Section 9

Working in partnership

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Section overview

In this section we will consider collaborative interventions to support survivors who are also affected by substance use and/or mental health problems.

1. Understand the survivor's perspective
2. Understand different types of partnership working
3. Be aware of challenges to partnership working
4. Identify your partners
5. Establish a partnership
7. Develop effective referral pathways

1. Professional overload – a survivor's perspective

Stop for a moment and think about yourself. How many professionals are involved in your life?

Most likely you have a named GP, or at least a particular surgery that you use. If you have children, you might have recently seen a health visitor or a teacher. Some of you will be in touch with primary or secondary mental health services, drug or alcohol support services or maybe you are receiving support from a sexual violence service. Bearing in mind that no-one is immune to experiencing domestic and sexual violence, substance use or mental health problems, it is quite possible that professionals will use some of the same services as their service users.

For many survivors who are also affected by mental health and substance use problems and come into our services, there may be many professionals involved all at one time.

Take Sylvia, for example. She has three children: Sian (9 months), James (3 years) and Paul (8 years). Sylvia separated from the children's father four months ago, after several years of violence and abuse. She has been diagnosed as being bipolar (manic depression) and

having a panic disorder. She also has periods of drinking very heavily.

Who might be involved with Sylvia and her children? The GP? A psychiatrist? Mental health social worker? A children's social worker, health visitor, teachers, child psychologist, family alcohol worker, parenting worker, domestic violence outreach worker, tenancy support officer?? The list goes on and on. Imagine having that many professionals involved in your life! Consider how many appointments Sylvia has each week, how many different people she has to update on what has happened with other professionals and how, if agencies do not work together, she will need to co-ordinate all the support she and her children need.

People who experience multiple difficulties in their lives can feel overwhelmed by the involvement of so many professionals in their lives. However, working collaboratively both within and between agencies, Sylvia's life can be made easier.

2. What is partnership working?

"The essence of partnership is sharing. It is marked by a respect for one another, role divisions, rights to information, accountability, competence, and value accorded to individual input" [1]

Cooperation, collaboration, teamwork, joint working, partnership working, multi-agency practice, integrated responses are all terms to describe the ways in which professionals and agencies can work together to support survivors and their families.

Partnership working can range from informal sharing of information about a service user (with their consent) between two professionals, to service level agreements between organisations that formalise inter-agency referral pathways.

Working collaboratively can be beneficial for professionals and service users. For clients, effective partnership working is vital in reducing:

- the number of inappropriate referrals between agencies
- the number of times someone has to 'tell their story'
- the number of appointments with and phone calls/letters from professionals to deal with which can feel overwhelming
- the time and stress of co-ordinating different professionals
- the feeling of being "passed from pillar to post" without getting anywhere
- the likelihood of getting lost in the gaps between services

"Every agency has a different form – why can't they all use the same? It's mainly the same information anyway and I just have to say it a million times over."

Survivors voice

The benefits for professionals are also multiple:

- not feeling alone in supporting clients with complex, intersecting needs
- better understanding of the client as a whole person and how different parts of their life can impact on the area that you specialise in
- more opportunity to intervene early and prevent crisis from arising or escalating
- greater engagement with service users who feel more supported
- ability to learn from colleagues and see things from a different perspective
- inspire innovation and creativity in the development and delivery of services

3. Challenges to partnership working

Take a moment to think about Sylvia and all the professionals that are working with her family. Whilst there are undoubtedly benefits to everyone working together, in reality this can be quite difficult.

Image Sylvia's alcohol worker, Jane. Each time Jane sees Sylvia, there are more letters from the different

professionals involved with the family, and more appointments to attend. Sylvia often seems confused by it all and can feel overwhelmed at times, which can trigger her drinking. Sylvia and Jane agree for Jane to contact the other agencies and clear up some of the confusion.

Jane may come across a number of difficulties in trying to work together with other professionals:

- Finding the right person, particularly due to frequent changes in staff
- Refusal to share information
- Other professionals being protective of their client
- Feeling threatened - when people's way of working or their identity is threatened, they may feel defensive, experience loss of confidence, emotional stress and be reluctant to collaborate with other professionals
- Different ways of working and models of understanding complex needs.

Working across sectors

Understanding how our partners work is vital to developing strong relationships between agencies. People working in domestic and sexual violence, substance use and mental health services will vary in their working styles and priorities, but in other ways the services can also be similar:

- Safety is key. Domestic violence services focus more on the risk of harm to their service users, whilst substance use and mental health may prioritise service users harming themselves and others.
- Focus on security. Refuges probably will not give their address to you, nor will they usually let male workers from other agencies visit (as anyone could be a perpetrator). Inpatient wards (for mental health) and some drug and alcohol detox units may be locked, so a worker will need to let you in/ out.
- Crisis is common. All three sectors with service users whose lives may be chaotic and include frequent crisis – be that an overdose, attempting suicide or being

seriously assaulted and needing to flee into a refuge. Workers are used to managing in a fast-paced and changing environment.

