Barriers and facilitators to partnership working between Early Intervention Services and the voluntary and community sector

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Abstract  Partnership working between health and the voluntary and community sector has become an increasing political priority. This paper describes and explores the extent and patterns of partnership working between health and the voluntary and community sector in the context of Early Intervention Services for young people with a first episode of psychosis. Data were collected from 12 Early Intervention Services and through semi-structured interviews with 47 voluntary and community sector leads and 42 commissioners across the West Midlands of England. Most partnerships were described as ad hoc and informal in nature although four formal partnerships between Early Intervention Services and voluntary and community sector organisations had been established. Shared agendas, the ability to refer clients onto an organisation that could provide a service they could not and shared training facilitated partnership working in this context. Barriers to closer working included differences in culture such as managing risk, the time required to make and maintain relationships and recognition of the advantages of remaining a small and autonomous organisation. The four more formal partnerships were also built on the organisations’ experience of working together informally, in one case through a specific pilot project. The voluntary and community organisations involved were also branches of larger national organisations for whom finding sustainable funding was less of an issue. In theoretical terms, eight Early Intervention Service: voluntary and community sector partnerships were at a stage of ‘pre-partnership collaboration’, three at ‘partnership creation and consolidation’ and one at ‘partnership programme delivery’. The empirical data viewed through the lens of the partnership life-cycle model could help early intervention services, and voluntary and community sector professionals better understand where they are, why they are there and the conditions needed to realise the full potential of partnership working.

Keywords: community settings, mental health services, psychosis
Introduction

Partnership working between health and the voluntary and community sector is a high priority for the government with a stated aim of making the ‘voluntary and community sector part of mainstream service provision while respecting and promoting the independence of the organisations’ (Department of Health 2004, p.7). It is seen as a mechanism for integration within an increasingly fragmented landscape and as a way of tackling complex ‘wicked issues’ (Stewart 1996).

Early Intervention Services provide specialised focused treatment for up to 3 years for young people aged between 14 and 35 with a first episode of psychosis. The National Plan for the NHS (Department of Health 2000) stated that 50 Early Intervention Services for young people with psychosis would be established across England by 2004, a situation that has now been largely achieved. As a statutory mental health service, they are being strongly encouraged to develop partnerships with the voluntary and community sector (Department of Health 2000). Indeed, a recent United Kingdom government report proposed that promoting pathways to social inclusion should be a core role for the National Health Service, but that mental health services cannot do this alone (ODPM 2004) and need to develop strategic partnerships with the social care and the voluntary and community sector. Such partnership working could be particularly important for the young population referred to Early Intervention Services, for whom the stigma and social exclusion attached to ‘sticky’ mental health labels can be particularly difficult. Eight per cent of first episodes of psychosis also occur between the ages of 16 years and 30 years at a time of maximal life changes, and educational and vocational opportunities that cannot always be addressed purely by the health sector. However, there is little empirical evidence to guide how an increase in partnership working might be implemented in practice.
The aim of this study was therefore to describe and explore the extent and patterns of partnership working between health and the voluntary and community sector in the context of Early Intervention Services. This paper presents the empirical findings and frames them conceptually within (Lowndes & Skelcher 1998) a four-stage partnership life-cycle model. We also identify a series of theoretical and practical tensions relevant to improving partnership working between Early Intervention Services and the voluntary and community sector, and key ingredients in creating successful partnerships.

**Methods**

The EDEN PLUS study, funded by the National Institute for Health Research Service Delivery & Organisation Programme in 2004, was carried out in the West Midlands region of England (population 5.3 million) between 2004 and 2006. In order to understand the complexities of partnership working, the study team collected data from three key groups: voluntary and community sector group leads, Early Intervention Service team members and senior management staff in mental health provider and commissioning (funding) bodies across the region.

