funding issues are also highlighted in the EDEN Study report.

5.3.5 Roles and responsibilities of EIS team members

Each discipline was seen as bringing different skills and perspectives to the MDT as well as their professional responsibilities. Team members acknowledged that they had individual skills that they felt could contribute to an individual's care plan. However, team members described a degree of sharing responsibilities, particularly in terms of caseload and generating an understanding of what was happening in each of the service user's lives on a regular basis.

There was potential for conflict, and breakdown in team working, between medical and non-medical team members. For example, for one dedicated consultant in a focus group, there was concern about team members being involved in management decisions:

> *'…I think what we have to try and do, is what we're very worried about, is the team making management decisions, you know, management by committee. They are anxious about that and I think what I've tried to do is to try and help, try and get them to view it in a different way; to use the team as a resource rather than looking at something that is going to enforce decisions that they don't agree with'.* [Dedicated Psychiatrist, F, 2].

Genericism versus specialism

The MDT model provided flexibility where there was a sense of the whole team taking responsibility for providing care to service users. Within this team approach, responsibility for assessments was shared amongst the non-medical team members, with functional assessments usually involving the full range of professional disciplines within the MDT. As an example, multidisciplinary care planning and comprehensive assessments were usually carried out jointly between two team members in a team that had dedicated medical input from a Consultant Psychiatrist:

> *'We all go out, usually we go out and joint assess with somebody with different skills, like a doctor and a nurse would go as well and bring that assessment back and then anybody that's taken onto a caseload, it's a team decision. We would bring back that assessment to the team'.* [CPN, F, 2].

EIS team members described a generic model of service delivery, which resulted in a degree of role blurring within the team. Psychosocial interventions and behaviour family therapy delivered by both psychologists and team members from other professional backgrounds were given as an example of this way of working. Furthermore, teamwork was described in terms of working flexibly, in a way that met the needs of the service users, with team members using generic mental health as well as specialist skills. For example:

> *'…we look at medical issues, we also look at occupation, social roles, social networks, so I suppose the way we work means that all the roles tend to overlap anyway. But I suppose I have probably less of a focus, more of a nursing focus, because that is where I'm coming from. But I think I would say the more cases we do, our roles pretty much overlap. We try to work flexibly, you know, in terms of what the client needs, you can never take a strict "I'm a nurse, I'm an OT, I'm a", you know, you kind of have to be led by what they want'.* [CPN, F, 20*].

However, in identifying similarities and differences between the roles of different professionals within the team, there were aspects of roles that were acknowledged to be specific tasks or unique responsibilities traditionally associated with a particular profession. As one interviewee said:

> *'I'm an ASW…that's the part of my role that nobody else can do in EI'.* [Social Worker, M, 37].

Another team member commented:

'Yes, I think there is [sic] certain things that only a social worker like [name removed]*, an approved social worker, so only she will do that particular role. Only myself and* [CPN name removed] *will do injections'.* [CPN, M, 25].

Clinical psychologists tended to emphasise their professional responsibilities over their team responsibilities. For example:

'My main role is to offer psychological assessment formulations and interventions, mainly CBT. I'm expected to carry research and teaching; to bring a psychological perspective to team meetings'. [Clinical Psychologist, M, 47].

And:

'I provide psychological therapy, consultation to the team, and do one-to-one therapy and, in particular also neuropsychological assessments. To be available, with a bit of expertise in psychology; to be on hand and consult for the team both in their work and therefore we don't actually carry a caseload'. [Clinical Psychologist, M, 52]*.*

And:

'…my job is to provide assessment formulation and intervention, psychological assessment of clients and carers and then I'll say to develop the psychological expertise, so to do that through supervision of members and training and that kind of indirect work as well'. [Clinical Psychologist, F, 11].

One reason given for a preference for specialism over a generic team working style was that specialism could enable team members to complement each other's different skills and expertise:

'That's why it's all the more reason I think that we, that each of us, maybe stick to a particular area and become extremely proficient perhaps in that'. [CPN, F, 23].

The genericism versus specialism debate also emerged in terms of perceived threats to professional identity. Some team members expressed concern while others were ambivalent when talking about role blurring and the value of generic roles within an MDT. For example, some EIS team members felt that the routine and time-consuming tasks such as transporting service users should be undertaken by non-qualified members of staff, such as support workers. For example, one clinical psychologist stated:

'We are struggling to get true multidisciplinary working. I mean one of the biggest needs I see at the moment is to get some support workers, STR workers, that can help us with generic working like engagement, like getting people to college, transporting people, taking them on the bus, public transport, and stuff like that; and that's one thing that we haven't got any support with at the moment. We've got three trained workers that are doing a lot of support work, particularly myself who I see myself as a sort of specialist clinician but it's very kind of hands on doing anything and

everything and I'm not using my specialist skills a lot of the time'. [Clinical Psychologist, F, 40].

For some team members who objected to an erosion of roles, a generic way of working within a MDT appeared to present a challenge to their professional identity. Team members with strong professional identities and with roles and responsibilities that are seen as traditionally belonging to them, for example Approved Social Workers, Clinical Psychologists and some CPNs, were more likely to be resistant to notions of team genericism whereas STR Workers who have less training and are a new role within mental health were less likely to be resistant. In the following quotation, a CPN links the Care Co-ordinator role to generic working and objects to the consequences of genericism in terms of de-professionalisation of the nursing discipline:

'I hate generic roles. Primarily because care co-ordination with enhanced grades – people just think we're all the same…I do probably the nursing stuff with medication, working with the mum, working with the guy, about concordance with medication and assessing mental health, but he's started to disengage with me. [The STR worker] *for a while did some bicycle riding around the country a bit, he disengaged with* [STR worker] *then went to* [Clinical Psychologist] *who did some psychological work, disengaged with* [Clinical Psychologist] *then came back to me. So it's quite defined pieces of work that we did, and I think that's the strength of the team. One of my pet hates is care co-ordination because it makes people think the same way'.* [CPN, M, 34].

Some consultants also appeared to object to the blurring of professional roles and the following quotes serve as examples of efforts to preserve professional expertise and protect professional boundaries:

'…You do sometimes get nurses who try and tell you what medication to prescribe, and so that's the patient, and then come back and want you to rubber stamp it – that's something that really narks me'. [Dedicated Psychiatrist, F, 4].

'…We see it as our role to do a proper admission physical, like what people used to get when they came onto the ward, and that's our job not the GP's job because it's our patient, our illness, our treatment…'. [Dedicated Psychiatrist, F, 5].

A lack of role clarity, particularly in developing teams where roles were still evolving, also influenced views within teams about the value of generic versus specialists within teams. As one Social Worker said:

'I think there's a lot going on in social work at the moment about wondering where social work is going. I'm not sure where I fit in with the team in a way, you know, my social work role. It's useful to explore'. [Social Worker, M, 37]

One Clinical Psychologist suggested:

'I think it's a tricky issue because I think being a new team we are actually finding our ways through that partly, so I think there is an issue about how

we all see our role and what that covers, and whatever that might be; whether everybody in the team should be doing a core, generic role…'. [Clinical Psychologist, F, 11].

And:

'…as the team has gone on, it feels like the roles have become a bit more defined and kind of narrowed down a bit so before I would have helped probably more with job seeking but now defer to [name removed]… it seems like the role as well has become people's expectations of things of what the role should be'. [STR Worker, M, 31].

However, there were a number of team activities that were seen as generic, and part of all team members' responsibilities. For example, engagement was viewed as a key generic mental health responsibility, an intervention that all team members should allow time for, regardless of professional status within the team:

'My main role is engagement, really. Trying to work fairly intensively with people at the beginning if possible, but the main aim is to try to encourage people to take part in what we have to offer really as a team and to engage in such a way that the client feels like they are a valid participant in their own care and in control'. [CPN, M, 6]

'I take partly a generic role with care co-ordination and am very happy to muck in and get my hands dirty…There are still things that need to be done, whether that's psychosocial or engagement. I do that.' [Clinical Psychologist, M, 36]

Team members talked about the importance of being creative and flexible with engagement strategies. This meant that team members undertook support work or leisure activities in an effort to engage service users:

'I work quite multidisciplinary anyway; … I don't mind going out and taking someone to sort their finances or to get their benefits, or take them down to the job centre…I think that's the nature of the engagement we've got with them'. [CPN, F, 30]

However, despite the view that these types of support and active engagement strategies were valuable in developing a therapeutic partnership with service users, tensions were once again expressed in terms of the value of using certain team members in engagement activities. Some professionals expressed a concern that particular engagement activities were inappropriate for specialist professionals to undertake:

'That's something that's put quite a lot pressure on case managers because on the one hand they've been recruited because they are highly qualified, highly experienced people, but a lot of the job is running around. Sometimes it's being a taxi service really as well'. [CPN, M, 1].

Role innovations

New roles, such as STR Workers and Community Development Workers (CDW) can provide additional flexibility to EISs and, in particular, respond

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to young people's and minority ethnic service users' needs. The relatively new STR Worker role also seemed to be a key part of service user engagement strategies:

'Well, as a STR Worker…which is really a new kind of role, I'm trying to feel out the difference still fully, the full difference between that of a support worker and the difference with the STR Worker. It mainly seems to be wellness and recovery focused, with a kind of plan to recovery, personal and family recovery. Getting people in work…I think the actual job's a mixed bag, it's a bit of everything, mainly engagement and observation with people who ordinarily won't engage with older people or professional people'. [group laughter] [STR worker, M, 31].

However, a small number of team members in EISs with STR Workers described missing being involved in activities typically used as engagement strategies. As one of the CPNs recalled:

'And now we've got STR Worker, I find that I don't do a lot of taking people out to do activities and I really miss that because I think that's quite nice. I think that always helps with engagement'. [CPN, F, 30].

Other key elements of engagement are discussed in more depth in the EDEN Study report.

5.3.6 Roles for Consultant Psychiatrists within an EIS context

Four of the 10 participating EIS teams had varying levels of dedicated consultant time. For example, one team had a lead Consultant Psychiatrist who provided two sessions each week, offering advice on assessments and any complex medical issues. The consultant also provided training and supervision to the team with the aim of developing team expertise. This team also used patch-based psychiatrists within the locality. In the other three teams, Consultant Psychiatrists were based within the team. In the remaining six teams, consultant medical input was provided by a variety of patch-based consultant and staff grade psychiatrists within their geographical area.

There was a sense that the roles and responsibilities of the psychiatrists within EISs had not been discussed, either formally or informally, between the psychiatrists and EIS teams in order to provide role clarity or meet the needs of service users. The dedicated psychiatrists suggested that cultural values and tradition set the boundaries of responsibility:

'I don't think we have actually sat down and said who does what. It's a bit more traditions come in…the doctors would deal with the crisis, the medication, the Mental Health Act, the taking blood… the doctor does that and the case managers do this. I don't think we have specifically sat down and discussed those roles except in a few instances where we needed to sort a problem and said, "well, will you do this?" but we haven't actually sat back'. [Dedicated Psychiatrist, M, 1].

Participants' perception of the role of psychiatrists within EISs was influenced by several factors, including the biomedical model; provision of

support; power, status and professional cultural differences between medical and non-medical team members; interprofessional working practices; clinical authority; assumptions concerning leadership roles; and role confusion concerning responsibility and accountability. Views on boundaries of responsibility also differed between teams and psychiatrists. These issues are discussed in the next section of the report.

Biomedical role

Diagnostic expertise and prescribing skills were identified as key features of the role of a psychiatrist within an EIS (see Table 3). There was agreement within the EIS focus groups and among the psychiatrists that medical expertise, psychiatric knowledge, and the range of skills and clinical services that psychiatrists could provide to the team, such as performing medical and risk assessments, prescribing medication, making complex diagnoses, and contributing to medical reviews, were a major part of the psychiatrist's role within the context of EISs:

'Well, obviously, their main role is they're responsible for decisions involving medication and responsible for risk assessments and medical reviews. They bring all their psychiatric knowledge to team meetings as well'. [Clinical Psychologist, M, 47].

'We prescribe the drugs'. [laughing]. [Dedicated Psychiatrist, F, 5].

'Here, it's fairly hands off in that there isn't a medical lead for the EIS…I wander over there once a week, their ward round, and my responsibilities have been fairly hands off and fairly medical; I do the prescribing side'. [Patch-based Psychiatrist, M, 5]*.*

'It tends to be a fairly medically'ish role…a role of a kind of diagnostic, medication side…'. [Patch-based Psychiatrist, M, 14].

'Sometimes they know [EIS team], *based on their experience, that they need some medical input rather than anything else, and so that's when I tend to intervene'.* [Patch-based Psychiatrist, M, 15].

'Not explicit [psychiatrist role], *it's very much dependent on what you want to do. Being simple, the two major tasks are 1) diagnosis and 2) medication…'.* [Patch-based Psychiatrist, M, 10].

'We use a variety of consultants. We actually attend outpatients meetings, take clients in to see them, to see the consultant, and then statutory meetings as well. So if we feel there is a problem we'll arrange a special meeting with a psychiatrist. Also for prescribing, but apart from that, I can't say we use the psychiatrist for much else, but that is the main role'. [CPN, M, 26].

'People are sent to sector psychiatrists…It's more about the medication issues really, about prescribing for a patient and being part of the CPN review, and somebody to, I suppose, liaise with around second opinions if you're worried by somebody…' . [CPN, F, 12].

Table 3.   Responsibilities of psychiatrists within EISs from the perspective of all stakeholders

> ▪ Prescribing medication
>
> ▪ Diagnostic expertise
>
> ▪ Conducting medical and risk assessments
>
> ▪ Attending medical reviews
>
> ▪ Responsible Medical Officer responsibilities
>
> ▪ Integrative overview

Role of champion

The role of champion was viewed as promoting the development of EISs within the wider mental health community. However, a view was expressed that the role of champion could have a detrimental effect, for example, by appearing to prefer the development and expansion of EISs to existing community mental health services. The champion role was seen as a role that was suited to consultants. For example, one dedicated psychiatrist commented:

'*…So you might be the person who is the champion who is pushing it with the Trust or whatever, and that might be a consultant's role I think. I think it could be'.* [Dedicated Psychiatrist, F, 2].

'*…I think that's always been the case with any new development. It's that whole kind of, yes, if you've got somebody who is putting the energy in, things happen, but it is very easy to think that apathy is there. I mean, I think one of the disadvantages of more specialised EI is because, certainly my take on it is that, actually some of the mainstream psychiatric services are getting much harder and much more medical model and people are getting much worse experiences of mental health services and almost like having a specialist service it's kind of saying well, make sure this group get a good experience, but it can be at the cost of the experiences of other people coming through the acute system. Yes, it would be a good point to sort of follow that path and I suppose that's the opposite in a way because if you've got a hero innovator I suppose the thing is they should be pulling people with them. But you can get a system where the hero innovator surrounds themselves by people who share their attitudes and have a very nice little team, and everybody else is kind of left out in the cold a bit'.* [Patch-based Psychiatrist, M, 14].

The concept, strengths and weaknesses of 'hero-innovators' are discussed in more depth in the EDEN Study report.

Professional dominance

Most dedicated psychiatrists were comfortable dealing with medical risk, clinical crises, and diagnostic uncertainty. Many psychiatrists also felt that their training, experience and higher professional status facilitated their

power and influence, and indeed, in some sense, made them part of a medical elite:

'I think we've got particular areas of skill in coping with crisis and disturbance from our experience that no one else has. But I also think that we have to make a claim for being as good as anyone else in the overall summary, seeing what the story is, putting it all together and trying to make sense of it. There are other people who are very good at that, but I think we are as good as the best person in the team but often better, in fact, in doing that…'. [Dedicated Psychiatrist, M, 1].

'So diagnosis and the ability to know from working with really skilled people over the years what is mad and what isn't…And the second thing is to be able to be the wall when there's a whole lot of people around you making you doubt your clinical judgment…so people telling you "there's nothing wrong with this person, they're just antisocial, I want them off my ward", and to be able to hold your ground…But it also has to do with confidence in your ability that you know what's mad and what isn't and they can say to you "this is not appropriate for my ward", or whatever, and the nurses may not be able to hold out, and the psychologists might not be able to hold out, but because you are invested with the power of the consultant, you can hold out'. [Dedicated Psychiatrist, F, 5].

However, the psychiatrists' professional status seemed at times to be threatened by the possibility that the nursing profession could increase their clinical autonomy through increasingly adopting new roles such as nurse prescribing. They felt that their expert knowledge was being undermined as a consequence of this proposed NWW:

'…We, as psychiatrists, have a very important role to play in terms of achieving diagnostic clarity, being driven, choosing the direction with regard to using medication and appropriate statutory monitoring. Not that other members of the team are not competent…And I'm sure more and more competencies are now being delegated…So to bring that kind of training to the whole thing I think we have an immensely crucial role in that…So I can see on the one hand, psychiatrists being completely dispensed with and maybe it's just going to be nurse prescribers…'. [Patch-based psychiatrist, M, 8].

'…I think all our personal medical aspirations are wonderful but are totally irrelevant to the Government's wishes. And I don't think they care two hoots about that. I think that in this point in time in terms of responsibility, ultimately the relationship is potentially a medical one. Medical staff can fall back on their medical past when in doubt. They are gradually gaining confidence in nurses prescribing, payment by results. I don't know whether you're aware but in nursing, somewhere in outpatients, and the doctor, pay exactly the same rate. So it's not going to be long before PCT staff start paying the nurses and not the doctors, so all our aspirations will go out the window and it will be the cheapest and most efficient that will be adopted'. [Patch-based psychiatrist, M, 12].

Leadership and management issues

There were sometimes differences in levels of understanding of leadership, management and clinical responsibility issues. Several EIS team members and patch-based psychiatrists gave different accounts of the management of EIS teams, giving the impression that the management of EIS teams was also difficult to define.

Most dedicated psychiatrists and some patch-based psychiatrists adopted a 'divine rights' attitude toward leadership that was grounded in notions of their perceived higher professional status, extensive training and greater knowledge and experience compared to other professions in mental health. Dedicated psychiatrists also felt that leadership was either 'earned' or attached to the profession:

'It's there, you either earn it, or you get it from your position or something. And I certainly think that if a psychiatrist isn't in some sort of leadership role and given some sort of leadership role, then there's a problem because the psychiatrist is trained to believe themselves as leaders and I think it gets their interest. I think we should get their interest because of the training and experience they have had'. [Dedicated Psychiatrist, M, 1].

'I worry about teams that don't have a psychiatrist in a leadership role. I think psychiatrists haven't grasped the opportunity. I blame my psychiatric colleagues as much as anything in other organisations. I think it's a tragedy, because I think, on the whole, doctors are recognised as having particular experience, you know, and they should be grasped by the organisation and have some sort of major role'. [Dedicated Psychiatrist, M, 1].

'There is a problem, you see. Anyone can be a manager, I don't really care who is the manager; it can be a SW, a CPN, anyone can be a manager. But their interpretation, their assumption that the manager is the clinical lead is wrong, and I think this is one of the biggest mistakes, which has been all over the country. And therefore you will see now the consultants go to these meetings just like anyone; they don't feel that they are the leader, the clinical leaders of these things, and I think this is wrong because, after all, the consultant is the RMO. If anything goes wrong, even the manager will not be called, summoned, it's the RMO, I'm afraid'. [Patch-based Psychiatrist, M, 8].

'Going back to roles, we actually had in our team a very explicit discussion fairly early on about roles and who was doing what and it was quite difficult but actually quite worthwhile. So we did actually have a bit more clarity and I did feel I had to sort of fight for my clinical leadership role, but I was very clear about that was it'. [Dedicated Psychiatrist, F, 2].

However, in contrast, a few patch-based consultants suggested that team leadership could come from any professional background and did not necessarily have to be a psychiatrist. Similar views were held by many of the EIS team members. It was also felt that the leadership role should be dominated by professionals who are trained in recovery principles, given the recovery ethos of EISs:

'I think a team leader can come from, probably, any mental health professional background and be successful depending on the individual. Although I think it probably might work best if the leader comes from a similar background to, say, the majority of team members'. [Patch-based Psychiatrist, M, 2].

'It doesn't matter really. [Laughter]. *I think it should be a multidisciplinary led team, and I think, I mean at the moment I'm a nurse-led co-ordinator but I don't necessarily think it has to be a nurse that's leading the team but I do think that…I don't know whether doctors are the best people to lead the team. They need to be part of the team, but I think in terms of engaging and working with the clients and understanding how that works I think that is best qualitatively and a non-medical member of staff. But I think what we do need is a dedicated member of staff here to give some development time and give thought to how the service can move forward and to keep it on the medical agenda, because we can do that within the Trust agenda but we're not invited to the senior medics meetings…'.* [CPN, F, 20].

'I don't think it matters. In this team we've got one that works perfectly well, a psychologist. I can see it working well with a nurse or a doctor'. [Patch-based Psychiatrist, M, 5].

'I think anybody who wants to take the lead and fulfil the requirements and can do the job. I don't have a preference'. [Patch-based Psychiatrist, F, 6]*.*

The EIS team members were aware of the widely held assumption and expectation of consultants that the leadership role belongs to the consultant but acknowledged that some consultants were willing to accept equality of status with other team members:

'…My personal experience is that the vast majority of consultants are trained to see themselves at the top of the tree, mainly because that's the way they've been trained to think and the whole education experience for medics in psychiatry and medicine as a whole is geared up to getting a consultant post, there at the top…Having said that, there are others in a small minority of cases, there are consultants who've been through that same educational process, they're actually very happy to work on an equal basis with all members of the team and all others…'. [CPN, M, 8].

In one of the EIS teams with two dedicated psychiatrists, clinical leadership was described as a tripartite arrangement within their team. The Clinical Lead was responsible for leading the team and the two dedicated psychiatrists, one of whom was a consultant grade, took responsibility for clinical management of cases and casework. This arrangement was viewed positively by team members who also mentioned that the Consultant Psychiatrist was not a 'natural leader' nor did she expect the leadership role:

'…I think it was recognised that it's different kinds of leadership and trying to embrace those so that those different views were looked at and embraced within that…[name removed] *isn't a natural leader…so I don't*

think [name removed] *assume that anyway, so* [name removed] *has acquired that'.* [Clinical Psychologist, F,].

Power and status

Some of the EI teams without a dedicated psychiatrist also recognised the value of the power and status of psychiatrists when negotiating access to inpatient beds:

'Getting access to admission base is not the easiest thing in the world to achieve, so where it's required, it's sometimes quite difficult to gain access to beds'. [CPN, M, 8].

Several dedicated psychiatrists acknowledged the power and authority psychiatrists had in terms of making final clinical decisions:

'…I mean, that's a bit of a question about who decides what and who's got the authority within the team. Like when there's a dispute, how is that dispute resolved? And I think in the end the consultant does have the authority'. [Dedicated Psychiatrist, F, 5].

EIS team members also acknowledged the issue of the power psychiatrists had in terms of strategic and operational team issues:

'What it brings to my mind is ultimately, basically, is the power that the psychiatrists have really…We were still targeting those that are most vulnerable in terms of age and need, but basically told to go and do a waiting list…and really if the psychiatrist had been here they would have probably said fine, but because it came from another practitioner it was shot down'. [CPN, F, 23].

However, EIS teams described routinely making clinical management decisions as a team where, regardless of professional status, team members' views were valued and given equal status. This is an issue where there could be tension between EIS team members and psychiatrists:

'I think in terms of clinical management we tend to sort of step away from the hierarchy and everyone's opinion is valued. Therefore, when we make a decision as a team, if you back down and they don't agree with it, you still feel supported in that…We take responsibility as a team rather than individuals'. [CPN, M, 57].

Boundaries of responsibility

Although all participants identified similar key biomedical roles for psychiatrists within EISs, the dedicated psychiatrists expressed more diverse views than most EIS team members or patch-based psychiatrists on their role and responsibilities within the EIS. In addition to incorporating prescribing and monitoring medication, performing medical assessments and diagnostic expertise into their professional role, dedicated psychiatrists identified additional traditional responsibilities as core components of their work, such as coping with crises, forming an integrative overview, performing admission physical examinations, facilitating and supporting team members, including containing team anxieties, supervision, and

negotiating with other health professionals. The dedicated psychiatrists and some of the patch-based psychiatrists talked about the unique aspects of their role, for example, their RMO responsibilities, including use of the Mental Health Act (1983), and their expert skills and functions within the EIS, which their extensive clinical training and work experiences had prepared them for:

'Well the unique bits I guess are the statutory parts of the Mental Health Act and prescribing abilities. Also the kind of, the breadth and depth of training of psychiatrists compared to other mental health professionals and the ability to take that overview, but prescribing is important in being able to look at medical illness in context'. [Patch-based Psychiatrist, M, 5].

'…In very rare events if there was a need to admit the person to hospital to use the Mental Health Act, then that would be my responsibility and I do also have some responsibility in liaising with, providing a link between, the EIS and consultant colleagues, as they tend to perhaps address problems or queries to me, being a sort of peer'. [Patch-based Psychiatrist, F, 16].

'Sometimes you do need quite a strong consultant, you need a role to help people to feel safe managing situations…'. [Patch-based Psychiatrist, M, 14].

'I think you'd expect to be able to contribute specific medical aspects of the patients' needs so, for example, assessments and detailed mental status assessments, psychopathology, the requirements for medication. Also how it involves an RMO in the Mental Health Act, as when necessary in inpatient work, mental status assessment. Having a general integrative overview of the patients and the patient's story as opposed to partial views from different professional's perspective. So, for example, an OT might see a particular case from the OT perspective and be developing activities to integrate into a programme from that perspective. They wouldn't necessarily be expected to see the case from other points of view, and similarly for some other professionals. I think a medical role would be, you would expect to be able to take in all of the different perspectives and progress the case'. [Patch-based Psychiatrist, M, 2]*.*

Several dedicated psychiatrists within one of the focus groups felt responsible for performing the physical health assessment of service users. Concern was expressed that the physical health of service users was neglected by GPs and therefore was, by necessity, incorporated into the psychiatrist's role:

'…We discovered that if we got the GP to do it, there were too many things that could go wrong. You know, like they could refuse to do it or they could do it badly and we would know or they could do it badly and we wouldn't know, or, you know, a million things, so it became really apparent at that stage that we had to do it…'. [Dedicated Psychiatrist, F, 5]*.*

Clinical responsibility

A range of views was expressed about the degree of responsibility that psychiatrists carry. Some participants were more uncertain than others about accountability and responsibility issues. Some EIS team members

believed that psychiatrists carry clinical responsibility for all cases regardless of whether the individual has been seen by a psychiatrist. Others believed that psychiatrists are not held accountable for the decisions and actions of other health professionals. Some of the EIS teams assumed that the Consultant Psychiatrist carried the ultimate legal responsibility as Responsible Medical Officer (RMO) for decisions that were made by other team members.

'There are people who feel that they are in some way responsible for the clinical care of all patients referred to a team regardless of whether they see them or not and feel very uneasy about other professionals taking prime responsibility. I wouldn't really go along with that. I think if other professionals have sufficiently developed seniority in terms of expertise and supervisory, the line of supervision and accountability, and that is backed by the Trust, then I am happy for that situation to develop. So, for example, I'm happy for a situation where we have consultant psychologists, consultant nurses, consultant whatever else, who influence the development of practice within the Trust and they skill up the other professionals in their abilities to take on autonomous working'. [Patch-based Psychiatrist, M, 2].

Within the EI focus groups, there was general agreement that accountability should not be carried by psychiatrists for the standard of care or work of other health professionals. For example, one participant questioned the perception that the consultant takes responsibility for other professionals:

'I'm not sure how much that's been misconstrued though because we are and we've always been responsible for our own clinical practice…And no professional is responsible for anybody else's work. So although there is this perception that the RMO is responsible for everybody else's clinical work that isn't…they can't be responsible for work that other people do. They can be responsible for recommending that something be done, or asking for it to be done, but they can't…Do you know what I mean?'. [Clinical Psychologist, F, 11].

'Well, the professional buck obviously stops with the professional. As professionals we are accountable for our own practice…'. [CPN, M, 39].

'I think that, in fact, the buck stops, yeah in three different places actually doesn't it? It does stop in terms of medical responsibility but it also stops in terms for me as clinical manager, sort of, you know. It would be my responsibility if the team screwed up. But ultimately it's each individual practitioner's responsibility and particularly I think because case managers are care co-ordinators and in terms of CPA if something terrible happens because somebody hasn't had a care plan review or, you know, it does come down to that sometimes. So I think case manager responsibility is actually more onerous in some ways than medical responsibility'. [Team Lead, CPN, M, 1].

The following comment, however, illustrates the ambiguity for some surrounding the issue of clinical responsibility:

'Well, I think we don't know who the ultimate responsibility is at the moment in the team per patient. There is an implicit understanding I think –

the team as a whole taking responsibility with a patient'. [Patch-based Psychiatrist, M, 13]*.*

The 'buck stops with the consultant' appeared to be a persistent perception amongst both EIS team members and some psychiatrists. For example:

'…It's with this changing culture as [name removed] *pointed out about people being more accountable for their own practice, taking on more responsibility, ultimately their own decision making. But if you're getting somebody like a Consultant Psychiatrist joining the team, that's an active part of that team, but not necessarily sitting at the top, then it's on the very unfortunately rare but sad occasions that things do go completely and utterly wrong, ultimately obviously resulting in death, but a team may be very tempted to point out that ultimately it is their responsibility as the consultant. As traditionally that's how it's felt; they take ultimate responsibility. People work under their umbrella. It's all sorts of levels and with that level comes a level of responsibility and accountability, but ultimately there's one person where that buck does stop'.* [STR Worker, M, 9].

Consultant Psychiatrists who provided dedicated sessions to EIS teams appeared to feel that they were held individually responsible for any problems that might occur. This appeared to reflect the more hierarchical organisational structure within those teams with dedicated consultant sessions:

'I think the key thing for all of them, is that actually when it comes down to it, when there's a real problem, you will be the one who is going to have to hold it or make a decision or whatever, and a lot of other disciplines don't have that responsibility I think, don't have that kind of core responsibility'. [Dedicated Psychiatrist, F, 2].

'Well, that would be the consultant that was named as the person that's treating that one in ten and if it happens to be this guy that I have never clapped eyes on, it would still be me'. [Patch-based Psychiatrist, F, 1].

And:

'I mean in some senses the nurses feel they do, like, and they do, although they will always refer to the doctor and the doctor is the one who takes the responsibility, and so they should, that's the way it goes…'. [Dedicated Psychiatrist, F, 5]*.*

Some patch-based psychiatrists discussed innovative styles of approach that match NWW proposed by the National Steering Group (National Institute for Mental Health in England, Changing Workforce Programme, Royal College of Psychiatrists, & Department of Health 2004; National Working Group on New Roles for Psychiatrists 2004). For example, some viewed the development of consultancy relationships with teams and distributed responsibility among other professionals as a good use of their time that might lead to a reduction in their caseloads:

'It's a good use of my time. It's not about supervision as such; it's more about the consultant perspective of the situation, with being asked to look at selected cases'. [Patch-based Psychiatrist, M, 3].

'If you do have a large general caseload in your team, you often find that you have a fairly stuck outpatient caseload, many of whom are also seeing a CPN or a SW, or other members of the team and the outpatient caseload, in some cases, seems to almost be a routine way of working that's done without thinking, that it's maybe not so necessary. So an alternative way of allowing that is to try and break up some of that large caseload stuff that's in outpatients is to delegate the primary contacts for the patient to their care co-ordinator, which is happening anyway. But probably only arrange outpatient reviews as and when necessary rather than routinely every three months or four months, or whatever. I think that could potentially free up quite a bit of outpatient time'. [Patch-based Psychiatrist, M, 2].

However, many of the participants held the view that advising on patients they had not seen would depend on good working relationships with the other professionals, particularly knowing that the professional asking for advice was competent:

'I would be responsible for the advice that was given and that would be dependent on the information given to me and knowing the individual clinician being consulted to, and having a working relationship with them and understanding their strengths and weaknesses. I suppose that would be part of the process really'. [Patch-based Psychiatrist, M, 3].

However, there was one patch-based psychiatrist who held a negative view of distributing responsibility between teams:

'Between teams, effectively teams, I'm saying I don't really like that model, but I work with it. Within my own team, I'm completely comfortable because we work together and that's fine…Also there's a lack of clarity. For example, I've just had a case, I had a consultant colleague leave and I took over the responsibility for a couple of his cases, and the boy is 14 and very psychotic, and he was taken to the cells under a 136, and the nurse from the [name of EIS team] *team was heavily involved. We didn't know anything about it at all. The next think we knew the patient was arriving in the intensive care, the adult intensive care unit here, without a doctor responsible for his medical care and I got a phone call to say he's arrived on the ward. That's what I mean about you can end up not knowing what's going on at all and maybe not agreeing; I didn't agree with that'.* [Patch-based Psychiatrist, F, 4].

5.3.7 Strengths and weaknesses of dedicated medical input

EIS team members described very different experiences in working with dedicated and patch-based psychiatrists. In comparison with EIS teams working with patch-based psychiatrists, EIS teams with dedicated consultant or staff grade psychiatrists expressed positive views about their experiences of working with psychiatrists and valued the psychiatrists for their expertise, particularly with more complex cases. These included

describing the psychiatrist as a 'team player' and, as such, fitting in with the EIS team ethos, being flexible, working 'out of hours', willing to make home visits, and being actively involved in providing family interventions:

'*I think she's* [dedicated psychiatrist] *contributed to team learning, team understanding, as well as assessment of people who are tricky…'.* [Clinical Psychologist, F, 7].

'*…almost acts as a kind of honorary case manager really in that she's very willing to make house visits'.* [CPN, M, 1].

And:

'*…when we started we had a staff grade doctor [dedicated psychiatrist] who was fantastic, you know; if it was difficult to go, she'd go into town. I mean that just worked wonders, you know, we had very little difficulty getting people to outpatient appointments…'.* [CPN, F, 20].

And:

'*I mean our psychiatrist* [dedicated psychiatrist] *has a very strong interest in EI and knowledge specifically on that field, very much so. So I'm a very strong believer in having a dedicated psychiatrist who understands the ethos and I think that's useful'.* [CPN, F, 41].

Many dedicated and patch-based Consultant Psychiatrists emphasised the importance of EIS teams having psychiatrists based within the team because the consequences of the alternative could be delays in assessing cases and the creation of waiting lists. These issues were also discussed in relation to continuity of care. Furthermore, concerns were expressed that in teams reliant on a number of patch-based psychiatrists, different views could be taken about the person from different psychiatrists and differences in clinical management might result. EIS team members also expressed frustration about the difficulties encountered when trying to gain access to patch-based psychiatric clinical services for service users, particularly when the need for a consultation or medical assessment was urgent.

Several patch-based psychiatrists, particularly those who had taken an active role in developing local services, saw the advantages of having dedicated medical input for EISs:

'*I think personally that the EI team would benefit* [from having a clinical lead] *in so many ways. If you have a consultant in your team, or on your team, who is solely dedicated to this team, he would have no distractions, no other distractions, and so on and so forth, and he can work out his job plan that this is what I'm going to do on Saturday, Monday, Tuesday, whatever, and everybody in the team would know who to go to when they need medical advice or changing medication or about an emerging side effect, and so on. How to manage it, how to stop it, switching the drug, and so on and so forth. And most importantly is the continuity. The continuity of care is very important because you will know that patients don't like to be seen, we run here patient surveys as part of the DoH thing, and in every survey you will see that the commonest complaint is "I'm seen by a different doctor every two or three months, I see so many". But this is the*

nature of it. If you have junior doctors who rotate then somebody works for you six months then he's off, then you have a new one. You can't just ask them to sit there; you have to see patients. So there are certain things which are under our control but there are certain things which we can't do much about, but I think that having a medic on the team will ensure clinical continuity, speedy access to the medics, more involvement of the medic in leading, if you like, so it's very, very important, that's my personal view'. [Patch-based psychiatrist, M, 8]

'I wish it could be a multi-disciplinary team with medical cover. I would think that, given my experience, you probably need a dedicated Consultant Psychiatrist who would work as part of the multidisciplinary team doing consultation work and seeing patients as and when needed and that would include carrying a specific dedicated patient load'. [Patch-based psychiatrist, M, 7].

'…We have decided that we will set up our own team, okay, maybe with less people, if you like, and we have concluded that the best way forward is to have a dedicated Consultant Psychiatrist, with that kind of interest. So we are really, if you like, trying to make a point to get the funding for the consultant post, hopefully with a unit doctor as well'. [Patch-based Psychiatrist, M, 8].

'I've done some work with our local PCT in developing various specialist teams over the past two or three years, and the EI team which we're just setting up this year has been the latest of those. You could say they're designed according to local need, but they're also designed according to the allocated resources. Actually in our case it is quite small, so we won't be able to have anything like a fully functioning, multidisciplinary team just for our area with the allocated resources, and we certainly won't have dedicated medical time, at least for the foreseeable future'. [Patch-based Psychiatrist, M, 2].

'I think that is important for the patients' [continuity]. *Patients do feel a lot of grief when they have to go through the same thing again. Individual psychiatrists have different sorts of views about the illness and how to deal with it…'.* [Patch-based Psychiatrist, F, 6].

From the perspective of EIS team members, the effect of not having a dedicated psychiatrist within an EIS team raised concerns about continuity of care; service users having to see different psychiatrists at each appointment, differences in team philosophy or way or working, disagreements with diagnosis and treatments provided by consultants. The following examples from EIS focus groups illustrate the effect of not having dedicated psychiatrist cover, including a lack of shared policy concerning medication, the issue of continuity of care and the logistical difficulties service users experienced having to visit psychiatrists at traditional outpatient appointments, accompanied by EIS team members:

'Of course, their treatment style as well; they don't want to treat someone with a very low dose of antipsychotic for quite a while, while they're

watching, whereas somebody else won't prescribe any medication…'. [Social Worker, F, 28].

'…Since she left, we've had quite a lot of consultants coming and going, I think within the last 12 months we're probably looking at about seven consultants, which has been quite a big issue for us as a team. So I suppose the way we use consultants has changed but also the way clients wish to see consultants has changed as well. So I suppose, I mean consultants are very much, they are a consultant, they come in and do their outpatients appointment and I suppose they kind of go…, but I think it would be nice too if we had a consultant like we did initially who was very interested in development and moving things forward, and I'm hoping that the Trust has found us a permanent consultant…'. [CPN, F, 20].

'Yes I think it's been quite difficult in terms…because within [name removed] *we work with all these centres, and we've got the psychiatrists within that. They all work very, very differently. They all have their own ways of working and you're still the outsider and the relationships that you try to develop with people that you might have close links with, it's harder to maintain when you're more distant. So it takes people longer to respect maybe your opinions, your assessments, your ideas, because you haven't been able to facilitate that long term relationship'.* [CPN, F, 10].

Practical difficulties cited included:

'I think there would be a value in terms of practicality and logistics of having access to a regular, consistent medical professional because working in secondary care for a number of years, the one thing that the patients tend to say is every six months their care is so different. It really did interact with their care and having to build new relationships and go through the same process again and again and again, which is not very therapeutic'. [CPN, F, 10].

'…The amount of doctors that the individual has to see has increased; I've got a client who has been on the books since June and already has seen five medics. It's all within the one team but with five different medics, so to keep somebody engaged, and to stop going over old ground, it's very difficult. You know they're going to somebody new, so that's certainly what's happened with my client…'. [CPN, M, 39].

'And sometimes getting people into outpatients is difficult, they're having to wait two or three weeks if people are on holiday or other reasons. They're just very busy, but it's quite hard to get a home visit. We like to do that if someone is very unwell'. [Clinical Psychologist, F, 40].

Dedicated psychiatrists also discussed the value of teams having dedicated consultant sessions and the disadvantages of a consultant-less team. The significance of dedicated medical input is reflected in the following quotation, in which the view is expressed that a variety of patch-based psychiatrists providing medical input who are not integrated into the team are rarely able to offer a level of consistency in the approach required within the EIS model. The limited involvement of patch-based psychiatrists

resulted in a lack of supervisory support of EIS teams, leading to 'anxious' and 'defensive' team behaviour:

'I think it's partly because they don't have the links with the other parts of the services. I think their medical ethos is very fragmented because they have input from lots of different consultants and they don't have a kind of feeling of a consistent approach emerging from people medically. They don't have a feeling that it's a team where things are held and contained. It's a very anxious team and they are very defensive, very defensive because they don't feel contained, because, you know, it's all over the place'. [Dedicated Psychiatrist, F, 2].

However, some of the patch-based psychiatrists recognised the importance of changing the way that they worked within EISs. They described NWW that reflected core values of EISs such as being more flexible about where they saw patients, placing less emphasis on the medical model, and the importance of providing age-sensitive services:

'Certainly within EI I think the psychiatrist has to work in a different way from, clinically in a different way; that it be less medical or more flexible as regards where they see patients. I think there is much less emphasis on sort of a medical disease model'. [Patch-based Psychiatrist, F, 16].

'Oh, yes, definitely, yes, yes, but I think I am a much more of a kind of social psychiatrist anyway, and I think a lot of the EI model fits in with my kind of attitude within the system'. [Patch-based Psychiatrist, M, 14].

'We can see a 16 year old this afternoon but we prefer the visit to be delayed because I know I've got a SW and a nurse coming on at 1.30 who work with younger people and who don't wear a suit and tie. So I think one has to have that flexibility. I think these are good bits of an EI service'. [Patch-based Psychiatrist, M, 7].

Both traditional working practices as well as NWW were evident from the interviews. EI team members without dedicated medical input described taking clients to see consultants at outpatient appointments or attending meetings with the consultant for prescribing medication. However, this more traditional way of working was perceived to be problematic. For example, hospital based visits to consultants raised issues concerning stigma about the hospital location, logistical difficulties and extensive waiting times:

'It's not ideal, you know, if the psychiatrist is prepared to do more outreach work rather than being hospital based because I think it's a bit old fashioned and all my clients don't like going to the hospital anyway for outpatients because they see it as stigmatising'. [CPN, M, 26].