Managers of the 12 active Early Intervention Services in the West Midlands region were asked to provide information about the type of partnership arrangements they were involved with, and nominate voluntary and community sector organisations they had worked in partnership with during the previous 12 months. For the purposes of the study, we defined *partnership* as any situation in which people worked across organisational boundaries towards some positive end (Huxham & Vangen 2005). Each of these voluntary and community sector organisations was then contacted by letter to ask if the lead would be prepared to be
interviewed. The letter also included a brief description of the study and Kendall & Knapp’s (1997) definition of a voluntary and community sector service: independence from the government, an element of voluntarism and all profits ploughed back into the organisation.

Focus groups were conducted with Early Intervention Service team members to explore their perspectives of partnership working with the voluntary sector. Focus groups were used rather than semi-structured interviews to maximise any dynamic interactions within the multiprofessional teams that might provide insights into attitudes, perceptions and opinions, and tap into underlying assumptions (Kitzinger 1994).

Invitations to participate in a semi-structured interview were also sent to senior managers in each of the four Strategic Health Authorities, the 30 Primary Care Trust mental health commissioners and 12 Mental Health Trust and Social Care Trust Chief Executives in the region at the time of the study.

An interview topic guide with a series of predetermined open questions was developed for each of the three sets of interviewees (voluntary and community sector leads, Early Intervention Service teams and service funders). The content arose from a priori issues, a literature review by the study team and ideas that emerged as the study progressed. Each topic guide included common questions around barriers and facilitators to partnership working, funding mechanisms and examples of good practice. At the end of each of the interviews and focus groups, participants were given an opportunity to add any further comments they felt were important.
Data were collected during a 12-month period between May 2005 and April 2006. Data collection and analysis were concurrent. Each interview or focus group lasted between 60 minutes and 90 minutes, was audiotaped and fully transcribed.

**Data analysis**

All transcripts were read by two of the research team independently, and a preliminary coding frame was constructed. A constant comparison method was used to interpret the data (Glaser 1978). Key concepts and categories were identified using an open-coding method from deconstructing each interview sentence by sentence. Key categories were then compared across interviews and reintegrated into common themes. Disagreements during this process were discussed until a consensus was achieved. ‘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 were modified in response (Silverman 1997). Analysis also took into account the different professional backgrounds of the participants where this was possible and appropriate (Barbour 2001).

In view of the volume of data, NVivo (QRS release 2.0) computer software was used to help manage the data. This relational database enabled both individual statements to be analysed according to the initial identified themes, and the overall set of themes to be collated and grouped into related issues from across the entire set of transcripts. All topic guides, transcribed data and thematic indices are available, on request, from the correspondence.
Results

The 12 Early Intervention Service managers nominated 68 voluntary and community sector organisations that they worked with. Four organisations replied that they were statutory in nature, one no longer existed, 10 did not respond and six did not wish to participate. Forty-seven of the 53 eligible voluntary and community sector professionals who responded (89%) agreed to be interviewed. Thirty-nine of the interviewees were the organisation’s manager or chief executive. Fifteen of the organisations focused on housing provision, 15 on youth services, 12 on mental health issues and five were categorised as ‘other’ (including counselling and drug treatment services). The number of full-time paid staff ranged from 0.75 to 368 (median = 15), and the number of referrals in 1 year ranged from five to 70,000 (median = 475).

Forty-two of the 62 (68%) Strategic Health Authority Mental Health Leads, Primary Care Trust mental health commissioners and Mental Health Trust and Social Care Trust Chief Executives agreed to be interviewed.

Focus groups were held with 10 of the 12 Early Intervention Services (83%), and included 60 team members from a range of professional backgrounds (see Table 1). Two Early Intervention Service teams did not participate in a focus group, citing time and workload pressures.

We report the extent and type of partnership working, and the facilitators and barriers associated with partnership working from the perspective of funders, Early Intervention Services and the voluntary and community sector. Quotes have been chosen on grounds of
representativeness with the Early Intervention Service member’s role and number, and voluntary and community sector organisation’s focus and number shown in brackets.