One team with medical input from a variety of patch-based consultants reported mixed experiences. For example, some consultants were described as being more adaptable and flexible than others, responding to the team's needs, and having *'a slightly different philosophy or way of working'* [CPN, F, 12]. However, this team reported also that referring individuals without clear symptoms to some consultants caused difficulties, with consultants reluctant to assess young people with vague symptoms:

'A recent example is we have a young child who shows signs, early signs of relapse. Now there's staff that psychiatrists usually work with in the resource centres and they would only seek an appointment with that psychiatrist if there were very clear warning signs like that the person's relapsed. So when we asked for an appointment and turned up with this child, who only had sort of vague symptoms, he wasn't very happy with us. The psychiatrist wasn't very happy with it because that's not usually what he expects from us, the team, if you like. So it's difficult really because, you know, obviously we want another opinion if somebody is relapsing and if there are early signs to think about, you know, the way to go, so we've got a lot of chipping away with some psychiatrists, definitely'. [CPN, F, 12].

A further aspect of EIS teams working with patch-based psychiatrists, which was considered problematic, concerned a lack of shared values and principles of EI. Working with patch-based psychiatrists meant that teams had to cope with different ways of working. The issues raised in this regard included differences in EIS core values and ethos. The EIS team members described having difficulty with the dominance of the 'medical model', which some patch-based consultants adhered to and which was at odds with their team values and more psychosocial philosophy:

'I just think they do work with traditional models in psychiatry, and I think they need to operate more towards a social perspective in terms of patterns of psychosis, which means more flexibility and more of an understanding of young people's needs I think rather than treating them as just sticking in needles and expecting them to come to outpatient appointments, which they find distressing a lot of them and having to travel to a place where they might have been recently admitted as well which holds bad memories. So I think they need to sort of evaluate their practice really and move along'. [CPN, M, 26].

EIS teams described strategies they used to resolve issues of concern when working with psychiatrists who had traditional ways of working:

'I think we do a lot of priming really don't we before clients come and speak to them. About this client will work better if you talk about or approach the appointment in this way or that way, and some doctors are more open to that than others. But trying to give the consultant a bit of background, so they know a little bit about the client before they walk through the door. Again, it doesn't really solve the issue but at least they feel like they've done a bit of research and we try most of the time to attend appointments with clients so we can give a bit of feedback to the doctor because sometimes you get that look like, "here we go again", so it helps kind of prompt them, let them know what the doctor really needs to know and to work with them'. [CPN, F, 20].

The same EI team also described strategies they used that involved 'empowering' the service user in those situations where traditional ways of working was seen to be a problem. The service users, for example, were given the opportunity to make an informed choice whether or not to see a new consultant:

'I think also which [name removed] *said earlier, one of the other things is that we do give the clients the choice as well in the sense of we do say to them, "you know, it is up to you whether you do come and see this new consultant, however, should you fall unwell again and we feel there is an emergency then we will be asking them to come and see you, or we'll want you to come and see them". And I think they quite like that because it does give them that sense of empowerment again that they actually have an option. So I think that works because very often then they'll say, "okay then I'll come and see them" …'.* [Occupational Therapist, F, 22].

Other EIS teams that experienced difficulties working with patch-based psychiatrists who did not share EIS values or had different, more traditional, styles of working, suggested reasons for the difficulties and reported ideas for overcoming those problems, including improving communication:

'They're a fairly traditional group in [town name removed] *I think, and there are a number of consultants that have been there for a very long time, and I suppose again, in the main, the majority would be sound in their practice but haven't necessarily moved with evidence-based practice. There are plans in our service specification for a point 5 consultant; but I've been making arguments that it should be whole time equivalent to cover the size of the patch. There's no point in just giving us a bit and then that bit to be of little importance, because if then all you are actually going to use them for is prescribing, it hasn't got a great deal of value to the service. It's also going to be really spread that whole time equivalent and the different styles of them. We've just had to work around that really because we use them mainly in that function. We've had a couple of cases where there has been some difficulties, haven't we? And that's been really down to the fact that you are removed from each other, and I have been always saying about using, use an email, keep such and such informed about what's happening, so it's kind of strengthened the communication'.* [CPN, F, 23].

Some advantages were identified in not having a dedicated psychiatrist. Some EIS team members suggested that not having a consultant within the team led to greater innovation; that the team has been able to operate in a non-traditional way and did not have to negotiate the traditional hierarchical set up:

'…it's freed us up to think outside the box a little bit more and I think that's been really, really valuable…Without a traditional set up, which I think is very difficult to get away from when you have Consultant Psychiatrists in the team. So they kind of take quite a biological approach but also having the traditional hierarchy and I think that may have kept the status quo and made it more difficult'. [Clinical Psychologist, F, 11].

'No profession has a god-given right to assume management responsibility for mental health services and psychiatrists bring with them a lot of negatives. But on the other hand, they are seen to carry influence and political sway. What we have managed to do though is to develop a robust and skilled team in the absence of a psychiatrist in place. The management of this team will remain relatively flat and non-hierarchical'. [CPN, F, 14].

There were some EIS team members who questioned whether appointing a consultant actually represented value for money and identified the importance of finding a psychiatrist who fitted into the ethos of the team:

'I think consultants have a lot of expertise, particularly in terms of prescribing, and if you can get the right person then that's great. If you can't, then you lose a grip of the pursuit of multidisciplinary working and the social model. Also, and back to the issue of value for money, if nurse prescribing comes more firmly on stream then it opens up the debate as to whether you need a medic. If you dismantle what psychiatrists do then there are other options. Okay, they section people but there are moves afoot to change that; there may be other professions that can take on that role'. [CPN, M, 15].

5.3.8 Value of EISs

Many psychiatrists were sceptical of the value of EISs. Negative attitudes included the perception that EISs were the 'latest fashion' in mental health services, resources were being diverted from CMHTs to EISs, psychiatrists would be deskilled, and opportunity costs included EIS teams 'poaching' the best quality staff from CMHTs. There was also a general feeling that more research evidence was needed to support the development and implementation of EISs.

'I think my biggest concern, and I've talked to my consultant colleagues about my concern, in general about all these teams, is that we are risking maybe deskilling our general psychiatrists, do you see what I mean? Because you have the CMHT people seeing the chronic stable whatever, you have the AO teams seeing psychotics difficult to engage and all the rest of it. You have the crisis and home treatment teams seeing people you know, and you have the EI and, in our case, the drug and alcohol and misuse service, so what's left for psychiatrists? And therefore, what is going to happen in our Trust? I think we've begun to see it happening now, that an acute psychiatric unit or hospital like ours is going to end up with the most severe end of the spectrum and probably those with complex needs and those who would mostly be detained under the Mental Health Act because if you're psychotic and you can be treated and managed at home then you won't be coming in here. So unless you're fit you will be sectioned under the Mental Health Act'. [Patch-based Psychiatrist, M, 8].

'…EI teams and Crisis Teams and Assertive Outreach Teams have all been set up by advocates of those particular models; I'm not aware of anybody that has been an advocate of a functional model as against a generic mode. These functional services have been developed piecemeal by people who think EI's a good idea, or that AO is a good idea or that Crisis is a good idea. Nobody's looked at the system that this produces and asked whether that system is a good idea; I have a sneaking suspicion that it's not'. [Patch-based Psychiatrist, M, 5].

'…Getting staff has been a problem because in order to build up the EI teams, somewhere like [town name removed], *it is hard to employ in from*

that side. We usually take people from other CMHTs, which are then diminished causing problems there. So we are affected by that. And very often it's the nurses that have been in CMHTs, they see them dwindling. And in my experience, not my view, it is the better, younger nurses are the ones that want to go into specialised services'. [Patch-based Psychiatrist, M, 11].

'…They take staff away from other services because of the recruitment climate…'. [Patch-based Psychiatrist, M, 5].

'The kind of opportunity costs I've alluded to, because it's not just EI teams, but also AO teams, Crisis Teams, are very attractive to staff because of the capped caseloads. Because they're new services that are regarded as being new and dynamic as opposed to CMHTs, which are set up in contrast…, as being old fashioned, and so they have become very attractive. One of the problems in this CMHT at the moment is that we've lost two out of our five to a Crisis Team, which is a problem replicated across the Trust and across the country, that staff have been pulled out of frontline services to go to set up these teams. That's the opportunity costs. The other opportunity cost is, as I said, that they are very expensive because they see fewer patients per staff member'. [Patch-based Psychiatrist, M, 5].

Several patch-based psychiatrists argued that if CMHTs were better resourced in terms of adequate finance, experience and workforce capacity, separate EISs would not be needed.

'My personal feeling is, we don't need one [EIS] *and what I think is that if the existing CMHTs are brought in and given enough resources - different psychologists, CPNs, people with enough experience - and training is established, then the CMHT can do wonderful work without establishing a dedicated EIS as such. But the fashion of the day seems to be – you should have a dedicated team everywhere. But I am yet to be convinced that they can do a better job than the CMHT, with a properly established, well established, well resourced, CMHT'.* [Patch-based Psychiatrist, M, 13].

Issues were also raised concerning the differences between EISs and other mental health services; whether they could, with additional resources, provide the same services as EISs:

'I also think that diagnosis itself can be very difficult and I can think of several clients that we have at the moment that we will be monitoring quite closely who are not psychotic at the moment but the warning signs are there. So we have quite a lot of experience in that kind of work really, and we work closely with the families and other professionals in trying to support them. So what specifically the EI psychosis team could have in addition to that, I am not entirely sure'. [Patch-based Psychiatrist, M, 3].

'I think there are very profound concerns that EI teams will suck people out of the generic community teams in a way that diminishes their ability to function. I would suggest that most of the work that we're talking about as EI is being done already anyway. I'm not aware of a service where these cases aren't being seen. If it were the case that they weren't being seen, and an EI psychosis service was able to come into an area and increase

awareness and education of those in primary care, as to this issue, I would like that, and to put resource to that educational side of the process, and that could be a benefit of the EI team together with the focus and expertise in that team. My hesitation in taking resource away from generic teams is that, and there's an almost gut feeling side to this, but it comes with experience, and by definition they need to be seeing all the cases that are non-psychotic cases, shall we say, in order to develop that. But I'm not sure that a specific team would work on their remit and their entry criteria if they were only taking people on with a definite diagnosis'. [Patch-based Psychiatrist, M, 3].

Other psychiatrists expressed concerns about service equity issues and problems with the three-year handover process of service users from EISs to CMHTs:

'…That would have been my argument 12 months ago, but pragmatically at the moment I just don't know. People have needs but so then again people that have been psychotic for longer than three years also have needs and what can be seen as a 'Rolls Royce' service for one when the others are getting a shelter service. It does seem difficult'. [Patch-based Psychiatrist, F, 1].

'Anybody that's working is going to have those concerns and the difference between a functional service and a sectorised service, or a consultant led service, or whatever. They all have advantages and disadvantages. But I do have concerns about the handovers between the teams and the waiting lists that are developing…and then expectations will have been raised and as general psychiatrists you get to pick up the pieces'. [Patch-based Psychiatrist, F, 1].

5.4 EIS perspective on partnership working

The findings reported in this section are supported by excerpts from the focus groups conducted with EIS team members, and semi-structured interviews with VCS professionals and PCT commissioners on partnership working between EISs and the VCS are reported in the following sections.

5.4.1 EIS participants

Demographic details of EIS participants are reported in Table 1.

5.4.2 How EIS team members understand partnership working

Coding of the focus group data generated seven themes relating to barriers and facilitators to partnership working. One of these themes related to EIS teams identifying the services that they felt best met the needs of their service users. Three themes related to the perception of the value of the VCS, the challenge of finding services, and factors related to the appropriateness of identified VCS organisations. Finally, three themes represented factors that could potentially facilitate the development of

partnership working and difficulties for team members in responding to the challenges of developing and maintaining partnerships with the VCS.

5.4.3 Identifying need: How can we develop new possibilities?

The first step in forming partnerships between EISs and the VCS was reflected in EIS team members identifying the various voluntary and community services within their local areas which they thought would meet the needs of their service users. Team members described a dependence on the VCS to provide the skills and resources that EIS teams lacked. The type of organisations EIS teams sought included local community facilities that could provide opportunities for service users to engage in sports, arts and leisure activities:

'We do quite a lot of work with particular agencies around particular things in terms of, it might be around training or it might be around personal support or it might be around…so you know linking in with perhaps Turning Point for substance difficulties or linking with Connexions in relation to the personal adviser assistants…We often use their bases to see kids in and they're big referrers to us and they're often jointly supporting kids in schools with us. And there are other agencies where it might be a grant to fit need or to buy up someone's care package. But we haven't actually got a Rethink or a young MIND employee within the team, or someone who comes regularly to team meetings'. [Clinical Psychologist, F,7].

'I think some of that as well though to be honest has strengthened some of that relationship if we as practitioners also have the confidence to actually refer to them as agencies. So it's not just a one way traffic and very often we've acknowledged that we haven't got the skills or we haven't got the resources or, for example, you know it's a specialist area, it's a bereavement counselling, for example, and don't be frightened to actually use those agencies. They're very skilled workers within those agencies and sometimes using them appropriately, actually getting to know them when you use them appropriately. So it's a two way thing…'. [STR Worker, M, 9]*.*

'There's a music project, and local sports centres do special deals for our clients. We've really networked well, I think'. [Community Support Worker, F, 18]*.*

'We have had great support from [local organisation name removed]. *They take people for a day and work with them promoting healthy eating and things'.* [CPN, F, 14].

'It has been informal, but we're looking at making it more formal. But on the whole, we're model building our key partnerships and I think at the moment we're looking at key partnerships with Connexions. We have a meeting with them, with the youth arts and we've been in talks with the local college. Again, we've sort of set up, we've started to set up links with Rethink because we haven't got MIND in [name of town removed]'. [Clinical Psychologist, F, 40].

Developing links with the VCS was seen as one way to address social exclusion issues. Many organisations provided support by offering service users opportunities to become involved in the organisation, an approach that can facilitate social inclusion:

'Rather than bring the voluntary sector into our service, what we tend to do is tap our clients into the voluntary sector sometimes. So we've had some contact where clients have wanted to do voluntary work…it also works the other way around as well, doesn't it? Not just whether voluntary groups can come and work with us but whether we and our clients can work with the voluntary sector'. [CPN, M, 1]*.*

5.4.4 Valuing the VCS

Most EIS team members were clear about the potential benefits of partnership working with the VCS. This appreciation of the VCS appeared to be due both to its ability to be more flexible compared to the NHS, and to the fact that the VC often addressed the important issue of social exclusion. EIS teams acknowledged their skill gap that the VCS could fill and were keen to access agencies with specialist knowledge that might benefit service users. Informal partnership working was stronger where the VCS was valued for providing services that were complex and outside the remit and skills base of mainstream mental health services:

'I think coming from a non-medical background has a massive impact on individuals and them wanting to use services. So I think yes, I think just that kind of being involved in ordinary services, rather than strictly mental health services, is valuable really. Most of our clients who don't particularly want to be seen in mental health services in the first place need to be grounded back in voluntary services'. [CPN, F, 20].

'Sometimes I think as well, sometimes if people have been gaining a very effective service from the voluntary sector…and sometimes if it's the same groups it is easier to access that service, and the individual I think sometimes is actually more comfortable within the voluntary sector because you're away from the stigmatisation and everything else that goes with a big organisation such as the NHS'. [STR Worker, M, 9].

'Young people don't want to attend outpatient clinics, they want to go to places where they feel comfortable and we think that's why they come here'. [CPN, F, 17].

Interestingly, I worked with the voluntary sector for three years before I came to this post. I worked with the NHS prior to that, so I can acknowledge both sides. It's been interesting really because I've seen practice on both sides and I've seen the voluntary sector. I mean they've got a lot to offer. I think the voluntary sector acted more responsive to me. It moved a lot quicker than the big machine at the NHS and I have a lot of respect for the voluntary sector…'. [CPN, M, 13].

5.4.5 Finding services: how can we make links with the VCS?

The VCS were found by a mixture of serendipity and focussed searching. EISs also noted that it was sometimes difficult to find staff capacity to take on this type of essential developmental work:

'*At various times two people will have found out…you went somewhere downstairs and there was an upstairs and you went upstairs and found out it was geared to our age group, and then went and met with them and invited them in to have a talk. You came across someone working with other individuals…'.* [Clinical Psychologist, F, 7].

'*CPNs are very good at finding out about voluntary agencies in their neighbourhood and that's part of a CPN's job really isn't it? The difficulty is because as the* [team name removed], *when we started off with just a couple of CPNs, case managers did a lot of ground work really in making links with all sorts of agencies in this sort of area. One of our problems has been since we've gone county wide, it's actually impossible to have good community links across the whole county. You can't know all the* [names removed] *in* [name of locations removed]. *So it's the neighbourhood, it's actually too big for community workers to understand all the community resources'.* [CPN, M, 1].

[Finding VCS organisations]'*For a while, it's almost part of your induction isn't it? Part of the induction process for a new case manager is that they put themselves about a bit. They get to know all the local resources. In doing that, they create links. They often generate referrals and they generate amounts for training, which again is part of our job raising awareness in the community and then the referrals start coming in and you start filling your case manager capacity and you lose that developmental capacity'.* [CPN, M, 1].

However, some EIS team members described challenges in finding VCS services that were appropriate for the young people who were referred to EISs:

'*Housing and Rethink. Again, MIND has nothing specific for young people and I've been sort of entering into negotiations with MIND. They might be saying they could possibly be one of the providers for our respite service, where in actual fact we are moving down a different sort of provider now. So the voluntary within* [name of town removed], *there are loads of voluntary services really now, particularly for the black and ethnic minority groups. This is what we found, but not from a young point of view. There's a big, massive gap there and so again like this BME worker would be the identified person, you know, that would actually start to develop much more sort of meaningful links'.* [CPN, F, 23].

5.4.6 Suitability of VCS

Shared priorities and principles appeared to underpin the development of some partnerships:

'One of our strengths is working with organisations that are socially orientated because that's what we're about'. [CPN, F, 14].

'Partnerships are not formal. I think one of the things with the forum that we were talking about, the service user forum, we also think about what voluntary organisations can do to get some say in what was involved in that forum as well. There were things that we thought about trying to improve partnerships really. But I suppose what I could say is that we have very good informal links'. [CPN, F, 20].

5.4.7 Developing partnerships

Most partnerships between the VCS and EISs were ad hoc and informal in nature. One team was investigating the development of more formal partnerships to complement their established informal links with voluntary organisations. However, partnership working with fewer partners was easier than trying to develop relationships with numerous partners. Several of the EIS teams had developed strong links with larger national voluntary organisations where funding was viewed as being less of an issue than with smaller VCS organisations. Many of the EIS teams had made efforts during the initial setting up of the team to forge links with the VCS, since in the early stages of EIS formation there had been more time for development activity. Active partnerships had also been developed between EISs and local multi-cultural community groups. This helped to provide services suited to individual needs and respected differences in religious and cultural beliefs:

'We've got links with housing associations and other non-statutory agencies which are less stigmatising for young people. This has come about through development work'. [CPN, M, 15].

'For a while it's almost part of your induction isn't it? Part of the induction process for a new case manager is that they put themselves about a bit. They get to know all the local resources, in doing that they create links. They often generate referrals and they generate amounts for training, you know, which again is part of our job, you know, raising awareness in the community and then the referrals start coming in and you start filling your case manager capacity and you lose that developmental capacity'. [CPN, M, 1].

As a solution to the challenge of developing partnership working, it was suggested that having a community development post within the team was beneficial because it allowed that team member more time to commit to finding local VCS organisations and to develop and maintain good working relationships with them:

'If community development had not been part of my job description, I guess I would have felt that I had less of a right to do development work. As it is, I can, and I think the whole team has benefited because they are able to tap into a range of groups and agencies that we probably would not even know about. It's been great to have it as part of my role'. [Community Support Worker, F, 18].

When asked if this was a feeling shared by the team, there was total agreement:

'It is something that we would do again and recommend to any developing service the need to have this sort of post'. [CPN, F, 14].

VCS agencies were used as and when needed, for example, in obtaining grants for service users or receiving referrals from them. These links were strongest where teams had sufficient resources, such as time or workforce capacity, to engage in developmental community work or where teams had a history of successful working with the voluntary sector that inspired confidence and encouraged further referrals. However, it was acknowledged that developing partnership working with the VCS takes time and effort to maintain relationships. It was suggested that another way to build up the profile of EISs with the VCS would be to publish information leaflets, which could then be distributed to GP surgeries and voluntary organisations. Alternatively, a specific developmental post could be funded to raise awareness and the visibility of EISs in the community:

'I think one of the other ideas, I mean it wasn't specifically for the voluntary sector, but we could do a similar thing that we came up with. Possibly getting leaflets back out there about the service, because obviously these last six months or so the team has had to manage on quite short staff. We've just had to kind of drum our other service along as much as we can but now we're at a stage where staff members are hopefully coming into the team that we can look at these developments. And one of the ideas was getting leaflets back out there. We were specifically thinking of GP surgeries but also spreading them around the voluntary services that are around but also we had said about having an article, which goes to lots of places, like in the free newspapers. So even if they sit at the voluntary sector places, that's just kind of building up the profile. I think it's that kind of way or perhaps whether another open day would be ideal. Or we've talked about having different money, hopefully, for different posts and one of the things that I know [name removed] *had thought of is for one of those posts is that they could actually take that on as a role; getting out there and chatting to people about EISs'.* [Occupational Therapist, F, 22].

Training was felt to be an important issue in developing relationships and facilitating partnerships with the VCS. However, training had taken place early in the development of EISs but decreased as caseloads increased. One EIS team suggested that training days were a potential facilitator to partnership working with the VCS, but that they needed to be recurring to maintain links:

[Facilitating partnerships] *'I think the forum. I mean whether we choose to have a separate forum, like…I think is still up for debate. But I think it's certainly around trying to get those things up and running. One thing that we did do quite successfully, although it's been about 18 months ago, was do a one off day for anybody in the voluntary sector; housing, outreach, anybody really. We did a teaching day for them and that actually helped, and we had a lot of referrals, albeit mostly inappropriate, but it did kind of*

open up those doors for a little while. But I think it is something that you need to do very regularly to keep things going'. [CPN, F, 20].

5.4.8 Maintaining partnerships

One EIS team commented that a large VCS organisation, Connexions, was jointly funding a personal adviser who was integrated into the EIS team. Physical co-location of the EIS and the VCS also created opportunities for easier communication and shared aims and objectives and added to the skill mix of a team. One EIS team was located within the same community building as the Connexions organisation, which contributed to easier access, communication and stronger relationships between VCS members and EIS team members. These factors potentially benefitted service users by providing a seamless service. It was acknowledged that extensive effort was needed to nurture and maintain partnership links, however, time was a limited resource for all EIS teams:

'I'm the [name removed] *person and my main responsibility is to help people get into employment, education, and training, access college courses. Also liaising with employers, such as needing to reduce their* [service user] *hours, and giving careers advice'.* [Personal Adviser, F, 35].

'I think it's very clear that they've got to be sustained and you've got to put a lot of work into partnerships to keep them going. You can't just make the partnership go away, it's got to be constantly fed, constantly supported. And I think that's what happened with [name removed]*, we've got good links with* [name removed]*. We got a presentation and then because we didn't have a lot of contact with them it sort of seemed to drift away a bit. You know, it's something that you've got to constantly feed'.* [Clinical Psychologist, F, 40].

'…The other thing is to remember that when we first set up we had a lot of time to give to development activity because we didn't pick up all our new inceptors. So it was like it was great, you had the luxury of time to go out and, well once you start getting your cases on your books and you've got a lot of assessments to do, your time gets much more reduced. I mean people like [name removed] *has the luxury of time where she's got some time now to explore and find out that she will get to a point where actually she gets saturated and we don't really have anyone within the team who has purely a development role, development worker role, to actually look at those kind of initiatives…We have to incorporate it alongside looking after people who are being case managed. Then I think our capacity has been that because of the way we've been staffed, we had that luxury at the beginning. We have it at the beginning of a new case manager post and we lose it when we get an influx of more cases. It's like, we'll have a run now because we've got someone and an OT coming in new, with freed up caseloads, who will have more time…'.* [Clinical Psychologist, F, 7].

5.4.9 Cultural differences and communication issues

Despite valuing and recognising the benefits of working with VCS, some EIS team members felt that there were also a number of significant costs to partnership working. It was felt that there was a lack of understanding on the part of the VCS concerning different organisational cultures and different ways of working. For example, differences in the use of stigmatising language and attitudes occasionally made it difficult for EIS team members to work jointly with the VCS (see EDEN Study report):

'*To be honest, our links with the voluntary sector aren't any, are not too good really. We've got some sort of links with Rethink, and all sorts of organisations have been welcoming, but one of the issues that we had is around the language themes of mental health. The sort of facilities I suppose within the small rural areas have stigmatised to some extent…so for our clients, we've had to really think about whether we want those links. They've got these posters on the walls that say severe mental illness…*'. [CPN, F, 12]*.*

Another barrier to forming partnerships concerned risk assessments and two-way communication between EISs and the VCS. EIS team members objected to some VCS professionals asking for risk assessments before they would consider accepting referrals from EISs. EIS team members felt that these requests for risk assessments reflected a lack of understanding about psychosis, which indicated that the VCS professionals were associating psychosis with potential violence. It was felt that a solution would be to form links with fewer individuals to enhance understanding of mental illness and that the exposure to service users would also help to banish negative stereotypes:

'*Everybody wants a risk assessment if they go* [to a voluntary organisation]…*we have to send a risk assessment anywhere they go'*. [CPN, F, 30].

'*…I have some specific links with people and then you kind of get them on board as needs be because if you kind of want a successful link with the client, they've got to understand what psychosis is, then it's easier and a bit more straightforward to get other clients into the same organisation. I think that's the way I kind of like to work instead of perhaps having, you know, that you've got 20 different people that you could have links with. Have some specific ones, because as they get to know the clients, and other things well, I think that is one of the things that we're looking at'*. [Occupational Therapist, F, 22].

5.5 Voluntary and community sector perspective on partnership working

The findings reported in this section are supported by excerpts from the semi-structured interviews with the VCS professionals on partnership working between EISs and the VCS.

5.5.1 VCS participants

Of the 63 eligible VCS professionals contacted, 47 (89%) agreed to participate (see Appendix 2: List of VCS interviewees). The organisations that participated varied considerably both by type and size. The demographic characteristics of these organisations are presented in Table 4. The organisations were separated into the following four self-defined categories: 15 housing service providers, 15 youth services, 12 mental health organisations, and five were categorised as 'other'.

Housing providers primarily provided accommodation to homeless people, usually aged from 16 or 18. Some housing providers were specifically for mental health service users, whereas others had a more generic client group. In addition to accommodation, some of the housing providers also provided training. Indeed, in some cases, it was a requirement to have a training need.

Youth agencies worked with young people, ranging from 11 to aged 30. They provided a range of services, including counselling, training, and outdoor/adventure type activities.

The agencies that were categorised as 'mental health' offered a variety of services that were specifically for people with mental health problems. Services included resource cafés, social drop-ins, training and counselling.

The organisations that were categorised as 'other' provided a range of services, including counselling, advice, training and drug treatment services.

The number of full-time paid staff ranged from 0.75 to 368 (M = 43.1, SD = 83.6), and the number of referrals in one year ranged from five to 70,000 (M = 3,999, SD = 13.37). Staff training was available to all, and gaps in training were regularly reviewed. There were a number of different funding streams, including social services and health.

Table 4. Information on types of VCS organisation

Organisation Type	Housing	Youth	Mental health	Other
Number of interviewees	15	15	12	5
Number of referrals				
Mean	334.25	6579.71	689.25	5808.33
Standard deviation	406.52	18365.26	780.21	9692.92
Missing data	7	1	8	2

Number of staff				
Mean	29.45	76.70	18.20	13.50
Standard deviation	29.88	125.02	33.53	7.77
Missing data	5	0	2	1

5.5.2 How the VCS understand partnership working

Four major themes emerged from our analysis of the VCS data. These were:

1. Initiating partnerships, divided into nine sub-themes:
   (a) added value
   (b) client-centred services
   (c) accessibility
   (d) flexibility
   (e) bridging the gap
   (f) cheap option
   (g) amateur status
   (h) dumping ground
   (i) accountability

2. Motivation to work in partnership, divided into two sub-themes:
   (a) networking opportunities
   (b) coincidence of agenda

3. Maintaining partnerships, divided into five sub-themes:
   (a) communication
   (b) working relationships
   (c) role clarity
   (d) joint training
   (e) funding

4. Formal partnerships, divided into two sub-themes:
   (a) formalising procedures
   (b) past history

5.5.3 Initiating partnerships

The VCS professionals were enthusiastic about developing partnerships with EISs in order to provide holistic services and service users not having to negotiate their care with several different organisations.

Added value

The VCS felt that there were certain key characteristics that set them apart from statutory services. They included being client-centred, accessibility, flexibility, and bridging gaps. However, the VCS also felt that the Government viewed them to be a cheap option, and that statutory services

perceived them to be amateurs, and consequently used the VCS as a dumping ground. However, the VCS valued their services, and this was demonstrated by service evaluations.

Client-centred services

Overwhelmingly, the VCS professionals commented that their services were client-centred. One person commented that statutory services just about met service users' basic needs but that non-statutory services were able to provide more:

'*…A lot of services after a long time just appear to meet needs as opposed to wants and potential and dreams. Giving someone a tablet is only the start of a journey'.* [40 Mental Health]

One person stated that they felt that their clients trusted the VCS because they were so client-centred and less target-driven than the statutory sector:

'*It's driven around the needs of the client rather than the needs of the funders…I like to think that because we are not target-driven, we are more holistic and the client group that we deal with feel relatively safe and secure because of that'.* [19 Housing]

Frequently, the VCS professionals spoke about the importance of user views in service planning and delivery. Many of them stated that they were able to engage service-users more effectively than statutory services because the VCS was perceived as more approachable:

'*…We've got access to a whole range of opportunities for service users and one of them would be to be involved in our organisation which is like service users become members of a project management team, can become members of the organisation, can become part of our regional structure, they can be part of our research department…'.* [36 Mental Health]

Accessibility

Many VCS professionals, especially from the youth organisations, spoke about accessibility, stating that they were accessible to the hardest to reach young people. They felt that this was because they often used an approach that would appeal to young people, as opposed to statutory services, whom they perceived as using a more traditional, perhaps less appealing approach:

'*…Some of the training programmes that we run traditionally would be run by bigger providers, by colleges. They are looking at coming out to smaller organisations. So that's really positive and helps us to engage with all sorts of people'.* [16 Youth]

Perceived independence from the statutory services was also seen as a positive attribute that might encourage young people to access services:

'*…Because we are an organisation that stands alone, it's a charitable organisation so it's not perceived to be part of The System'.* [18 Youth]

Accessibility seemed to be closely linked with stigma. Many youth agencies spoke about wanting to provide a non-stigmatising service and stated that young people would feel more comfortable using their services. One person commented on the prospect of having an EIS worker doing a surgery at their premises:

'It could be a good selling point for us in terms of reaching them. We could say it's not necessarily an issue and if you have any needs, we have some support'. [7 Youth]

Flexibility

Another key feature of the VCS appeared to be its flexibility. Many VCS professionals felt that they were responsive to the needs of their clients, and that they had the ability to try new things:

'I think that we are much better than anybody else at engaging communities, at being flexible and reflecting the needs of communities. We are much more responsive and much more accountable. I think we are generally trusted and do tend to offer that non-traditional, non-intimidating, non-scary type of face that nobody else does…'. [2 Youth]

Another stated that the size of the organisation may be the reason for this flexibility. She stated that if she felt like trying something new she could, and she compared it to turning a mini, as opposed to in the statutory sector where it could feel like turning a juggernaut. Innovation seemed to go hand in hand with flexibility, where new ideas could be piloted more easily:

'It's how it is, so that's the factor of huge institutions. Somebody once described it to me, if you want to make a change and do something in a different way it's like turning around a juggernaut, where for us it's like turning a mini. So we can do things differently on Monday morning if we want to, because that's easy to change…'. [45 Youth]

Bridging the gap

Many VCS professionals stated that they were filling the gaps where statutory services were failing and on some occasions were able to take risks. For example, one person stated that statutory services had such stringent entry criteria, perhaps due to funding shortages that some people fell out of the system. They went on to describe an incident where social services refused to enter the house of a client because they had assessed it as too risky. This particular organisation worked with this client until she was not perceived as a risk to social services:

'…Other agencies won't go in because there is a risk with the client. Social Services refused to go into a lady's house because it was in such dire straights. We shouldn't have gone in…but we went in and cleaned it ourselves…Yes there was a risk factor here, so what do we do? Do we do nothing? But we did something about it… we then got Social Services back'. [31 Housing]

There were comments related to the VCS, not only bridging the gaps in service provision, but also actively seeking out where the gaps were as the following comment demonstrates:

'When I first started out 16 years ago, it was to open a hostel for homeless young people which became [name removed]. *When I arrived, I was told to bog off as there was no homeless problem in* [name removed]. *There were lots of people telling us that there wasn't a problem, and there wasn't a problem because no-one had looked for one. We opened the hostel and within a week we had filled all 12 beds'.* [45 Youth]

'Cheap option'

While Government policies explicitly promote the benefits of the VCS, they may have inadvertently reinforced its subordinate role by giving the impression that it is a 'cheap option' in respect to delivering publicly funded services. Although the VCS professionals maintained that they were value for money, they stated that this was not the same as being a cheap option:

'But I think if the Government sees the voluntary as a cheap option, that's where I have a problem. It should be seen as more effective'. [3 Mental Health]

Many VCS professionals stated that they felt able to provide a high quality service that was cost-effective but that there needed to be some recognition of this:

'I think people find voluntary sector organisations more accessible and I think that makes us more effective. But I think that there has to be a true recognition of the cost. Just because we are a voluntary sector it doesn't mean that we can do things on the cheap'. [33 Housing]

Amateur status

There were a number of comments related to the VCS being seen as 'amateurs' by statutory services, although not by EISs:

'…there's a kind of mindset that because you are voluntary, you're amateurish…so you've got to get over that and for people to take us seriously…'. [3 Mental Health]

However, the VCS professionals commented that they were perceived differently once they had built up a relationship with an agency, but there was a sense that they had to earn that trust:

'I guess some professionals take the view that we are not professionals, we are not from statutory agencies and therefore we are not important. But on the whole they treat us equally and they can see the value because the fact is, we see their clients more than they do in terms of actual time because we are around them'. [1 Housing]

And

'…They respect me now because I have earned my spurs'. [9 Other]

Dumping ground

Interestingly, and allied perhaps to feelings expressed by some VCS professionals that they were treated as amateurs, a few interviewees felt that their organisation was also used as a dumping ground by the statutory sector. This was usually resolved by good communication and being specific about the roles and responsibilities of all the organisations involved:

'*…We, as an agency, do become a dumping ground. So once they've referred over to us they say, "they're yours now, we don't want them", but that is getting better…what we try to do is say, "we will prefer it if you kept them on your caseload for at least a few weeks and see how things go"'.* [12 Other]

Accountability

Accountability was valued by the VCS in several ways. Many VCS felt that it was important to monitor and evaluate their service to ensure quality:

'*…it ensures the quality gets better because they are benchmarked so it is a constant assurance that the young people, ex offenders are given that assurance if they come into any of our accommodation they will get quality living and service'.* [29 Housing]

Being accountable to the users of the service was considered to be a particularly significant aspect of the work of voluntary organisations:

'*Our service is evaluated internally, but by the client, so what happens is that questionnaires go out and [name removed] are past masters at evaluation questionnaires, hundreds of them! You can take your pick so you can send out client evaluation, referral evaluation, employer evaluation. In my project I tend to send out client evaluation'.* [9 Other]

Many of the VCS professionals commented on the time pressures that the extra paperwork necessitated. One person stated that a full time equivalent staff member was now devoted to administration and paperwork, time that previously would have been used on client work. Another stated that 80% of time was spent on paperwork, rather than with clients and felt they would be able to halve the paperwork and still be able to provide the same quality service:

'*I mean when I first started at* [name removed] *I probably spent about 80% now just sitting and talking to people which is what most of the residents want, just a bit of attention and time… now I'm spending 80% of my time on paperwork, so in some ways the resident can be a nuisance'.* [1 Housing]

Related to the amount of paperwork created from monitoring and service evaluation was full cost recovery. The VCS professionals commented that the cost of services needed to include the cost of monitoring:

'*…I think we need to be accountable for what we do and to produce evidence, but there are cost implications there and they've not paid for perhaps what the services do but that's just for the case workers'.* [34 Other]

5.5.4 Motivation to work in partnership

There were two main factors that were related to whether a VCS would want to work in partnership with any agency. The VCS were interested in learning about local services, and this was usually achieved through networking. This then enabled the VCS to check whether local agencies had shared objectives, or 'coincidence of agenda' before deciding whether it was useful to work in partnership.

Networking opportunities

Networking was valued by the VCS and was viewed as a way to establish contacts with organisations that may have similar targets, including EISs. The VCS were proactive in networking, and new members of staff often spent time getting to know local services:

'*I think networking is important, you know. I have been in the organisation for two years and if it hadn't been for the fact that I spend most of my time out of the organisation networking with agencies right across all sectors, I don't think [name removed] would have progressed as much as it has…but the only way I have actually managed to establish us locally is by working in partnership and networking with both statutory and voluntary sector agencies, particularly things like the EI service'*. [38 Other]

However, due to time constraints, they often had to prioritise which meetings to attend and who to network with:

'*There's a time aspect to that and time is very precious. It then takes away client time and service user time and that's got to be the most important thing. But it's nice to have open days where you can do a lot of networking in a very short space of time and that doesn't take up a huge amount of your diary time either'*. [25 Mental health]

A difficulty associated with networking was getting to know all the relevant local services, and this included becoming aware of EISs. This was sometimes by chance:

'*It's about two years ago, the psychologist that was setting up the team and I were working together coincidentally and I felt it would be very good for the new service he was setting up was based in a youth friendly environment which again was the whole focus of early intervention services, that they should be youth friendly'*. [45 Youth]

However, many of the VCS professionals stated that EIS team members had attended staff meetings or training events to do a workshop on the nature of EISs and on FEP, especially when EISs were in their development stages:

'*…early intervention did a play. That was in the early stages of early intervention when they launched it'*. [30 Mental health]

'*I have attended the workshop in* [name removed] *when early intervention came to being and came to introduce themselves and I know of a similar workshop happened in* [name removed] *also. Whenever my colleagues feel*

they need support from early intervention services they may get in referrals so it is a very good working relationship'*. [7 Youth]

Coincidence of agenda

There was agreement among many of the VCS professionals that partnership working was necessary to provide services to their clients, as no one service in isolation could provide all services. Someone already engaging in a formal partnership with EISs suggested:

'*I think nobody can know everything or do everything and so the only way we are going to get this all round is by cultivating and developing partnerships'*. [45 Youth]

The same person went on to say that working in partnership could be to the benefit of both organisations as they could help each other reach their targets, referring to this as a 'coincidence of agenda':

'*…They will need to hit their targets. If I can help them hit their targets and they can help me hit mine, then we can all work together. The Chief Executive of our PCT calls it coincidence of agenda'*. [45 Youth]

It was important to establish whether there was coincidence of agenda between organisations, and this usually occurred at the networking stage. The majority of the VCS professionals commented on the informal nature of their contact with EISs, and this was because more formal partnership working was not considered necessary. This was because many of the VCS professionals interviewed provided generic services, and EIS service users accounted for only a small proportion of VCS referrals:

'*It's a very informal really we have very little workings with the early intervention'*. [29 Housing]

'*I'm trying to think, in terms of numbers on our project, I would say probably less than 10%'*. [6 Youth]

A facilitator to partnership working was where coincidence of agenda existed and working practices and styles of EISs were similar to the VCS. There were comments about EISs having comparable working patterns to the VCS in sharp contrast to other statutory mental health services as the following comment demonstrates:

'*There are similar styles of working, which help because we're community based, and so are they, more so than the old resource centre mental health services'*. [37 Housing]

Some VCS professionals felt that EISs were different from conventional mental health services. Words such as 'pragmatic' were used, particularly from mental health organisations that may have had previous experience of more conventional teams. Comments were also made about the type of staff that EISs attracted, in comparison to other statutory mental health services:

'*I think the good thing about EI is that mostly the core members of those teams are people who actually believe in working with people who challenge them*'. [36 Mental health]

5.5.5 Maintaining partnerships

There were a number of factors that facilitated both informal and formal partnerships. They included, communication, working relationships, role clarity, joint training, and sustainable funding.