TABLE 1 ABOUT HERE

Extent and type of partnership working

Only four of the 12 Early Intervention Services had any form of formal partnership with a voluntary and community sector organisation. One of these more established Early Intervention Services described a formal partnership with a voluntary and community sector organisation where a legal agreement had been entered into, on both strategic and operational levels, documenting the type of partnership and how it would be managed to achieve its aims. Three Early Intervention Services described partnerships where voluntary and community sector staff were integrated into Early Intervention Service teams with geographical co-location in one case. The Early Intervention Service in this case benefited from respite units provided by the voluntary and community sector, and funded by the Primary Care Trust. Each of these four more formal partnerships was built on the organisations’ experience of working together informally, in one case through a specific pilot project. The voluntary and community organisations involved were also branches of larger national organisations for whom finding sustainable funding was less problematic than for some of the smaller organisations. Each of the remaining eight Early Intervention Services described a range of more informal partnerships with the voluntary and community sector.
Facilitators to developing partnership working

There were three issues that both voluntary and community sector and Early Intervention Service staff highlighted as important in fostering good formal and informal partnership working.

Coincidence of agenda

Shared priorities and principles appeared to underpin the development of both formal and informal partnerships. These included an emphasis on a social model of care and on prioritising a return to independent living.

One of our strengths is working with organisations that are socially orientated because that’s what we’re about. (CPN, 14).

The aims and objectives are the same as in it’s the well-being of the young person that counts and that’s the secret and essence of it all and then we have targets as a sideline. (Youth, 24).

Partnership working was also more likely to occur where the arrangement led to some form of mutual benefit and where there was a coincidence of agenda.

If I can help them hit their target and they can help me hit mine, then we can all work together. The Chief Executive of our Primary Care Trust calls it a coincidence of agenda. (Youth, 45).
Complementary skills

Almost all voluntary and community sector leads were enthusiastic about developing some form of partnership working with Early Intervention Services because they felt they were able to provide holistic services which added value for the client.

I think there’s a good fit with what we do and what they do particularly in a family context because of the issues and also the stigma attached. If we’ve got that partnership then I think we are working a lot more safely and if we are working with them then I think the outcomes, perhaps, have a better chance of being positive. (Other, 38).

Early Intervention Service team members echoed the voluntary and community sector view of the value of working in partnership in terms of providing clients with skills outside their own remit. The services most commonly sought included substance misuse, bereavement counselling, housing advice and access to local community facilities that could provide opportunities for clients to engage in sports, arts and leisure activities. They also recognised that the voluntary and community sector provided a lower stigma setting, which might be more conducive to service engagement.

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 into the community in voluntary services. (CPN, 20).

A further advantage of working in partnership with the voluntary and community sector from the perspective of most Early Intervention Services was the ability to access vocational and educational resources. Many offered clients opportunities to become involved in volunteering within the organisation, facilitating social inclusion and increased self-esteem and self-worth. Some of the voluntary and community sector organisations employed vocational workers who were able to help access work placements for clients, helping to address ongoing pervasive issues of social exclusion through increasing opportunities for employment.

...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. (Mental health, 36).

Joint training initiatives

Joint training initiatives underpinned many of the examples of good practice in formal and informal partnership arrangements. These enabled separate organisations to forge relationships and understand different organisational perspectives.

We have done some training with the ...team and they also provide training. We run a core training programme which is a 12-week programme for all new staff and volunteers and they deliver at one session about general mental health awareness
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and in addition to that they run some slightly more in depth mental health training that has been hugely beneficial. Then they come to our training on drugs. (Youth, 45).

**Barriers to partnership working**

There were five major barriers to partnership working described by Early Intervention Services and the voluntary and community sector organisations. Many of the barriers reflected the cultural differences between statutory and non-statutory services.

*Cultural differences*

A frequently noted barrier to forming more formal partnerships concerned communication about levels of risk and the need for a risk assessment prior to referral. Many Early Intervention Service team members objected to a minority of voluntary and community sector professionals asking for risk assessments, and felt the requests reflected a misunderstanding about associations between psychosis and violence.

Everybody wants a risk assessment if they go [to a voluntary organisation]...we have to send a risk assessment. (CPN, 30).

Information-sharing protocols, which enabled information about risk to be passed between organisations, appeared to facilitate better partnership working in this respect, especially from the perspective of the voluntary and community sector, many of whom also wanted this to be accompanied by a rigorous confidentiality policy to protect clients.
In our neck of the woods, there’s a new information-sharing protocol set up between the local voluntary and statutory sector and I think everybody, not just the Early Intervention Service. All the services now are much more willing to share care plans and risk assessments which, just a few years ago we wouldn’t have had access to.

Interviewer: How was it before that?
Absolutely awful and that has made one heck of a difference. (Other, 12).

A minority of Early Intervention Service members commented on the difficulties of working with individuals who used potentially stigmatising language and sending clients to organisations where notions of recovery from mental illness were not widely accepted. This was not, however, an issue highlighted by any of the voluntary and community sector.

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 mental health 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, 12).

*Investing in the partnership*

Barriers were described from both perspectives in terms of the time and resources required to make any form of partnership working a reality. Early Intervention Service team members reported that organisations were identified by a mixture of serendipity and focused searching for local organisations that could provide a specific service. However, it was difficult to find the staff time to take on and, as importantly, maintain such developmental work.
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. (CPN, 1).

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, 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, 40).

Two of the better-funded and more established Early Intervention Services included a community development offer post which allowed them the time to find local voluntary and community sector organisations, and then to develop and maintain good working relationships with them.

If community development had not been part of my job description, I guess that 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, 18).

Many voluntary and community sector leads also commented on time pressures in the context of the number of meetings that occurred in 1 week and the need, particularly within
smaller organisations, to make every second count. Most felt that the time and resources required to both develop and maintain formal partnership working outweigh potential benefits.

Amateur status

A number of voluntary and community sector leads highlighted the advantages of their autonomy and independence from the statutory sector. They felt that young people might trust them more than the statutory sector, and therefore, be more likely to access their services.

We are an organisation that stands alone. It’s a charitable organisation so it’s not perceived to be part of The System. (Youth, 18).

Indeed, some voluntary and community sector professionals expressed a reluctance to engage in more formal partnership working with an Early Intervention Service, feeling their independence could be compromised both in terms of choosing which referrals to accept and a potential over reliance on one source of statutory sector funding.

However, one of the consequences of independence from the statutory sector was a perception of a majority of voluntary and community sector professionals that statutory service staff viewed them as ‘amateurs’, at least until they had worked with them informally for some time. This ‘second-class citizenship’ within a hierarchy of organisations was at the same time recognised as incongruous, because most were also highly valued by the statutory sector precisely because of their particular expertise.
There’s a kind of mind-set that because you are voluntary, you’re amateurish, so you’ve got to get over that before people can take us seriously. (Mental health, 3).

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 we’re not frightened to actually use those agencies, the very skilled workers within those agencies. (Early Intervention support time and recovery worker, 9).

Economies of scale

The majority of voluntary and community sector organisations in this study were small (median 15 staff), flexible and easy for clients to access. Most voluntary and community sector leads said they felt this gave them a distinct advantage over the statutory sector in being able to respond to clients’ needs flexibly and innovatively.

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, whereas 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... (Youth, 45).

Interestingly, I worked with the voluntary sector for 3 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 of the NHS. (CPN, 13).

However, the corollary of being small and flexible was a lack of capacity at times to respond to issues beyond the immediate client work.

**Funding issues**

Barriers were also created by Primary Care Trust commissioners’ apparent lack of understanding of partnership working issues, strategically or locally. Only five of the 42 commissioners who made decisions about funding services could describe meaningful examples of partnership working within their locality.

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), 6].

Indeed, two commissioners felt that their efforts to engage the voluntary and community sector were largely ‘tokenistic’.