Communication

There was consistent evidence to suggest that good, clear channels of communication were one of the most significant factors, underpinning relationships with both EISs and other health and social care organisations. At a general level, the following point was made:

'*So in terms of organisation, you know its about organisations recognising that we, if we're all working for the benefit of the clients, then we have a responsibility to engage with each other, to share information and that kind of thing. But I think it is about having those individuals as well who want to see that happen. Because you know, someone once said that every enquiry that there's ever been, and god knows in mental health there have been loads of enquiries, there's never been an enquiry that has said the problem was because communication was good. It's always because there was poor communication*'. [3 Mental health]

Continuing with this theme, the same person said:

'*It's key. If you're not communicating, you can't do anything else. If you can't talk to each other in one shape or form, then nothing's going to happen, so for me that is crucial…they're going to fall out sometimes…but then if you don't communicate, you don't even get chance to discuss those issues…*'. [3 Mental Health]

One person described how partners from different organisations needed to speak in simple language, and to avoid abbreviations and acronyms. They went on to describe an incident that demonstrated how it could lead to misunderstandings:

'*I have witnessed a conversation between health people and education people around the SHA and one group thought they were talking about the Strategic Health Authority and the other thought it was the Secondary Heads Association. And you find all these silly things, where these three letters mean the world of difference between health people and educational people, and it's fascinating that they never thought there could be another meaning of these three letters*'. [43 Youth]

Where the formal partnership with the EIS was newly formed, the VCS professional highlighted the potential for difficulties to emerge due to organisational and cultural differences. However, they felt that clear lines of communication would help to overcome these hurdles:

'*As long as the communication is open and we're frank and honest with each other and committed to the partnership, we can discuss those things and nip them in the bud before something happens*'. [42 Housing]

Communication channels were generally described as clear and efficient between the VCS and EISs, especially in relation to confidentiality and risk. Many of the VCS professionals commented on the importance of receiving confidential information and risk assessments from statutory mental health services, including EISs. In some areas, an 'information sharing protocol' (ISP) existed which was an agreement between Social Services, the NHS and various VCS organisations. This enabled anyone signed up to the ISP to share relevant information between them, including risk assessments:

'*There's a new information sharing protocol set up between the local voluntary and statutory sector and I think everybody, not just the EIS, but all the services now, are much more willing to share care plans and risk assessments*'. [4 Mental health]

Working relationships

Good communication was underpinned by good working relationships with EIS staff. It was noted, however, that relationships tended to have been formed between two individuals rather than at an organisational level. This was particularly true for informal partnerships between the VCS and EISs, and raised concerns about the potential fragility of such relationships:

'*It's very effective because we have got a good relationship. We both know what each other is trying to achieve, we both understand each other's huge workload as well… I mean it would be nice to have something more formal in place because if anything happens to either him or myself, then a lot of that relationship would disappear, if you see what I mean?*'. [2 Youth]

However, the good relationships formed between front line staff were not necessarily found at all levels of the organisation in informal partnerships. One person commented on the difficulty of engaging with statutory services at a senior manager level, especially those able to make decisions:

'*It's very, very difficult to get the people who have the power to make decisions within those statutory agencies to fit in with the voluntary sector locally*'. [26 Housing]

Role clarity

The VCS felt that it was important to be aware of exactly what roles both the VCS and EISs would be fulfilling so that duplication of work could be avoided which would lead to service users receiving a seamless service:

'*…sometimes we do a joint meeting with clients and early intervention worker as well and let the client know exactly what we can do with them and what we can't do with them and also inform the early intervention what we're hoping to do*'. [31 Housing]

Joint training

The VCS valued joint training as it was an opportunity to network with professionals and gain knowledge of different working practices from a variety of agencies:

'*I think joint training would be a massive bonus because the discussions that normally go on with joint training and the networking that's done would give understandings from two or three different sides*'. [33 Housing]

Funding

Sustainable funding was an issue for a number of VCS organisations. Many of the VCS professionals commented on the short-term nature of funding. Many VCS professionals stated that they spent considerable time applying for funding, and that not all bids were successful as there was competition:

'*…Because it is not often that it is ongoing funding. Mostly its new funders all the time, so its quite hard to, because there are so many charities developing, the community and voluntary sector is growing and they're all bidding for the same small amount of money so you have to be quite creative in keeping it going. So I dream of the day that I can go back to the same funder year in year out*'. [11 Youth]

A VCS professional commented on the difficulty of short-term contracts in relation to the recruitment and retention of staff and in service planning:

'*If you're an employee you are told at the beginning of January that your contract will end in March and you look for another job. You leave at the end of February and then in March the money turns up…it always does*'. [22 Mental health]

However, one organisation with a formal partnership with an EIS proved to be an exception:

'*At this moment in time it's a five year contract with staff this year for the first year it's four assistant case managers and two vocational workers so its six at the moment but goes up to 11 so in total its 11*'. [42 Housing]

5.5.6 Formal partnerships

Despite the support for partnership working, there were only three formal partnerships with EISs, two had VCS staff integrated into EIS teams and one shared a base with an EIS in the community.

Formalising procedures

One of the formal partnerships that was at a stage of formalising policy and procedures clarified strengths of each of the partners and decided what paperwork to use. Interestingly, the policy and procedures of the VCS were to be used by all the partners, including statutory services. The VCS professional commented on how far partnership working had moved forward, as the following comment demonstrates:

'*…if anybody had told me two or three years ago that we would get the NHS,* [name removed] *and the Borough Council to sign up and say they will work for our policies and procedures while they are in that building, we will do all the first line assessments and they will use all of our paperwork, I would not have believed you'*. [45 Youth]

One of the partnerships where the VCS were to employ staff to work with EISs described how both the VCS and EIS were involved in writing job descriptions for these new staff. The VCS professional stated that this allowed both the VCS and EIS to recruit a diverse range of people, rather than having to focus on professional mental health qualifications:

'*We've had discussions around people having the right attitude but not necessarily having a qualification and how we can still attract those people and work with them and try and develop them and train them'*. [42 Housing]

Past history

In all three formal partnerships, the VCS organisation had worked with the EIS in an informal capacity prior to engaging in formal partnership working. This was useful for building up working relationships. One VCS professional spoke about a smaller scale project, a pilot project, which was useful to see how it would work, and to see how partners met their targets:

'*I've got these relationships with some managers of those teams so this was about us being able to share a vision of what services could look like and how they could be for people but also how we all met our agendas'*. [45 Youth]

5.6 PCT Commissioners perspective on partnership working

The analysis of the commissioners of services semi-structured interview data highlighted three main themes: understanding partnership working, level of commitment to partnership working and perceived barriers.

5.6.1 PCT Commissioner participants

Of the 62 PCT Commissioners contacted, 42 (68%) agreed to participate.

5.6.2 Understanding of partnership working between EISs and the VCS

There appeared to be variability in the level of understanding of the need for wider partnership working incorporating the voluntary sector in EISs. Generally, those individuals who had broader experience of the health and social sector and the VCS (either having worked in the voluntary sector, or held more senior positions, or who had experience in social care) appeared to have a more in-depth understanding of the need for non-statutory sector agency involvement.

'*The other thing I do in my spare time - it does have a bearing I suppose - is run a charity. That does mean that often I work with other wider companies and organisations related to mental health, which can involve EI principles so that does get me wider access than if I was just a SHA Lead and probably a better understanding of the issues involved*'. [SHA Executive: Mental Health Lead, M, 4].

'*I think our emphasis or perspective is different to health. We want to focus on recovery, being able to live in the community and so on. Health seems more narrow minded in a way. We are more used to engaging with wider organisations - we have to - like housing, voluntary groups and so on*'. [Social Service Executive: Director for Organisational Development, F, 18].

'*I think my background in social care has been helpful from one point of view. I'm more used to commissioning services and interacting with colleagues from the voluntary sector from my social care role*'. [Joint Commissioner for Mental Health (PCT), F, 25].

'*Obviously coming from social care, commissioning was deemed somewhat differently and is predominantly with the voluntary sector, an independent sector. So really, I am quite used to this side of things*'. [Joint Commissioner for Mental Health (PCT), F, 33].

'*I suppose I'm rather keen that a major chunk* [of money] *goes to the voluntary sector rather than an NHS Statutory provider. I think they have got a huge role to play - they can relate a lot more to a youth group rather than a CPN or a psychologist can*'. [Joint Commissioner for Mental Health (PCT), F, 34].

5.6.3 Level of commitment to partnership working

Some of those commissioners who had a predominantly clinical background or had less experience appeared to be less committed to the process of wider partnership working. This was demonstrated by their devolution of wider partnership responsibility to others:

'*I don't really have much interaction between the wider non-statutory groups. I think that is down to the operational manager's role rather than mine really*'. [Joint Commissioner for Mental Health (PCT), F, 12].

'*It doesn't really work like that. Someone delegates tasks to me and developing EI is one. But I haven't really got a handle on what is going on within the PCT let alone trying to get other groups on board*'. [Joint Commissioner for Mental Health (PCT), F, 6].

'*I couldn't really comment on that. I don't really have any involvement there. I leave that to* [name of EIS Team Leader removed] *as he knows what we should and shouldn't be doing there*'. [Joint Commissioner for Mental Health (Partnership Trust), M, 11].

These less experienced commissioners also appeared to view the process of wider partnership working in what appeared to be a more superficial way. In particular, they focused on performance monitoring aspects of the role and

seemed to experience greater difficulty in establishing wider inter-agency partnership working:

'*My role is really about contract monitoring, performance monitoring of day centres etc. So I take the lead on monitoring things like MIND day centres, Rethink day centres, MIND services, ensure they're doing what we have asked for*'. [Commissioning Support Manager (PCT), F, 21].

'*We have psychologists, representatives from CAMHS, we have a psychologist from adult services and the team manager from EI Services - oh yeah and the finance manager overseeing this service. But no, no users and carers or voluntary organisations at these meetings, no*'. [Joint Commissioner for Mental Health (PCT), F, 26].

'*I don't find it's the lack of mental health that's the problem, it's the number of different agencies I have to engage with. Coming from a provider unit, I'm not used to the degree of inter-agency working that's required at this level*'. [Joint Commissioner for Mental Health (PCT), F, 9].

Two commissioners felt that that their efforts to engage wider non statutory organisations were 'tokenistic' in order to be able to say that their PCT had been working with these groups:

'*We've changed the way our groups work. It used to be a big group with clinicians, managers, users, carers, voluntary organisations and Uncle Tom Cobbley and all. You had to be seen to be doing it. That level of representation has now shifted down a level and we have two groups - a directors level group with senior representation from non-statutory organisations and the other group. It's a smaller group with more authority [the director group]*'. [Partnership Officer for Mental health Development (PCT), F, 12].

'*We set out to get broad representation from all of the stakeholders: so service users, carers, psychologists, psychiatrists, social workers, the voluntary sector- about twenty people in total. My view is that it was unmanageable and we were doing 'what we were required to do' rather than engaging wholeheartedly in the process*'. [Director of Service Development (MHT), M, 15].

It appeared that certain, usually the larger and more established organisations from the voluntary sector engaged with PCTs more frequently:

'*I think our Local Implementation Team is one of the strongest because of this - eighteen members including the strategic health authority, three voluntary organisations, the Black organisations and the Patient and Public Involvement Lead; public health, social care are there, NIMHE and MIND: I'm just visualising who is sitting around the table*'. [Joint Commissioner for Mental Health (PCT), F, 23].

5.6.4 Perceived barriers to partnership working

Three commissioners felt there were negative aspects to partnership working, which included duplication of services and effort and slowing service planning and development:

'*Can be good, can be bad, having a larger number of people on board. Good from the sense that you have a lot of support - wider support than you might do otherwise to get things up and running. Bad from the perspective that you tend to go round in circles a bit as everyone seems to have their own agendas. Never really move forward with any purpose'*. [Assistant Director for Mental Health planning (PCT), M, 15].

'*And people were still sitting in the multi-agency planning group and education didn't seem to have much interest in joining us. We would go round and round in circles and no decisions were ever made'*. [CAMHS Project Lead (Partnership Trust), F, 20]

'*I was talking to somebody from* [area name removed] *from* [organisation name removed] *- it's for young people to gain employment. They were very interested in EI but said all their counsellors work with vulnerable groups anyway so they weren't sure if it was adding anything. I think EI is too specific for some of the younger people. You need services to help young people more generally'*. [Joint Commissioner for Mental Health, F, 33].

Four commissioners described why they felt they had experienced barriers to establishing effective partnership working with different non-statutory agencies, based on issues such as organisational maturity, organisation culture and historical ways of working:

'*There are a lot of issues - for example we are on different pay scales, we have different career trajectories and so on. We all tend to get a different deal, which doesn't actually bode well for a coherent and cohesive team! It's not just social care and health that are different; it's complicated by the other groups such as education and the voluntary sector that we have to liase with'*. [Joint Commissioner for Mental Health (Social Care Trust), M, 20].

'*The more mature Local Implementation Teams say in* [name removed] *have got really good engagement with local services and all of the different elements of the community tend to be well represented. Perhaps the processes of the less established Local Implementation Teams aren't quite up to that yet and so that reflects on their ability to develop effective EISs amongst others'.* [SHA Executive: Mental Health Lead, F, 5].

6 Discussion

6.1 Aims

In this section of the report, we discuss the themes that emerged from all our data, in the context of previous research and in relation to achieving the aims of the study. We present first a discussion of the findings relating to interprofessional working in practice between EIS team members and psychiatrists.

Following this section, we present a discussion of the findings relating to each of the objectives on exploring aspects of partnership working between EISs and the VCS.

In section 7, we draw implications for policy and practice and summarise areas identified for future research.

6.2 Interprofessional working within EISs

Recent announcements by policy and professional groups have emphasised the need for changes in the roles and responsibilities of mental health professionals, including psychiatrists. Increasingly, MDTs provide mental health care and team members and psychiatrists are expected to work together in a more collaborative way than previously. The findings of this study suggest a number of constructive approaches to NWW (see Section 6.2.3).

However, obstacles to effective interprofessional role relations between psychiatrists and non-medical team members of EISs reflect some of the findings of previous research in other settings (Asthana, Richardson, & Halliday 2002;Coid, Williams, & Crombie 2003;Harris, Cairns, & Hutchinson 2004;Larkin & Callaghan 2005;Matka, Barnes, & Sullivan 2002). In addition, our study adds to previous knowledge by identifying sources of tension in the interprofessional role relations between psychiatrists and non-medical EIS team members that could contribute to professional frustration and less satisfactory care for service users and their families.

In the concluding part of this section, we draw together the themes that emerged from the data on understanding the barriers and facilitators to partnership working between EISs and the VCS, and set out the key objectives of this part of the study, including examples of good practice. Furthermore, in relation to partnership working between EISs and the VCS, the views expressed by all our participants – including EIS team members, VCS leads, and PCT Commissioners – suggest that partnership working between EISs and the VCS was seen as positive and beneficial for service users. However, for partnership working to be successful, a range of obstacles will need to be overcome.

The key objective of this study relating to interprofessional role relations between psychiatrists and EIS team members was:

to explore interprofessional role relations between psychiatrists and non-medical team members and identify challenges created by and constructive approaches to NWW.

6.2.1 The importance of multidisciplinary team working in EISs

Developing a MDT is a crucial component of an effective EIS. Individuals with FEP who commonly have multiple and complex needs require care from many professionals, from both statutory and non-statutory services (Sainsbury Centre for Mental Health 2003), including psychiatrists. Therefore teams need to contain an appropriate skill mix so that a comprehensive view of the service user's problems can be taken, a range of interventions can be offered, care efficiently co-ordinated and continuity of care provided.

The majority of the EIS teams that participated in this study did not have dedicated medical input from Consultant Psychiatrists; various 'patch-based' psychiatrists provided medical input on an ad hoc, informal basis within their geographical area. However, the level of understanding of the aims and objectives of EISs, as well as how teams operate, varied amongst the patch-based psychiatrists. One possible explanation is that patch-based psychiatrists were less familiar with EIS principles and philosophy of care because they had infrequent contact with EISs and were more likely to work within a hospital setting, CAMHS, or have links with CMHTs. These differences in understanding have implications for NWW and the way EIS teams function.

6.2.2 Obstacles to effective interprofessional working

Barriers to effective interprofessional role relations between EIS team members and Consultant Psychiatrists appeared to be *operational, structural or professional* (see Table 5 and Table 6). The quality of interprofessional relationships varied between the EIS teams with dedicated and 'patch-based' medical input. Although there were few reported overt conflicts between EIS team members and psychiatrists, tensions highlighted included the importance of communication, trust, leadership, role clarity, cultural differences and differing understandings of responsibility and accountability. These issues reflect findings in a number of other health and social care contexts (Herrman, Trauer, Warnock, & Professional Liaison Committee (Australia) Project Team 2002;Tan 2001).

Operational and structural obstacles

Operational and structural obstacles were a constant theme within the data (see Table 5). In EIS teams without dedicated medical cover, interprofessional role relations between some of the patch-based psychiatrists and EIS team members were strained because of a lack of

shared values and aims relating to the EIS. This lack of understanding of EIS principles led to the absence of a consistent medical approach to individual service users and negative consequences to EIS teams. The dedicated psychiatrists believed that consultant-less EIS teams could become anxious and defensive without the consistent support that a team-based psychiatrist could bring to the team. Indeed, providing supervisory support and advice to EIS team members, particularly in response to anxiety-provoking situations such as managing risk, was seen as an important team-working role by the dedicated psychiatrists.

The patch-based psychiatrists who provided medical input to EIS teams on an 'as needed' basis were described by EIS team members as adhering to more traditional ways of working. This way of working, which was described in terms of the traditional medical model, was often felt to be problematic. The absence of an agreed approach to medication, with treatment that did not conform to EIS principles about the philosophy of care, such as the use of low dose antipsychotic medication, created tensions between team members and patch-based psychiatrists.

Table 5.   Operational and structural barriers to interprofessional working between EISs and psychiatrists

- A lack of shared values, priorities and EIS aims and objectives

- Dominance of traditional medical model

- Care less sensitive to the needs of young people

- Accessibility (location and waiting list issues)

Furthermore, home visits when service users were unwell were difficult to arrange and therefore service users had to attend hospital based outpatient appointments to see patch-based consultants. This raised concerns about the stigmatising hospital location, and the problem of extensive waiting lists, particularly when service users needed to be seen urgently. Continuity of care was also an issue for EIS teams without dedicated medical input. Concerns were raised about service users having to see different patch-based psychiatrists at each appointment, often leading to inconsistent care and the service user having to retell their story. EIS team members saw these issues as obstacles to engagement. Previous work has suggested that individuals are more likely to engage with services that are non-stigmatising and provided within a normalising context (Tait et al. 2004). Furthermore, these working practices are also counter to national policy directives that emphasise the importance of providing services tailored to the wishes and main concerns of service users (Department of Health 1999a;Department of Health 2000).

One possible explanation for the EIS teams' unsatisfactory working relationships with patch-based psychiatrists may be due to the fact that

they have less direct contact with them compared to teams with dedicated medical input to the team where more time spent together appears to lead to better working relationships.

Professional obstacles

The findings of the study raise several key issues relating to the importance of professional identity and its effect on the ability of teams to work collaboratively (see Table 6).

Influences on professional identity

Our data suggest EIS teams valued multidisciplinary working and a teamwork approach, linking this flexible way of working to improving the quality of services provided by EISs.

Within EIS teams with dedicated psychiatrist input, the psychiatrist was seen as an indispensable contributor to the EIS team, bringing extensive medical knowledge to the team, providing expert advice on complex cases and offering emotional support to the team. These EIS teams and the dedicated psychiatrists seemed to understand each other's roles and their respective work-related pressures. The dedicated psychiatrists were described as 'team players', fitting in with the team ethos, working flexibly, providing therapeutic interventions, working 'out of hours' and making home visits.

One reason why dedicated psychiatrists within EIS teams were more open to NWW, in addition to demonstrating an interest in EI by taking up a consultant post within EI, may be that their views had been shaped by the positive interpersonal and working relationships with EIS team members that have developed over time. Consequently, the dedicated psychiatrists may have incorporated the EIS ethos and philosophy of care and value of team working into their professional identity.

There was evidence that roles and responsibilities within EIS teams were still evolving, and therefore it was perhaps inevitable that there would be varying levels of role ambiguity in different teams. EIS teams without dedicated medical input described a different picture (see Table 5). Team members with strong professional identities, such as clinical psychologists, appeared less flexible when defining boundaries in team working; they tended to be resistant to role blurring where they found themselves having to take on support work due to staff shortages or team expectations. There was a feeling that their specialist skills were under-used as a consequence and that routine and time-consuming tasks should be undertaken by less qualified members of staff.

These findings certainly reflect the wider literature in this area. When staff share tasks and operate outside their area of expertise, such as when clinical psychologists or CPNs help organise accommodation for clients or when social workers implement psycho therapeutic programmes, there is often a loss of efficiency (Wall 1998). Putting people in cooperative groups has also been found to erode a sense of professional identity.

Multidisciplinary team working can also be isolating for certain members. This has been shown to be particularly acute for social workers if out posted into an environment dominated by others from NHS backgrounds (Berger 1991).

Table 6.   Professional barriers to interprofessional working between EISs and psychiatrists

- Professional identity issues

- Blurred roles

- Protecting professional boundaries

- Power relations and status issues

- Conflict over leadership

- Unclear boundaries of clinical responsibilities

- Differing understandings about accountability and clinical responsibility

- Barriers to recruitment concerning the value of EISs

Power and status

With respect to power and status, many of the dedicated psychiatrists felt that their training, experience and higher professional status gave them greater power and influence within an EIS. In terms of professional identity, many of the dedicated psychiatrists felt they were part of a medical elite. For example, participant F5 described psychiatrists as holding clinical authority ('*you are invested with the power of the consultant*'). However, some patch-based psychiatrists reported that nurse prescribers might, in the future, undermine the important role of psychiatrists in terms of diagnostic clarity, choice of medication and the statutory monitoring function. They felt their professional identity and status was being threatened by another professional group.

Leadership and management

Most dedicated psychiatrists and some patch-based psychiatrists adopted a 'divine rights' attitude toward leadership that was grounded in notions of their perceived medical dominance demonstrated through their higher professional status, training and distinctive knowledge, compared to other health professionals. This assumption that they were the clinical leaders was a potential source of tension within consultant-less EIS teams. Some dedicated and patch-based psychiatrists indicated that the assumption that the team manager was the clinical lead was a misperception on the part of managers and that non-medical EIS professionals should not be clinical leads. This echoes professional guidance (British Medical Association 2004)

as well as the NSGNWW reports (Care Services Improvement Partnership 2005; Care Services Improvement Partnership, National Institute for Mental Health in England, Changing Workforce Programme & Royal College of Psychiatrists 2005a; National Institute for Mental Health in England, Changing Workforce Programme, Royal College of Psychiatrists, & Department of Health 2004) that assume that the responsibility of leadership in a clinical setting resides with the Consultant Psychiatrist.

However, in contrast, some patch-based psychiatrists thought that any competent professional could take the role of leadership in a clinical setting such as EISs. Their views were therefore more in accord with NWW guidance (Care Services Improvement Partnership et al. 2005b; National Institute for Mental Health in England, Changing Workforce Programme, Royal College of Psychiatrists & Department of Health 2004).

Clinical responsibility

Misperceptions existed about the role of the Consultant Psychiatrist and the limits of their responsibility. This study found that some participants, including EIS team members, dedicated and patch-based psychiatrists, believed that the consultant was clinically responsible for all service users regardless of whether or not they were part of the consultant's caseload. It appeared that this perception of consultant responsibility was associated with the role of the RMO, which is a legal requirement under the 1983 Mental Health Act. However, this perception is unrealistic in terms of the consultant caseload, and was seen as a contributing factor to the development of their unmanageable caseloads; it is one of the key issues debated by the NSGNWW (Care Services Improvement Partnership, National Institute for Mental Health in England, Changing Workforce Programme & Royal College of Psychiatrists 2005a; National Institute for Mental Health in England, Changing Workforce Programme, Royal College of Psychiatrists & Department of Health 2004).

According to the NSGNWW reports (Care Services Improvement Partnership, National Institute for Mental Health in England, Changing Workforce Programme & Royal College of Psychiatrists 2005a; National Institute for Mental Health in England, Changing Workforce Programme, Royal College of Psychiatrists & Department of Health 2004) guidance issued by the General Medical Council (General Medical Council 1998) and the Royal College of Psychiatrists (British Medical Association 2004) has failed to clarify the position of the limits of consultant responsibility. As a result of consultation with the Royal College of Psychiatrists and other professional bodies, the NSGNWW has proposed NWW that distributes responsibility among other health professionals in teams. When necessary, the consultant is expected to provide consultative advice to teams, however, clinical responsibility resides with those team members providing care to service users.

Some of the patch-based psychiatrists viewed the development of supervisory and consultancy relationships with other professionals and the issue of distributed responsibility as a new and positive way of solving the

problem of unmanageable caseloads. They acknowledged that they would be responsible for any advice given to teams but that the advice given would depend on having trust in the competency and knowledge of the professional asking for advice.

The medical profession first attained its professional dominance in health care during the 19th century. The introduction of licensing and regulation of medical practitioners placed medicine in a strategic position to own the powerful technologies that developed during the 19th and 20th centuries (Larkin 1983). The monopoly and the power of the medical profession gave it the ability to control the development and position of other health practitioners by limiting their access to particular roles and particular skills bases. This clear hierarchy of occupations established throughout the growth of hospital medicine and also of primary care is a major contributor to the dominance of medicine in the division of labour (Freidson 1985).

Medical dominance has four foci: the content of its own work (clinical autonomy), control over other professions allied to medicine, of patients and of the conditions of medical work (Freidson 1970). Similarly, there are four approaches used by medicine to maintain its professional dominance over other healthcare disciplines: the subordination of other workers, restricting the occupation boundaries of other workers, exclusion by limiting access to registration and incorporation of the work of other disciplines into medical practice (Willis 1989).

During the last three decades, however, there has been a continuing debate in the sociological literature over whether or not doctors are becoming deprofessionalised (Haug 1973) or proletarianised (McKinlay & Stoekle 1988), and therefore losing their privileged social status and political power. Proletarianisation predicts a decline in medical power as a result of deskilling and the salaried employment of medical practitioners. Deprofessionalisation describes a loss for professional occupations of their unique qualities, particularly their monopoly over knowledge, public belief in their service ethos and expectations of work autonomy and authority over clients, and differences in the way that knowledge is applied through increasing specialisation.

Previous work has suggested that teams are most effective when free from problems related to large discrepancies in status and power between team members (Gair & Hartery 2001). In their study of medical dominance in MDT work in the context of geriatric assessment units, they suggest that where medical dominance is reduced, this is accompanied by a commitment on a part of all members of the team to become involved in the decision making process.

EDEN Plus, however, found that dedicated psychiatrists saw themselves as natural leaders, as elites, and the EIS with dedicated psychiatrists appeared to function well. Indeed many team members expressed a need for team members with a medical background to help in terms of accessing beds, championing the service locally and raising the profile of the EIS with funding bodies.

Whilst this seemed to work well within EISs with dedicated psychiatrists, those teams that relied on patch-based psychiatrists appeared to find intermittent medical dominance problematic. Patch-based psychiatrists, however, appeared to be most comfortable with notions of teams led by non-medical personnel and of distributed responsibility.

NWW encourages nurse prescribing, nurse led clinics and MDT work whilst at the same time suggesting that psychiatrists should become specialists and maintain medical leadership roles. In a sense NWW is encouraging medical professional dominance whilst also encouraging workforce flexibility for allied professionals. In teams with relatively pronounced hierarchical structures (such as those with dedicated psychiatrists) this may be less of an issue than for those EISs with limited medical input, many of whom appear to have risen to the challenge of NWW and may find the proposed elements of medical dominance difficult to incorporate as part of their team ethos or working practices.

Critics of EIS

Not everyone supported either EISs as a NWW or felt that EIS teams needed a dedicated psychiatrist within the team. One EIS team felt that the absence of a team psychiatrist allowed them to be more creative in delivering care and finding solutions to problems, and facilitated innovative ways of working. They felt that if a psychiatrist had joined the team they would have had to work in a more traditional, medical model way and this was felt to be problematic.

Many patch-based psychiatrists regarded EISs with some cynicism. The psychiatrists expressed objections to the implementation and composition of EISs, which they felt had negative consequences for other more traditional 'mainstream' mental health services. For example, the diversion of resources from CMHTs, which was identified as an 'opportunity cost', was a source of concern to some of the patch-based psychiatrists.

Other consequences of setting up specialist teams were that the best staff members were being drawn away from CMHTs to staff EISs, that general adult psychiatrists would become deskilled, and concerns about the exit strategies of EIS teams to CMHTs where general adult psychiatrists would be expected to take over their care. These issues have been identified in debates about the value of EISs by other authors who have argued that, with the appropriate resources, CMHTs could provide effective FEP services (Harrison & Traill 2004;Pelosi & Birchwood 2003).

6.2.3 Constructive approaches to new ways of working

EIS teams and some patch-based psychiatrists reported important changes to the way that they worked, reflecting core values of EISs. NWW involved being more flexible about where service users were seen, providing age-sensitive services and placing less emphasis on the medical model. This appeared to be due to a number of different factors, including the efforts made by EIS teams to improve communication with psychiatrists, strategies

used by EIS teams to overcome differences in styles of working, and individual clinician personalities.

The second objective of this study relating to the role of psychiatrists within EISs was to inform ongoing national work in re-defining the roles of psychiatrists within the context of EISs that may be generalisable to other parts of the mental health system

Although there is policy guidance, there is not yet a clear theory to describe and help us understand the current changes to the healthcare workforce that impact on re-defining the roles of psychiatrists. For established or aspiring professions, occupational strategies often centre on the protection and maintenance of role boundaries, coupled with an ongoing campaign to expand areas of control (McDonald 1995). This may include strategies that involve an advance in professionalisation through legislation and regulatory control (Larson 1977). Also relevant here is Larkin's 1983 formulation of 'occupational imperialism' which suggests that professions advance by acquiring high status skills and roles which they poach from other occupational groups whilst delegating lower status roles to subordinate groups. These models are useful in that they acknowledge the dynamic capacity of professions to act and counteract exclusionary strategies and both defend and expand their own role boundaries.

In terms of changing professional boundaries, as we have highlighted earlier in this report, healthcare is subject to explicit and implicit controls and regulations so that boundaries are influenced by the dominance of other disciplines, regulatory and legislative frameworks and the ability of the profession to convince funders and the public to purchase their services (Freidson 1974). Health providers can, however, change their boundaries by identifying new areas of work or by adopting roles normally undertaken by other providers. This allows movement of the workforce in four directions: diversification, specialisation, horizontal substitution and vertical substitution (Nancarrow & Borthwick 2005). These concepts are applicable both to EISs and to other parts of the (mental) health system.

Diversification and specialisation involve the expansion of professional boundaries within a discipline. Diversification may involve the creation of a new task or simply a new way of performing an existing task. It can take on a number of forms including new philosophies of care, the adoption of new language to describe existing treatment, the introduction of new types of technology such as new therapies, new ways of providing existing services and the identification of new markets or new settings for the delivery of certain services. In an EIS context, this is exemplified by the adoption of CBT by nurse therapists.

Specialisation has traditionally been associated with greater professional autonomy, improved financial awards, higher social prestige and increased professional security. Larkin suggests that the development of specialisation may depend on the ability of the professional group to delegate certain aspects of their work to other providers. It involves the creation of subordinate sub groups within a profession that undertakes lower status duties, freeing the professionals to pursue higher status autonomous roles.

In an EIS context, this might include the growth of psychology assistants who undertake the routine tasks freeing up the psychologists to undertake more complex assessments (Nancarrow 2004).

Vertical and horizontal substitution involves the movement of the discipline outside its traditional boundaries to take on tasks that are normally performed by other health service providers. Substitution can also arise by a profession actively discarding unwanted tasks to another provider, by delegating to subordinate workers. Vertical substitution includes the extension of nursing roles to include prescribing, a role that was traditionally owned by the medical profession, and which is now becoming a routine feature of EISs without a dedicated psychiatrist. Horizontal substitution arises when providers with a similar level of training and expertise but from different disciplinary backgrounds undertake roles that are normally the domain of another discipline. Horizontal substitution is more likely to occur where practitioner roles are similar. In an EIS context, this may be occupational therapy and social work graduates working as generic caseworkers. Horizontal substitution is more easily applied at the social end of the spectrum than in highly medicalised areas and therefore is more likely to be found in teams such as EISs where an overt psychosocial ethos has been adopted. These changes are also more likely to occur in response to situational factors such as staff shortages, when pragmatism becomes an overriding feature (Nancarrow 2004).

NWW legitimises the blurring of interprofessional role boundaries by endorsing vertical and horizontal substitution, specialisation and diversification. There is a disaggregation of knowledge from the more highly specialist groups to the generalist or less specialised groups. Where tensions may, however, be created is in actively encouraging medical dominance through the acquisition and use of even more specialised knowledge and medical leadership of MDT whilst at the same time promoting the knowledge base and autonomy of other professions within the teams. These issues are generalisable throughout the NHS and are not specific to EISs. Policy needs to acknowledge these tensions, allowing flexibility to guidance where needed.

6.3 Partnership working between EISs and the VCS

Partnership working between the health and social care sector is central to Government policy in delivering effective health services (Department of Health 2004a). At the Trust level, partnership working, both formal and informal, takes place across the health and social care system. Partnership policies describe the conditions under which each party enters a formal partnership, including defining the aims and roles and responsibilities of individuals involved in developing and maintaining formal partnerships. Trusts act as contracting partners in numerous schemes and projects, participate in Strategic Partnerships, and work closely with other Trusts, health, social care, and voluntary organisations to meet the diverse needs of local communities.

Previous research work on partnership working has suggested that there are general principles for partnership working that can be applied to any context (Wildridge et al. 2004). Although barriers and facilitators to partnership working have been identified (see Section 3.5: Partnership working in mental health), as yet previous work has not identified the barriers and facilitators to partnership working specifically within mental health that could enable managers of EISs to implement changes in practice.

In relation to partnership working between EISs and the VCS, the themes from the different perspectives of EIS team members, the VCS, and PCT Commissioners are drawn together and discussed separately in the following sections.

One of the key objectives of this study relates to understanding the barriers and facilitators to partnership working between EISs and the VCS.

6.3.1 Partnership working between EISs and the VCS: EIS perspective

Identifying needs and finding VCS services

EIS team motivation to enter into a partnership was influenced by recognition that specific skills and resources needed to provide care and tackle social exclusion often associated with mental illness were lacking within EISs. Identifying service user needs was therefore the first step in making links with the VCS (Blackmore, Bush, & Bhutta 2005). EIS teams, in filling identified gaps in service provision, reported finding opportunities within the VCS involving sports, arts and leisure activities and specialist areas such as bereavement counselling. However, the findings highlight the difficulties facing EIS teams in their attempts to identify opportunities to work with the VCS. Some EIS team members found useful local community organisations through chance. Others, through meeting their responsibilities as case managers or greater familiarity with the local area, actively sought VCS organisations in the local community. Some VCS organisations were discovered as a result of direct development work by EIS teams.

Perceived benefits of EISs working with the VCS

Despite EIS team members understanding the potential benefits of partnership working with the VCS (HM Treasury 2005), most existing partnerships were ad hoc in nature. It appeared there were no formal arrangements in place for partnership working and most informal links were at an early stage of development. The reason why there were no formal partnerships warrants further attention. According to an important principle of establishing successful partnership working, robust partnership arrangements need to be in place (Hardy, Hudson, & Waddington 2000). Limited time and finance were perceived as barriers to establishing partnership working (see next section). Section 31 of the Health Act (Department of Health 1999b) was intended to allocate greater flexibility in sharing financial resources through pooled budgets and lead commissioning.

There was recognition from EIS team members of the need to work in partnership with the VCS, a view shared by VCS representatives and highlighted in previous work (Asthana, Richardson, & Halliday 2002;HM Treasury 2005). The EIS team members valued the contribution that the VCS could make in providing services to meet the needs of service users, particularly with respect to addressing social exclusion issues and offering a non-medical perspective. The VCS was also seen as being more flexible than large organisations such as the NHS and were viewed as more responsive to local need. This reflects previous work that partnerships are more likely to be formed where multi-agency partners share local priorities and interests (Glendinning 2002) and recognise the benefits of a partnership (Milne, McAnaney, Pollinger, Bateman, & Fewster 2004;Rummery & Coleman 2003;Wilson & Charlton 1997).

A useful development in future research would be an assessment of whether partnerships between EISs and the VCS do deliver better services. Much of the work on partnership working tends to focus on the process of partnership working, how to ensure partnerships are effective, rather than concentrating on the outcomes of such partnerships.

Feedback from service users is a key feature in evaluating the usefulness of potential partner organisations (Glendinning 2002). Although formal service user evaluation of the acceptability of services offered by the VCS has not yet been conducted, EIS team members had formed the impression from informal service user feedback that service users valued the VCS because they could offer a non-medical perspective in contrast to services offered by traditional NHS secondary mental health services. This non-medical perspective was seen by EIS team members as useful in helping to engage service users who would otherwise fall through the net, perhaps because statutory mental health services were viewed by service users as stigmatising (Tait et al. 2004).

Barriers and facilitators to partnership working with the VCS

EIS teams had established informal links with local housing associations and other non-statutory organisations that could provide services for young people. As suggested by previous studies, shared priorities and shared principles appeared to be important in the process of developing strong partnership links (Glendinning 2002). The social orientation of some voluntary organisations was felt to match the social model of EISs. The present finding underlines the potential value of considering the importance of shared goals in future research concerning partnership working, and is consistent with previous research evidence on important features of partnership working (Hardy, Hudson, & Waddington 2000;Hudson 1999) and findings obtained in a longitudinal study examining the development of partnership working (Rummery & Coleman 2003) (see Table 7).

Time was also a key factor in the development of partnership working, confirming previous work (Matka, Barnes, & Sullivan 2002). Stronger links existed where teams had either a community support worker, whose main responsibility was development work, or had time to allow other team

members to commit to building relationships with non-statutory organisations when initially setting up the service before caseloads increased. Having more time to devote to developing relationships between sectors enabled better working relationships and EIS teams to find out what organisations existed in their local areas.

Previous work suggests that raising awareness of both partners may strengthen partnership links (Milne et al. 2004) and account for increased understanding of each partner's agenda, objectives and difficulties (Wilson & Charlton 1997). Previous research on partnership working has found time constraints to be an important barrier. Administrative activities and attending meetings, required by partnership working, are time-consuming, and sometimes outweigh perceived benefits of partnership working (Harris, Cairns, & Hutchinson 2004).

EIS teams recognised that they needed to raise the profile of services, particularly to promote a better understanding of its aims and objectives. However, there was time to perform outreach work to raise awareness of EISs only in the early stages of the development of EIS teams. This outreach work involved the distribution of educational materials about EISs to the wider community. However, due to limited time and funding, particularly the fact that delivering services is the EIS team's main priority, many of the EIS teams had not yet contacted VCS organisations in this way. Time allocated to outreach work, specifically targeting the VCS, could facilitate potential partnerships in raising awareness of the aims and objectives of EISs. The need to develop mutual understanding has been implicated in successful partnership working, particularly with respect to roles and responsibilities and the purpose of each service (Harris, Cairns, & Hutchinson 2004).

Providing training to the VCS was felt to be an important strategy in the development of partnerships with the VCS. However, the dilemma is that increased awareness may lead to inappropriate referrals or EISs reaching capacity sooner than they would have if they had not promoted the service.

Table 7. Key facilitators to partnership working (EIS)

▪Shared priorities/shared principles

▪Time to discover VCS organisations in local area

▪Time for outreach work

▪Time for developing relationships

▪Training

▪Co-location of statutory and non-statutory agencies

Physical co-location of an EIS and the VCS could create opportunities for more effective communication, which facilitates partnerships (Glendinning 2002), and can lead to increased opportunities to share skills between

sectors. Working in partnership within the same building also provides a seamless service.

Barriers to partnership working were primarily difficulties associated with organisational cultural issues (see Table 8). For example, it was felt that that VCS representatives lacked an understanding of the aims and objectives of EISs, as well as knowledge of mental illness and knowledge of when risk assessments were appropriate. Training would be of benefit in addressing these issues as would the suggestion of increased exposure to service users with mental illness (Repper & Perkins 2003). A cultural difference between organisations has been identified as a barrier to partnership working (Wildridge et al. 2004). As mentioned above, however, time pressures prevented EIS teams raising awareness of their aims and objectives, which decreased the opportunities that the VCS had to increase their understanding of mental health issues and knowledge about EISs.

Table 8. Key barriers to partnership working (EIS)

▪Barriers to partnership working influenced by differences in organisational cultures and values

▪Funding and capacity issues

▪Lack of time to develop and maintain partnership relationships

▪Building trusting relationships

Conclusions

Our research focused on how EIS team members and the VCS work together to provide care to service users with FEP. The findings of this study on partnership working between EISs and the VCS from the perspective of EIS team members clearly show that the VCS make useful, and often appreciated, contributions to providing a wide range of services to individuals referred to EISs.

The important issue of social exclusion is more likely to be addressed by providing opportunities for service users to be involved in the local community. However, more development work needs to be done to establish and maintain partnerships between EISs and the VCS, as the majority of partnership arrangements were informal and ad hoc. Shared priorities and principles, time to devote to partnership development, opportunities to train VCS representatives and co-location of partners were identified as facilitators to partnership working between EISs and the VCS. Furthermore, EISs identified their main challenges as: organisational cultural differences, coping with funding and capacity issues, lack of time to develop relationships and mutual trust.

Placing the findings within the current policy context, our findings confirm the importance of the expanding future role of the VCS in contributing to partnership working with mental health services (HM Treasury 2002;HM Treasury 2003;HM Treasury 2005;ODPM 2004). They are broadly consistent

with previous studies that highlight barriers and facilitators to partnership working, which include time constraints, capacity, funding and accountability issues, cultural differences, sharing information and confidentiality issues, and difficulties in getting to know local services.

6.3.2 Partnership working between EISs and the VCS: VCS perspective

The VCS professionals were enthusiastic about delivering public services and working in partnership. The findings highlight the facilitating factors (see Table 7) and difficulties facing the VCS in their attempts to initiate, and respond to, partnership working with EISs. In keeping with previous research, the VCS reported multiple facilitators and barriers to partnership working, but had few options in which to respond to barriers. Their views highlighted challenges in their day-to-day practice (such as service planning, retention of staff and lack of time and money), concerns about maintaining autonomy and the relevance of working with EISs.

The findings highlight factors that both facilitated and hindered partnership working. Key characteristics of EISs and the VCS, opportunities to network with each other and with decision makers, and current Government policy on partnership working influenced the decision to enter into partnerships between the VCS and EISs. In order to understand partnership working, we have adapted a model of partnership that proposes a 'four stage partnership life cycle' (Lowndes & Skelcher, 1998).

In the partnership life cycle model, the first stage of 'pre-partnership collaboration' emphasises the importance of informal personal relationships, building trust and deriving mutual benefit from the potential partnership. In the second stage of 'partnership creation and consolidation', relationships and partnership procedures become more formalised. The third stage of 'partnership programme delivery' is characterised by formal contracts, which introduce competition for funding and associated need to demonstrate added value. The final fourth stage of 'partnership termination or succession' is characterised by time limited funding and the consequent need to review the renewal of the funded partnership. Our data support Lowndes and Skelcher's (1998) view of the first two stages of partnership life cycles, as the majority of VCS partnerships were in the early stages of development. The findings of the present study suggest that an adaptation of the partnership life cycle model could help EIS and VCS professionals to understand and resolve key issues in contacts between potential partners.

Pre-partnership collaboration

Key issues in initiating partnerships concern recognition of added value, the opportunity to network effectively, coincidence of agenda and funding issues. VCS professionals stated that their ways of working were different from statutory organisations and this was one of the features of the VCS that they felt added value to service provision. These features of the VCS included working in a client-centred way, being accessible to the hardest to reach individuals, and having the flexibility to be responsive to gaps in

service provision. However, they perceived that the Government viewed them as a 'cheap option' and felt that statutory services, in particular, viewed them as amateurs and sometimes used them as a 'dumping ground'. However, the VCS professionals demonstrate their value through accountability: service evaluation and monitoring by funders.