We set out to get broad representation from all of the stakeholders: so service users, carers, psychologists, psychiatrists, social workers, the voluntary sector – about 20 people in total. My view is that it was unmanageable and we were doing ‘what we were required to do’ rather than engaging whole-heartedly in the process. [Director of Service Development (MHT), 15].
Many of the commissioners at Primary Care Trust level expressed views that responsibility for mental health services was often seen as a difficult brief within their organisation, and that arguing for money to fund services was not easy in competition with other general medical services. Some felt this could be an expression of the stigma of mental illness.

I think what I’ve found within NHS organisations is that it (mental health commissioning) doesn’t seem to be everybody’s business and you have to work really hard to get it profiled onto other people’s agendas. I have come across NHS managers that still don’t want to have to attend to, or prefer not to be involved with mental health. They just don’t want to know. [Commissioner for mental health (PCT), 3].

Worries over funding, in particular of achieving caseload targets to be eligible for a future funding, were also a problem within most Early Intervention Services. This reduced their ability to undertake the development work that was critical to creating future partnerships with the voluntary and community sector.

I think one of the issues with us is to find the time to support those relationships and those partnerships. I do worry about having time to feed them because there’s pressure on us to take the 1-15 ratio of clients. (Clinical psychologist, 40).

In turn, voluntary and community sector leads describe the problems that uncertain funding created in terms of the administrative burden of constantly having to bid for further funding. These time commitments and uncertainties meant that many voluntary and community
sector organisations had limited capacity to create formal partnerships with Early Intervention Services and to make or commit to longer term plans.

...It takes time to write bids and then if you don’t get them, then you have wasted 1 or 2 weeks of your time and it might be that it is only a £5,000 or £10,000 bid which is quite disheartening. (Youth, 2).

Discussion
This is the first study to examine partnership working between Early Intervention Services and the voluntary and community sector. While most previous work has described forms of partnership working and focused on managerial perspectives (Glasby & Peck 2006), this study has highlighted the type, extent and practical requirements necessary for implementing partnership working from multiple perspectives. It adds to our knowledge of the complexities of the issues, and highlights practical solutions such as joint training, the value of community development posts and information-sharing protocols that could be adopted to encourage partnership working.

Limitations
This study has a number of limitations. Only one person within each voluntary and community sector was interviewed (almost always the organisation lead), and it is possible that other team members might have had different views. The study design also meant we focused mainly on describing processes rather than on possible relationships between partnership working and service user outcomes.
Relevance to previous work

These findings support previous work on partnership working between health and social care. Glendinning (2002), for example, found that shared priorities and principles were important in developing strong partnership links. Harris et al. (2004) highlighted a lack of time and resources as a critical barrier to developing partnerships. Coid et al. (2003) and Alcock et al. (2004) both identified short-term non-sustainable funding as a key hindrance to partnership working. Perhaps of most interest, however, are the resonances between our data and Lowndes & Skelcher’s (1998) conceptual work on the partnership working life-cycle (see Box 1) which may increase the generalisability of these findings to settings and patient groups beyond Early Intervention Services (Green 1999). In particular, an appreciation of the life-cycle model could help Early Intervention Services and voluntary and community sector professionals understand where they are, why they are there and the conditions that need to be created and then maintained to realise the full potential of future partnership working.