The level of self-evaluation and external monitoring, however, was perceived as challenging, as smaller organisations indicated the associated administrative requirements of accountability were burdensome, as monitoring requirements were not proportional to the size of the organisation, a finding similar to Coid, et al. (2003). VCS professionals indicated the extra paperwork associated with monitoring meant that VCS professionals had to adapt their working practice to meet accountability requirements rather than focus on client contact. Smaller organisations also had difficulties with full cost recovery. This meant they were only paid for delivering services and not supported for the associated administrative activities. This is despite Government guidance for the VCS to charge contractors on a full cost recovery basis (HM Treasury 2002a).

Despite the enthusiasm for partnership working, VCS professionals felt that although they had good informal links with EIS team members, relationships at senior management level (for example, PCT commissioners) were more difficult to initiate and develop. This is an important issue for the VCS, as they indicated that it was those individuals with whom they needed to network most who could influence decisions about commissioning services.

Networking opportunities with EISs arose through the EIS approaching the VCS in their local area when EISs were in the developmental stage (see Section 5.4). This was useful in raising awareness of the nature of EISs and increasing knowledge of FEP so that the VCS professionals could make appropriate referrals. In addition, networking provided an opportunity to decide whether the two agencies were compatible to work in partnership and to decide upon the extent of the working relationship. One of the VCS professionals described this compatibility as 'coincidence of agenda'. Furthermore, the VCS professionals recognised that EISs had a shared ethos, comparable working patterns and appeared to attract staff who were open to partnership working. All these key elements facilitate partnership working, as they are motivating factors in the desire to work together in providing holistic services.

Networking needed to be prioritised because many of the VCS professionals emphasised time constraints as an important issue in relation to burdensome monitoring requirements and bidding for funding. These findings confirm previous work (Alcock et al. 2004; Coid et al. 2003). The VCS needed to be selective when networking to ensure effective time management; it was important to access the agencies in the local community that matched their client group. This finding is in keeping with the 2004 Spending Review, which encourages 'joined up working' by combining previously separate targets.

Many VCS professionals were concerned about sustainable funding; many of the VCS contracts with other agencies were between 12 months and three years in length, with only one five year contract to provide services to an EIS. Previous literature has identified the difficulties associated with short-term contracts (Alcock et al. 2004; Coid et al. 2003). Short-term contracts prevented long-term planning and led to difficulties to both retaining and recruiting staff, and time spent in bidding for funding and renewing contracts each year, which added to the administrative burden, findings consistent with previous work (Alcock et al. 2004).

The nature of the majority of partnerships between EISs and the VCS were informal, ad hoc arrangements. This appeared to be because EIS service users formed only a small proportion of the VCS target client group. As mentioned above, coincidence of agenda is an important facilitator to partnership working. In our data, the EIS and the VCS engaged with each other when service users needed services from both organisations. Service users benefited from having holistic services provided in this manner, as suggested by guidance provided by The Sainsbury Centre for Mental Health (Sainsbury Centre for Mental Health 2000). Time was also saved by non-duplication of service provision. However, disadvantages of informal arrangements were also highlighted. The ad hoc partnerships involved one or two individuals from each organisation working together. In our data, there was concern that if one person left, the whole networking process would need to be restarted. This is more likely to happen if the VCS continue to be awarded short-term contracts.

Partnership creation and consolidation

Past history of working together on an informal basis, such as a pilot project, facilitated the formalising of partnership arrangements. Having worked together in the past, partners were more willing to enter into partnership agreements because they understood each other's agenda and shared a vision of service provision. However, one VCS professional suggested that formalising previously informal partnerships might change the nature of the relationship, adding complexity where it did not previously exist. There are some processes that work well on an informal level, and these can become complicated by formal procedures. For example, paperwork associated with formalising procedures that were informal, to demonstrate accountability, can be time-consuming and complicates previously simple tasks.

Partnership creation involves establishing hierarchical relationships and agreeing formal processes (Lowndes & Skelcher, 1998). This was reflected in our data where there were three partnerships that were described as formal. In one of the formal partnerships, the VCS appeared to be in a strong position because their policies and procedures were being used by a multi-agency partnership, including an EIS team. This was said to benefit both service users, because they could access all the services in one place with a single assessment, and service providers, because duplication of work was reduced.

Partnership programme delivery

At this stage of a partnership, the key issues are establishing the partnership by bidding for formal contracts to deliver services and maintaining working relationships. Although the VCS welcomed competition because they felt that this would ensure quality, funding for the provision of their services was not guaranteed. The time taken to build up relationships, including networking and formalising procedures, could be futile. The necessity to encourage competition was a potential barrier to partnership working.

Longer-term contracts were a key facilitator in formal partnership working. In our data, one VCS professional reported securing a five year contract, which enabled stability in terms of staffing and the ability to plan for the future, confirming previous research (Alcock, et al. 2004; Coid et al. 2003). EISs directly benefited from long-term contracts secured by the VCS because it enabled them to employ team members who were also jointly recruited and integrated into the EIS team. Since the EIS was recruiting jointly with the VCS, they were not limited to employing individuals with only professional mental health qualifications. Rather, they could employ people on the basis of their personal qualities in terms of fitting the job description and ethos of EISs and the VCS. This could potentially help to break down interprofessional boundaries.

Maintaining working relationships involves clear lines of communication, role clarity and joint training. The VCS professionals highlighted the importance of communication when working in partnership. Good communication and role clarity allowed both organisations to be kept up to date with a service user's progress, to avoid duplicating service provision. Communication was facilitated by the introduction of information sharing protocols, which allow various organisations, including the VCS, NHS and Social Services, to share the same confidential information. This also helped reduce concerns about risk. Furthermore, the VCS had opportunities to train with EISs. Joint training facilitated relationship building and increased opportunities to network. In addition, joint training provided the opportunity for members of each organisation to understand each other's perspective and organisational limitations. All these factors are also important at the pre partnership stage where there are more ad hoc arrangements, as this not only facilitates good working relationships but also could potentially facilitate the partnership creation stage.

Partnership termination and succession

Our data does not provide any information for this stage of the partnership life cycle. The existing formal partnerships in the present study had not reached the end of their contract. However, funding is again an issue at this stage of partnership working. At this stage, partners need to review the success of the partnership and to consider reapplying for further funding to continue the partnership. Short-term nature of contracts could potentially create a barrier to pre-partnership collaboration, the willingness to enter into a partnership, and to partnership termination and succession, as there

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may be a reluctance to continue with the partnership if it is only renewed on an annual basis.

Table 9.   Key facilitators to partnership working (VCS)

- Mapping services – getting to know local services

- Needs shared vision and values

- Enhance communication between operational staff and senior management

- Good communication

- Understanding each other's priorities

- Clarify roles and responsibilities

- Shared information

- Data protection and confidentiality issues

- Building trust

- Better understanding of organisational jargon

- Clarify accountability

Conclusion

To work in partnership, one of the key issues is sustainable funding. To access the funding for public service delivery (HM Treasury 2002), the VCS will need to engage in formal partnerships, including providing additional services to EISs. However, as discussed, the main reason for informal arrangements appeared to be compatibility between service organisations. As formal partnerships can take time to develop and because the VCS have to prioritise networking opportunities, it is important for partnerships to be worthwhile to both parties. The proposed model of partnership working should be treated as a working model, and subjected to further development by qualitative and quantitative methods.

The next section discusses the findings on partnership working at the structural level from the interviews with PCT commissioners.

6.3.3 Partnership working between EISs and the VCS: PCT Commissioner perspective

There were four key findings from the interviews with PCT commissioners of Adult mental health services and CAMHS, SHA Mental Health Leads and Social Service Directors. Areas identified as important included:

- inconsistency between some commissioners' interpretation and understanding of the guidance on wider non-statutory agency

involvement as outlined in the Mental Health Policy Implementation Guide (MH PIG) (Department of Health 2001)

- variability in the commitment of commissioners to this guidance

- the predominance of certain voluntary organisations

- negative aspects and barriers to partnership working

The MH PIG (Department of Health 2001) recommends that a joint commissioning approach involving PCGs/PCTs, SHAs and social services should be adopted, with commissioners being advised by their broad advisory group. Formal links with key agencies, including local careers advisory services, Connexions, New Deal, Training and Enterprise Agency, further education colleges and voluntary organisations are also strongly encouraged. Of the forty-two interviews undertaken, only fifteen individuals were able to comment on voluntary organisation or non-statutory group partnership working. Of these, only five individuals were able to discuss any positive meaningful engagement that had taken place with wider agencies. It appears from these interviews that not all commissioners are fully engaged with the process of wider non-statutory agency working or fully committed to the process of wider inter-agency working.

6.3.4 Good practice in partnership working between EISs and the VCS

Partnership working in this study was found to range from:

- informal relationships between EISs and the VCS executed as needed (ad hoc)

- collaboration (relationships between EISs and the VCS are more formalised, with evidence of shared planning and delivery of care, meeting mutually agreed goals).

The final objective of the EDEN Plus Study relating to partnership working between EISs and the VCS was to identify examples of good practice in partnership working between EISs and the VCS that are generalisable beyond the specific setting to other parts of the mental health system.

It is not easy to define 'good practice' in the provision of mental health services. Therefore, we have identified examples of good practice that conform to standards to which mental health services are expected to achieve and the values underpinning the National Service Framework for Mental Health (Department of Health, 1999). The primary purpose of the EDEN Plus Study objective in relation to good practice examples was to identify examples that in our view represented exemplars in working practices promoted in published guidance with the aim of improving the quality of care for FEP clients and their families (Sainsbury Centre, 2003).

Working in partnership with a range of non-statutory services is one of the core principles included in guidance for setting up (MH PIG: Department of

Health, 2001; Sainsbury Centre, 2003). However, the majority of EIS teams in the West Midlands, the participants in our study, are newly developed teams and therefore it is premature to evaluate the impact of partnership working.

We also sought examples of 'good practice' that reflect elements of partnerships which research evidence suggests contribute to successful partnership working. We could not identify 'good practice' in performance nor evaluate the effectiveness of services delivered by the VCS; this remains for future research. Therefore, our review of the partnership working literature and our findings reflect what is currently known on the process of partnership working and thus is incomplete in regard to research on successful outcomes of partnership working and service delivery by the VCS.

We suggest that all of the examples of good practice identified in the findings of the EDEN Plus Study are generalisable to other community based mental health teams such as AO teams and CMHTs. In particular, the MH PIG (Department of Health, 2001, pg 33) recommendations specify that AO teams provide access to local services, including educational, training and employment opportunities, all of which can be provided by the VCS working in partnership with statutory services. Furthermore, there are recommendations that links with external agencies, including voluntary agencies, should be established to enable direct referrals to be easily made (Department of Health, 2001). We therefore suggest that, in addition to EISs, CMHTs and AO teams may benefit from the partnership working good practice examples identified in this study.

Sustainable funding

Short-term funding presents challenges to partnership working, making it difficult to plan effectively (Coid et al. 2003). Funding is widely recognised as a facilitator to partnership working (Harris et al. 2004, Matka et al. 2002). Our findings highlighted the contentious issue of funding and revealed different types and lengths of contract. The majority were ad hoc, informal partnership contracts, and appeared to be designed to fit the rate of referrals from EISs to external agencies. However, there was one VCS organisation with a five-year contract to work in partnership with an EIS, which had been provided through the PCT commissioning process. This level of support enabled partnership working to develop within a stable environment.

Shared aims and objectives

Rummery and Coleman (2003) highlight the importance of shared values and joint objectives to the success of partnership working. There was evidence from our findings that some of the VCS organisations had shared aims and objectives with EISs. Participants from both sectors in our study recognised the value of shared aims and objectives to the development of partnerships, and this appeared to facilitate partnership working between EISs and the VCS. Knowledge of an organisation's aims and values

appeared to underpin EIS teams' stated reasons for seeking partnerships with particular VCS organisations.

Communication

Effective communication is critical to the success of partnerships (Wildridge et al. 2004). Trust and understanding of each other's roles and responsibilities is built upon effective channels of communication between organisations. As an example of good practice in conforming to the principles of partnership working in relation to effective communication, many VCS professionals from a variety of organisations were invited to Care Programme Approach (CPA) reviews held by EIS teams, and when the VCS organisation had their own version of a review, EIS team members were invited to attend. This was where roles and responsibilities of each organisation could be decided, with the client present. Good communication was also facilitated by the VCS and the EIS using information sharing protocols to share confidential information, and helped to reduce concerns about risk.

Joint training

The chance to network and enhance skills is provided by joint training initiatives (Matka et al. 2002, Wildridge et al. 2004). An example of good practice in the area of joint training was the evidence for joint training provided by EISs, particularly in the developmental stage of the EIS. Joint training sessions were useful in raising awareness of the aims and objectives of EISs. Publicising EISs in this way could lead to the VCS making more appropriate referrals to EISs and provide opportunities to develop mutual understanding of roles and responsibilities of each organisation. Joint training initiatives would also help to increase the VCS professionals' knowledge of FEP, which would also affect the appropriateness of referrals to EISs and increase understanding of how to manage clients with psychosis.

Co-location and integration

Co-location refers to examples of where EISs share the same building with one or more VCS organisations and integration refers to instances where staff members are seconded from the VCS to work within an EIS team. Both situations were identified as good practice examples within our study. Partnership working in these circumstances allows greater service choice, reduced fragmentation (Sainsbury Centre for Mental Health, 2000) and facilitates better communication and opportunities for networking and joint training.

6.4 Strengths and limitations of this study

This study included the views of professionals in 89 per cent of the VCS organisations identified by EISs in the West Midlands as partners in providing care for young people with FEP. Organisations included representatives from housing, youth services and health. The study was,

however, limited by only talking to one member of each organisation and through not including the views of service users, which would have provided a more in depth picture of the effectiveness of partnership working.

Our aim was to obtain a broad range of medical views and this was achieved by inviting both dedicated EIS psychiatrists and patch-based psychiatrists, with a wide range of years of clinical experience, to participate. Seventy-eight percent of Consultant Psychiatrists involved with EISs in the West Midlands participated in the study, although it is possible that those with the strongest views and opinions were more willing to participate.

Some of the EIS teams were in an early stage of development and thus many team members were still adjusting to their new teams and responsibilities. These factors, therefore, may have limited the depth of description when discussing roles, responsibilities and work practices.

There was an unintentional change to the protocol. It was not possible to conduct the second round of focus groups with EIS teams and psychiatrists because of the difficulties encountered in arranging the first round of interviews. There were logistical difficulties in arranging further focus groups to which the psychiatrists and EIS team members from a wide geographic area, across the West Midlands, could attend; we were mindful of constraints on their time as well as finding a date when all participants could be available at the same time. We believe that this minor deviation had no substantive effect on the overall findings and conclusions.

7 Implications and recommendations for future research

7.1 Problems in the current relationships between psychiatry and EISs

One of the benefits of collaboration between EIS teams and psychiatrists is the opportunity for EIS team members to increase their skills and knowledge as well as working together to enhance continuity of care, ensure accessibility of mental healthcare, and benefit from the expertise of the psychiatrist, particularly in comorbid and complex cases. EISs are an innovative and new service development, with non-traditional working practices, which will require changes in the way psychiatrists work with EIS teams if they are to succeed. However, our study data illustrate the slow pace of change within this high priority area of healthcare.

7.1.1 Recommendations for local action

There are several implications for local action from our findings.

Role of psychiatrists and non-medical team members in EISs

In NWW, psychiatrists are expected to function as members of MDTs and to act as consultants. They are valued for providing diagnostic expertise, comprehensive assessments, forming integrative overviews in developing treatment plans, prescribing skills and, where appropriate, playing an active supporting role to non-medical team members. These activities should complement the mental health care provided to service users within EISs. Within our data, there are positive examples of effective interprofessional working between EIS teams and dedicated psychiatrists who were described as 'team players', working flexibly and fitting in with the EIS team ethos (similar issues are discussed in the accompanying EDEN Study).

However, there are also examples of challenges facing psychiatry and EISs in the pattern of interprofessional working with patch-based psychiatrists. Our data suggest that patch-based psychiatrists are too distanced from EIS teams to provide mental health care that is consistent with the biopsychosocial and youth sensitive approach of EISs.

There is one local implication.

- Job descriptions need to ensure the psychiatrist has the ability to work flexibly and the ability to be a team player.

New ways of working

Our data generate concerns about the use of patch-based psychiatrists by EISs. Specific problems that have been identified include a lack of communication between psychiatrists and EISs providing care for the same

individual, lack of mutual respect for the contributions that EIS team members and psychiatrists make in delivering care, difficulties for EISs in accessing timely consultation services and treatment for service users, continuity of care for service users and logistical difficulties in attending traditional outpatient appointments. EIS team members regularly attended ward rounds and outpatient appointments with service users, which is not an optimal use of their time or skills. These findings suggest a need for reappraisal of the use of patch-based psychiatrists in EISs and, in line with guidance from the NSG (Care Services Improvement Partnership, National Institute for Mental Health in England, Changing Workforce Programme, & Royal College of Psychiatrists 2005b) on the use of traditional outpatient clinics, based on a more efficient use of resources that are more responsive to the needs of service users and their families.

There is one local implication.

- The consequences of patch-based psychiatrists providing mental health care to service users in EISs in traditional outpatient clinics is not necessarily an inexpensive option for commissioners.

Role clarity

The roles and responsibilities in EIS teams and the roles and boundaries of responsibility of the psychiatrists were generally not well understood (similar issues are discussed in the accompanying EDEN Study report). The psychiatrists providing medical input to EISs were given no initial role definitions. This can create challenges for professional identity and resistance to NWW, reflected in efforts to protect professional boundaries. In NWW, roles and responsibilities will continue to develop; therefore, it is essential that all professionals are clear about the priorities of particular roles and responsibilities.

There is one local implication.

- Roles and responsibilities of EIS team members and psychiatrists should be defined, particularly in terms of the issue of genericism versus specialism.

Value of EISs

Our data suggest that there is scope for raising awareness within the wider mental health community of the value of EISs for young people with FEP (similar issues are discussed in the accompanying EDEN Study). However, there were few development opportunities for EISs to improve communication with psychiatrists or resources to provide educational materials within the local community. Many psychiatrists were unconvinced of the benefit of specialist services and were concerned about the potential for diversion of resources away from CMHTs. It is therefore essential that research builds on knowledge of the factors that are effective about EISs

and the provision of education materials to the wider mental health community may assist in raising the profile of EISs.

There is one local implication.

- There needs to be better communication with the wider mental health community to raise awareness of the value of EISs.

7.1.2 Recommendations for wider policy issues

There are policy implications from our study data on interprofessional working between psychiatrists and EIS non-medical team members.

Leadership and management

In our data, misperceptions existed about the role of the Consultant Psychiatrist, the limits of their responsibility, and definitions of leadership and management (similar issues are discussed in the accompanying EDEN Study). There was also evidence that dedicated psychiatrists saw themselves as natural leaders, corresponding to assumptions in the NWW publications (Care Services Improvement Partnership, National Institute for Mental Health in England, Changing Workforce Programme & Royal College of Psychiatrists 2005a; National Institute for Mental Health in England, Changing Workforce Programme, Royal College of Psychiatrists & Department of Health 2004), whereas patch-based psychiatrists appeared comfortable with notions of teams led by non-medical professionals and distributed responsibility. However, these responses suggest there is the potential for conflict between some Consultant Psychiatrists and non-medical staff members in the context of NWW. Furthermore, NWW encourages nurse prescribing, nurse-led clinics and MDT work whilst at the same time suggesting that psychiatrists should become specialists and maintain medical leadership roles.

Clearly, NWW is encouraging medical professional dominance whilst also encouraging workforce flexibility for allied professionals. In teams with apparent hierarchical structures, such as those with dedicated psychiatrists, this may be less of an issue than for those EISs with patch-based medical input, many of whom appear to have risen to the challenge of NWW and may find the proposed elements of medical dominance difficult to incorporate into their team ethos or working practices. These issues are generalisable throughout the NHS and are not specific to EISs. Policy needs to acknowledge these tensions, allowing flexibility to guidance where needed.

The policy implications of these issues are:

- clarification of difference between leaders and managers

- policy tension between NWW encouraging medical leadership and the development of nurse prescribing and nurse leaders.

Medical management approach

In considering the emerging NWW guidance on the need for comprehensive mental health care in MDTs (National Institute for Mental Health in England, Changing Workforce Programme, Royal College of Psychiatrists, & Department of Health 2004), psychiatrists have an important role to play in providing specialised mental health services to young people with FEP in EISs. However, clearly, there is the issue of differences in approaches to the medical management of service users between psychiatrists and EIS team members and tensions around issues concerning the perceived dominance of the biomedical model preferred by some psychiatrists. There is a need for psychiatrists to consider models of care that correspond with EIS principles (these issues are also discussed in the EDEN Study report).

Therefore:

- tensions between biopsychosocial approach of EISs and biomedical approach of psychiatrists need to be discussed and addressed.

7.2 Facilitating partnership working between EISs and the VCS

Partnership working between EISs and the VCS will not happen without the motivation and commitment from professionals at both the local and national levels of organisations. To complement this, appropriate levels of funding are needed to support the implementation of partnership working between healthcare and the VCS.