The life-cycle of partnership working

In their four-stage partnership life-cycle model, Lowndes and Skelcher describe the first stage as pre-partnership collaboration’. This is characterised by an ‘ideal type’ network relationship based on informality, trust and a sense of common purpose, including deriving mutual benefit from the partnership. Most of the relationships described by Early Intervention Services and voluntary and community sector fell into this category, underlining the importance of coincidence of agenda and of informal personal relationships. These informal partnerships are theoretically and were, in practice, vulnerable to short-term funding and staff turnover, and took time to build and maintain.
The second stage of the life-cycle, ‘partnership creation and consolidation’, is characterised by increasingly focused activity including the development of more hierarchical relationships and the formalisation of procedures. Three Early Intervention Services described this type of partnership with the voluntary and community sector. This relationship was perceived as less vulnerable to staff turnover and could be (and indeed was) strengthened by joint training. It was seen as a vital part of the partnership’s life-cycle as it moved from exchanging ideas and information towards a focus on a specific project. However, our data also suggest that greater formality can also limit flexibility and innovation, which was particularly prized by the voluntary and community sector. The perception of amateurism noted and disliked by many voluntary and community sector leads and differences in approach to risk and use of language voiced by some Early Intervention Services reflect cultural differences and the potential for misunderstandings between sectors. They also highlight the need to negotiate the rules of partnership working and spend time learning about each other’s worlds if more Early Intervention Services and voluntary and community sector want to move towards this second stage of the life-cycle. It is noteworthy that one of the partnerships at this stage of the life-cycle had initially engaged in a formal pilot project. This was described as helpful in establishing which policies and procedures would be used, and in highlighting potential difficulties in working together formally.

The third stage, ‘partnership programme delivery’, is characterised by formal contracts which theoretically introduce competition for funding, lower levels of co-operation and the associated need to demonstrate added value. Only one of the more established Early Intervention Services had recently entered into such a formal legally binding partnership with a voluntary and community sector organisation, and such tensions were not yet in evidence.
The final fourth stage of the life-cycle, ‘partnership termination or succession’, is where the partnership comes to an end with an exit or succession strategy. No Early Intervention Service in this study had reached this stage of the life-cycle, perhaps because of the relative youth of most of the services. However, the theoretical model suggests a number of caveats as Early Intervention Services in particular become more widespread and established. Increased competition between different partnerships can lead to the fragmentation of resources and duplication of effort as neighbouring localities bid against each other. This has costs for broader inter-agency relationships and time costs for the ‘losers’. Relationships built initially on mutual trust can become undermined by the imperative to compete. Secure funding, currently seen as a panacea by many services, may not necessarily cement partnerships but could potentially damage emerging relationships built on trust.

**Conclusion**

This study suggests that although informal collaboration is widespread, there is, despite strong policy encouragement, relatively little evidence of more formal partnership working between the Early Intervention Service and the voluntary and community sector. Four of the Early Intervention Services had developed formal partnership links with larger national voluntary organisations for whom funding was less of an issue. These links were strongest where the Early Intervention Service had been established for some time and teams had a history of successful working together that inspired mutual trust and confidence. For these organisations, the policy framework has provided support for the creation of vibrant partnerships built on a bedrock of good local relationships. However, most partnerships between the voluntary and community sector and Early Intervention Services were ad hoc and informal in nature, constrained by issues of time and insufficient workforce capacity to
enable more formal links to be developed and insecure funding, particularly for the voluntary and community sector.

Key ingredients in creating successful partnerships between Early Intervention Services and the voluntary and community sector appear to be initial capacity to seek out relevant potential partner organisations who share coincidences of agenda. These can be fortified through joint training, sharing information about clients where appropriate and pilot runs of more formal arrangements to highlight and address cultural differences.

Our findings also suggest that a better understanding of the complexity of the issues at a commissioner level and sustainable funding for Early Intervention Services and voluntary and community sector organisations may also better enable partnership working to flourish.

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Contributors

HL, MB and LT designed the study. LT undertook the literature search. HL, LT, SS, EE collected data. LT was responsible for drafting the paper and the final report. All authors contributed to the critical revision of the paper. HL is the guarantor of the paper.
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Table 1  Characteristics of focus group participants

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<thead>
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<th>Professional background</th>
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<tr>
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<td>Community support worker</td>
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<tr>
<td>Occupational therapists</td>
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<td>Social workers</td>
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<tr>
<td>Youth workers</td>
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<td>Team secretary</td>
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<td>Total</td>
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Box 1  Lowndes & Skelcher’s (1998) model of the partnership working life-cycle reflecting the status of partnership working from the Early Intervention Service perspective in the West Midlands

- Pre-partnership collaboration  8
- Partnership creation and consolidation  3
- Partnership programme  1
- Partnership termination and succession  0