7.2.1 Recommendations for local action

There are two implications for local action from the study findings.

Raising the profile of VCS organisations

The opportunity to network within the community with other statutory and non-statutory organisations, including EISs, could raise the profile of VCS services and help develop partnerships. Solutions to raising awareness could be simple descriptions of the services offered by the VCS. Therefore:

- appropriate information about the potential benefits of VCS services needs to be disseminated and opportunities to network created.

The development of positive working relationships was supported by good communication between the VCS and EISs. However, close-working relationships existed between two individuals. This may lead to increased mutual understanding and enable each party to understand the constraints of the other. However, when partnerships involve only two key individuals, if one party leaves the partnership will be difficult to maintain.

▪ Partnership cannot be based only on a small number of interpersonal relationships.

7.2.2 Recommendations for local and national action

There are a number of implications for local and national action from our findings.

Funding and infrastructure

The under-funding of VCS organisations is an important obstacle to sustainable partnership working. Most of the funding was short-term. Funding was made available for the services element of the VCS but no additional monies were made available for the resultant running costs of the VCS. This has several implications. Time was spent bidding for funding in an attempt to ensure that funding was continuous, and therefore resulted in less time for core activities. Short-term funding affected staffing and also affected the ability to plan. New funding approaches need to be developed to support the day-to-day operations. For example, longer-term contracts would have two benefits. Firstly, time would be saved from constantly bidding for new funding. The time saved would enable the VCS to spend more time developing partnerships and networking. Secondly, the VCS would have more stability in terms of service planning, and this would then be conducive to maintaining partnerships.

▪VCS organisations need long-term funding to enable effective planning of services, which potentially facilitate partnership working.

Accountability

Any statutory or non-statutory service must have a comprehensive system of audit. This allows modifications to the operational policies as well as providing information on quality standards and service user satisfaction. However, the audit process created pressures in meeting multiple stakeholders' expectations and audit procedures. Recent research demonstrates the utility of ensuring accountability procedures reflect the size of the VCS organisation (Coid, Williams, & Crombie 2003).

▪Appropriate levels of accountability proportional to the size of the organisation are needed.

Importance of information sharing protocols

Difficulties in communication between the VCS and EISs were frequently cited. Confidentiality policies were a routine and essential part of the management of VCS organisations, and service user consent was regularly documented. Service users have a right to confidentiality. Confidentiality is important to building a trusting relationship (engagement) between the mental health professional and the service user. However, EISs need to make access into the VCS as efficient as possible. This means that, although

confidentiality is respected, there were occasions when confidential information needed to be shared, with the prior approval and consent of service users. Breaches of confidentiality needed to be explained to service users. EIS teams, however, do not always provide sufficient information about service users to the VCS. This is thought to be an expedient way to access VCS services but can create difficulties for the VCS who may not be aware of problems service users are experiencing.

▪Acknowledge the importance of information sharing protocols.

Value of the VCS

The value of the VCS should not be underestimated. Partnerships with different organisations can assist service users to access opportunities in their local community and increase opportunities for social inclusion. Partnerships should be based on mutual respect and trust but sometimes VCS organisations were viewed as less professional than statutory organisations. The solution appeared to be dependent on the VCS earning the trust of statutory services. These findings have implications for improving information about VCS organisations and raising awareness about their value and usefulness in mental health care.

▪There needs to be increased communication about the value and

potential benefits of the VCS.

Vulnerability of smaller VCS organisations

A key feature of the VCS appeared to be flexibility, which enables the delivery of responsive local public services. However, smaller VCS organisations appear vulnerable because of critical mass issues regarding workforce capacity and funding.

▪There needs to be recognition that smaller organisations are more

responsive to local needs but are also less able to make an

impact on strategic decision making at a national level

7.3 Recommendations for future studies

Further research is needed to assess the level to which the findings in this study are generalisable to other mental health services.

Although we found several factors that influenced NWW and barriers and facilitators to partnership working, questions regarding the ways in which attitudes and beliefs about interprofessional working between medical and non-medical team members and between mental health professionals and the VCS are influential in implementing NWW remain unanswered. Qualitative longitudinal research could be used to explore the impact of NWW policies and continuing experiences of the professionals involved in working together. This research would be useful in eliciting views on the evolving relationships between professionals involved in NWW and partnerships with the VCS and provide further information on the

professional barriers to interprofessional working which were raised in our study.

There is a need for further research on strategies EISs find useful for building relationships with psychiatrists and working in partnership with the VCS. Findings discussed in this study highlight the challenges faced by EISs seeking to work effectively with psychiatrists and the VCS, and emphasise the importance of securing the resources necessary for building long-term co-operation with the VCS and implementing NWW for psychiatrists. Focus groups with EIS teams could be used to explore the strategies found to be useful and those found less useful and the reasons why.

The NHS Plan (Department of Health 2000) emphasises improvement of 'the quality of the patient experience'. Therefore, there is a need to understand how service users perceive services. Robust qualitative research on the experiences of service users will need to be conducted. Exploratory research on the experiences of treatment received from EISs using patch-based and compared with those from dedicated services to evaluate new approaches would also be useful. In addition, user involvement in defining outcome criteria is considered necessary and desirable.

Our study has raised several issues, which need to be addressed if successful partnership working is to be achieved between EISs and the VCS. However, there are also several issues that we did not address in our study that are important to increasing our understanding of partnership working between EISs and the VCS. Future research is needed on examining the quality of services provided to EISs by the VCS. Important issues that need to be address are: do partnerships deliver better services? How is the quality of services provided to EISs assured? Who is responsible within EISs for assessing quality, monitoring progress, and assessing outcomes of services provided to EISs? And how are complaints dealt with? Quantitative research would be useful to explore these issues. A set of evaluation tools could be used to evaluate the VCS performance in supporting service users of EISs. It would be necessary to develop outcome measures on service satisfaction and a tool to assess the quality of mental health service provision by the VCS. Qualitative research could be used to explore the issues concerning the VCS accountability through interviewing EIS teams involved in partnership working with the VCS.

8 Dissemination

8.1 Planned dissemination strategy

8.1.1 Conference presentations

Papers have been presented at the following conferences:

1. Shah S, Tait L, Lester HE. Barriers and facilitators to effective partnership working between the VCS and EIS.*12th NCVO/VSSN Researching the Voluntary Sector Conferenc*e/University of Warwick, 13-14 September 2006

2. Lester HE, Shah S, Tait L. Partnership working between EIS and the VCS. *National EIS conference*, Birmingham, October 4th, 2006.

3. Shah S, Tait L, Lester HE. Barriers and facilitators to effective partnership working between the VCS and EIS: VCS perspectives in the UK. *35th annual ARNOVA Conference*. Chicago, November 16-18th, 2006.

4. Tait L, Shah S, Lester HE. Progress towards partnership in mental health and voluntary organisations: Evidence from EI Services. *35th annual ARNOVA Conference*. Chicago, November 16-18th, 2006.

We will continue to work with the NIMHE/CSIP to disseminate the study findings at regional and national mental health events.

8.1.2 Publications

We have discussed both the publication strategy and authorship criteria at our steering group and the publication policy is attached as Appendix 3.

We intend to publish a series of papers in high impact factor peer reviewed publications aimed at an academic audience in 2007/8.

We will continue to work with NIMHE and our VCS contacts to help disseminate findings through their newsletters and web based media.

With the help of our steering group members we will also liaise with the Department of Health, the Royal College of Psychiatrists and the National Workforce Programme and provide summary versions of our main report for these audiences, as required.

8.1.3 Articles in preparation

We plan to submit the following peer reviewed publications:

- Paper summarising the main findings of the voluntary sector data in EDEN Plus written for Health and Social Care in the Community. (Autumn 2007) IF 1.0

- Paper summarising the main findings of the psychiatrist data in EDEN Plus written for the *British Journal of Psychiatry* (Spring 2008) IF 5.4

- Paper with a predominantly theoretical focus, detailing how different organisational cultures and professional backgrounds affect the development and efficacy of services and of NWW written for *Sociology of Health and Illness* (Spring 2008) IF 1.32

As a team we have decided to concentrate on writing high quality data filled papers. However, ideas for other papers may emerge as we write these four key papers.

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10 Appendices

Appendix 1: Topic guides

Focus group guide for EIS

1. Team Member Roles & Responsibilities

Can you describe your role and responsibilities as team members of an EIS?

Can you describe any situations where roles overlap between disciplines?

> PROBE Can you describe any pragmatic decisions taken to enable the team to function in a multidisciplinary way?
>
> Does interdisciplinary education and training have a role here?
>
> Who decides whether or not you take on a specific referral?
>
> Where do less highly qualified (less expensive) workers like STR workers fit in the team?

What is the role of a Consultant Psychiatrist within a specialist team?

> **PROBE** IF APPLICABLE:
>
> What are the consequences of being a consultant-less team?
>
> Can you describe the strategies you use to resolve those issues?
>
> When do service users need to be seen by a psychiatrist?
>
> NB-THINK about any status issues or power struggles

2. Management & leadership

Who is best placed to fulfil management and leadership roles in your team?

Who fulfils management and leadership roles in your team?

Who is accountable (e.g. in terms or risk taking and "buck stopping") within your team?

When could other team members take medical responsibility?

3. What are the characteristics of a good team?

Do differences in professional culture, training &/or language create issues working for the team?

What strategies do you use to resolve those difficulties?

4. Partnership working with the voluntary sector

Can you describe how you liase with the voluntary sector in your area?

Can the voluntary sector provide anything that a health sector organisation can't?

Are there any barriers/facilitators to working with the vs from your perspective?

Are there are any mechanisms that could be put in place to facilitate partnership working?

5. Closing Comments

Are there any other issues that we should have raised?

Is there anything else you would like to say in relation to the issues we have been discussing?

Focus group guide for dedicated Consultant Psychiatrists

1. How would you describe what an "EI service" is?

2. Who is involved in delivering EIS?

   PROBE for overlap between disciplines and involvement of users/carers and role of vcs

3. What are the roles of the different people responsible for delivering EIS?

   PROBE for specific roles and responsibilities of psychiatrists

   Who deals with physical issues in an MDT

4. What do you see as the key differences between team members within an EIS?

   PROBE for differences in professional history, training, culture and language, differences in accountability and rewards and differences in requirements, regulations and norms of professional education.

5. What kind of health professional is best placed to fulfil management and leadership roles in EIS?

   PROBE for who supervises consultant-less teams

   (Can you advise on a patient you haven't seen?)

6. So what are the key contributions that psychiatrists make to EIS?

   PROBE for how psychiatric expertise can be used to best effect in running an EIS

Any other issues we should have raised?

Focus group and in-depth interview guide for patch-based Consultant Psychiatrists

1. What is an "EI service"?

   PROBE who is involved in delivering EIS?

2. Do we need separate EIS?

3. How does EI work in your patch?

   PROBE for **specific roles and responsibilities** of psychiatrists

   PROBE for issues of a team identity – **would an EIS see YOU as part of their team?**

   How do you "belong" to a team

   PROBE for who supervises consultant-less teams

   Can you advise on a patient you haven't seen?

   PROBE for how teams are able to work with consultants with different ideas and styles

   Who deals with physical health issues in a MDT?

   How do CMHTs and EIS communicate?

4. What do you see as the key differences between EIS and a CMHT?

5. What kind of health professional is best placed to fulfil management and leadership roles in CMHTs?

   Any other issues we should have raised?

Semi-structured interview topic guide for VCS leads

Partnership with EIS

How would you describe your client group?

How would you describe your partnership with the EIS? Is it a formal or an informal relationship?

> **PROMPTS:**
>
> Decision making
>
> How the relationship came about and when
>
> Amount of contact between two services

Aims and objectives of the partnership

Do you feel that you have shared aims and objectives with the EIS?

What are the similarities and differences?

Is there a clear goal for the partnership?

> **PROMPTS:**
>
> Has your organisation thought about effective ways of working?
>
> How do you deal with the differences
>
> How does this affect the service users
>
> Are both your organisation and EI clear about what each other's role? (Who does what?)
>
> Have difficulties arisen with overlaps between service provision, etc.

Training

How easy is it to access high quality training or personal development opportunities?

> **PROMPTS:**
>
> Supervision arrangement to ensure quality of service delivery
>
> Link workers
>
> Joint training – does this help people to value others' roles

Communication

Can you describe how you communicate with EIS?

> **PROMPTS:**
>
> Do you have regular meetings (e.g. once every two months)
>
> Does a member of staff attend EI business meetings and vice versa?

How are teams notified of any changes either to staffing or service provision?

What if there is a problem, do you have a named person to contact at EI?

Were communication pathways discussed initially, or have they developed as the relationship has progressed?

Referral Pathway

Do you receive referrals directly from EI? What are the referral pathways? Are you able to refer directly to EI?

PROMPTS:

Other referral routes

Capacity of org

Numbers of referrals

Have you noticed a change in the number of referrals you receive since your partnership with EI began?

Confidentiality

Are there issues around confidentiality?

PROMPTS:

How do EI inform you of their service user needs

Can you describe how you feedback relevant information to EI about service users

How do you overcome issues of confidentiality?

Risk assessment

How do you carry out your own risk assessment?

PROMPTS:

If NO Do you feel training in risk assessment would be useful to your organisation?

If NO then is this an issue you can discuss with EI?

Does that raise any issues?

Accountability

How are you accountable for EI clients that use your service?

PROMPTS:

If anything goes wrong

If a client makes a complaint

Can you tell me how the support you provide to your clients is evaluated?

PROMPTS:

Set of standards

Do EI monitor your support to ensure quality care?

Government policy

How do you think recent Govt policy has affected your organisation? E.g. Compact, Cross Cutting Review, Third Way

PROMPTS:

Way it is run/organised

Forming partnerships

Funding

Capacity

Does your organisation have a balance between service provision and campaigning?

What do you feel about the Govt's current expectations of the VCS?

PROMPTS:

Do you feel under pressure to take on a role that was previously undertaken by the public sector?

Is there anything else that you feel I should have asked?

SHA executives (involved in EIS) interview topic guide

Role and responsibilities of the SHA relating to EIS and on a wider level

- background

- role and responsibility within the SHA

- role or involvement if any with EIS

- SHA role in monitoring EIS and the lines of accountability

Involvement in the strategic planning of EIS

- current level of involvement in service planning and development

- attendance or membership of planning meetings or fora

- wider membership of these for a

- SHA working in wider partnership with other organisations

- focus of fora (on EIS only or wider focus)

- benefits or barriers to belonging to these fora

- consideration of implementation of EIS policy at the strategic planning level

Challenges associated with implementing and establishing the EIS

- consideration of challenges of implementation of EIS at planning stage

- challenges involved in establishing the EIS

- overcoming the challenges

- role of the SHA in implementation of EIS and associated benefits or drawbacks

- key individuals involved in this

- influence of wider organisations upon this e.g. NIMHE

Future influences on EIS development

PCT executives interview topic guide

Role and responsibilities relating to the EIS and on a wider level

- Background

- Role initially in EIS and current role

- Lines of accountability and responsibility

Involvement in the strategic planning of EIS

- Involvement in the initial development of services

- Current level of involvement in service planning and development

- Attendance at planning meetings or fora

- Wider membership of these for a

- Inception into fora

- Focus of fora (on EIS only or wider focus)

- Benefits or barriers to belonging to these fora

- Consideration of implementation of EIS policy at the strategic planning level

Budgetary issues and finances

Commissioning issues

- Identifying need

- Determining appropriate service model

- Developing the service philosophy (cultural sensitivity, innovation, adaptation and flexibility)

- Staffing and skill mix

- Role of clinical medical staff

- Internal and external staff recruitment

- Leadership and peer support

- Communication with key and broad range of stakeholders

- Project management

- Finances, budgets and resources

Challenges associated with implementing and establishing the EIS

- Consideration of challenges of implementation of EIS at planning stage

- Challenges involved in establishing the EIS

- Overcoming the challenges

- Key individuals involved in this

- Influence of wider organisations upon this e.g. SHA, CHAI

Operational Issues

- The aims and objectives of the EIS

- The accessibility of the EIS

- How the service is responsive to the needs of young people

- Involvement of service users, carers and family members

- Psychological services available

- Staff training and development

Appendix 2: List of VCS interviewees

Main Title	Category	Gender
Project manager	Housing	M
Regional manager	Youth	F
Service manager	Mental Health	F
Service manager	Mental Health	M
Chief Executive	Housing	F
Project coordinator	Youth	F
Development manager	Youth	F
Programme manager	Youth	M
Development officer	Other	F
None specified	Youth	M
General manager	Youth	M
Public development officer	Other	F
Project manager	Mental Health	M
Project manager	Housing	M
Manager	Housing	F
Centre manager	Youth	F
Chief Executive	Youth	F
Youth counsellor	Youth	M
Programme development officer	Housing	M
Coordinator	Mental health	F
Counselling coordinator	Youth	F
Chief Executive	Mental health	M
Group coordinator	Mental health	F
Manager	Youth	F

Main Title	Category	Gender
Outreach worker	Mental health	F
Finance manager	Housing	M
Chief Executive	Mental health	F
Regional director	Youth	F
Team officer	Housing	F
Coordinator	Mental health	F
Housing support manager	Housing	F
Manager	Housing	F
Community worker	Housing	F
Manager	Other	M
Team leader	Mental health	M
National clinical services manager	Mental health	M
General manager	Housing	M
Chief Executive	Other	F
Manager	Housing	M
Project coordinator	Mental health	F
Project manager	Housing	M
Operations manager	Housing	F
Chief Executive	Youth	M
Manager	Youth	M
Chief Executive	Youth	F
Director	Housing	F
Coordinator	Other	F

Appendix 3: Publication policy – EDEN Plus Study

1. Introduction

1.1   This policy represents an agreement between research colleagues directly involved in the EDEN Plus Study.

1.2   Our intention is for there to be a significant number of publications resulting from this study (both reports to our funders as part of our contractual agreement and peer-reviewed papers). We are committed to the principle that authorship is accessible to all team members. Report writing will be shared according to the respective involvement of various team members in specific aspects of the project.

2.   Types of publications

Level 1: Publications central to the evaluation

These are papers that directly answer the main research questions of the EDEN Plus study both from the viewpoint of the voluntary sector and the psychiatrists' views. All authors who fulfil the authorship criteria will be listed. There will be designated writers for each level 1 paper, but the lead writers who will convene the writing team, be responsible for writing the first draft of the papers and be the first/second authors on the paper will be HL and MB for each of the level 1 papers.

Level 2: Publications clearly related to the evaluation but not central to it

These are papers that do not directly answer any of the main research questions but make use of data from the EDEN Plus Study once level 1 papers have been written. Anyone involved in the project can put himself or herself forward to lead in the writing of a level 2 paper and must offer the opportunity for authorship to all other team members. All authors who fulfil the authorship criteria will be listed on the paper.

Examples of level 2 publication: further more detailed exploration of key themes in level one papers; comparisons of EDEN Plus data with work in other areas.

Level 3: Publications of work derived from the evaluation, but not part of it

These are spin-off papers that do not directly answer the main research questions and do not make use of any of the data from the EDEN Plus Study. All authors who fulfil the authorship criteria will be listed. A statement in the paper's acknowledgements should refer to the link to the National Evaluation. Anyone involved in the project can put himself or herself forward to lead in the writing of a level 3 paper and must offer the opportunity for authorship to other team members.

Example of level 3 publications: conceptual consideration of broader themes e.g. the role of hero innovators in implementing policy; literature reviews of the issues considered within EDEN Plus.

3. Process

3.1 "Publications" will be a regular item on the agenda for joint team meetings, including conference calls and meetings that include team members in 2006.

3.2 All draft publications at any level (1, 2 and 3 publications), by any individual members of the study team, will be circulated to the whole team prior to submission. Where there is doubt about whether a publication is directly related to the work we are doing, it should still be circulated to ensure transparency.

3.3 All draft publications (as outlined in 2.2) will be forwarded to the SDO before submission to a journal or, in exceptional circumstances, simultaneous with submission.

4. Authorship criteria

4.1 Authorship should be reserved for those who have made a substantial contribution to at least two of the following criteria:

▪ conception or design of the EDEN Plus Study (HL, MB)

▪ data collection and processing (LT, SS, HR, JT, HL, NJ)

▪ analysis and interpretation of the data (LT, SS, HR, HL)

▪ writing substantial sections of the paper (LT, HL, SS)

All members of the study team are eligible for inclusion on author lists, including those contracted to work on the project, Steering Group members, and other colleagues who contribute to various aspects of the work (e.g. library staff who assist with systematic review) if they meet the criteria. Study team members who leave before the end of the project and new members who join after the start date can be considered for authorship.

The list of authors for each paper will be agreed at joint team meetings, including conference calls and meetings that include the Steering Group. In situations of disagreement, the team and the Steering group would nominate an independent arbiter as or when the need might arise. Arbitration, if needed, would not be applicable to level 3 papers.

4.2 Everyone who is listed as an author should have critically reviewed successive drafts of the paper, should approve the final version, and should be able to defend the paper as a whole (although not necessarily all the technical details).

4.3 Order of authorship should be a joint decision between the co-authors. In situations of disagreement, the team and the Steering group would nominate an independent arbiter as or when the need might arise. Arbitration, if needed, would not be applicable to level 3 papers.

Discussed and accepted at joint team and steering group meeting.