- Have our own language. Please check the glossary on p.287 if you are not sure what DASH, IDVA, ISVA, MARAC, SARC, CPN, DTTO, or a Section 136 are. Most services today work from a principle of empowering service users and supporting recovery, but substance use and mental health workers are more likely to talk about diagnosis and treatment.

- We are experts. Practitioners develop a wealth of knowledge about the issues they work with most frequently, yet we cannot be expected to know everything. If you do not know something, be direct and ask. Conversely, don't expect colleagues in other services to share your knowledge. Take time to answer their questions – we can all educate and learn from each other.

For frontline workers, much of the difficulty in partnership working comes from a lack of opportunity to meet colleagues in other services, to get to know what they do, how they work and to understand their approach. Professionals work to and often hold on tightly to different models – social care, biomedical, feminist – which can seem completely incompatible. Being able to spend in another service and see how they work can overcome some of these problems.

There may also be differences in terminology (see glossary on p.286 for commonly used terms), in the levels of information professionals are willing to share even with the survivor's consent, and you may be working to different targets or outcomes.

Therefore, there is a need for agencies to develop protocols for working together alongside providing opportunities for professionals to spend time together and learn about each other's services and work.

4. Who are your partners?

Before looking at how you can form partnerships, consider who you might form partnerships with. You may already have a directory of local services. If not, it can be a useful idea to make a staff member responsible for collating a list of local services, or nominate 'champions' who are tasked with finding out about certain types of services, for example mental health, drug and alcohol, sexual health, childcare, local doctors, employment services, domestic violence and sexual assault services.

The list will help prepare you for all forms of disclosure, and the process of collecting the information can help build relationships with partner agencies. Take the initiative and instigate the process rather than expecting another organisation to do so.

Local organisations
Details of relevant national umbrella and membership bodies as well as information on how to find out about local domestic and sexual violence, substance use and mental health services can be found in appendix H.

5. Creating integrated responses

Research into the lack of successful integrated approaches to addressing multiple needs[2] routinely suggest taking the following steps to promote collaboration:

- Develop a shared **vision** that all parties involved can agree on and that is interpreted the same way.

- Learn each other's **language** and create shared meanings. 'Risk', for example, evokes different priorities – in substance use services a key risk is drug- or alcohol-related offending; in mental health the main risk is harm to self; for domestic violence the perpetrator is the major risk assessed.

- Enable **relationship building** through regular meetings between agencies, inter-agency visits to get to know partners. Give short presentations about your services at a partner agency's team meeting. Protect staff time to attend multi-agency fora and networking events.

- Make **communication** between agencies easy by clarifying information sharing and confidentiality protocols (more information on this can be found on p.117) and having a named person to liaise with certain agencies or around particular issues, e.g. nominate a domestic violence champion within a drugs service and vice versa.

- Promote **joint training.** Multi-agency training has been identified as a beneficial way for people to meet each other as well as to teach them about fields that are not their primary specialism. Similarly, training swaps between agencies can be useful in building relationships, particularly when money is tight.

- **Respect** the fact that partner organisations have constraints, responsibilities and outcomes to meet that are not completely the same as yours.

- Address **dissatisfaction and complaints** directly rather than letting them bubble under the surface.

"We need to formalise partnerships, stop relying on old relationships" [3]

We often assume partnership working is a formal and time-consuming process, yet making an informal phone call to a service, finding out a named contact and asking for advice and information can be an effective exercise in partnership building.

It is nonetheless important that in addition to enabling professionals to build relationships with colleagues in other agencies, more formal structures are put in place that will withstand changes in staffing:

- **Joint care/support plans.** Survivors with drug, alcohol or mental health problems often require a collaborative response. If a survivor is being supported by more than one worker, can workers come together to devise a joint care plan with the service user? This can cut down on duplication of work, improve information sharing and reduce the chance of professionals working at cross purposes. In such cases consensus about

each professional's roles and responsibilities is needed.

- **Co-locating staff in multi-disciplinary teams** who routinely work together to support service users, such as combined health and social care teams with Community Mental Health Teams.

- **Multi-agency meetings.** MARACs and child protection conferences are examples of a forum where professionals come together to discuss an individual or family who is at risk of harm. It is important that the meetings are not used solely for the purpose of sharing information, but to identify relevant actions for professionals/ agencies to take to support and protect the individual. Systems must also be in place to ensure that agreed actions are followed up on.

- **Service level agreements.** If two organisations feel that they would benefit from each other's services a formal written agreement may be developed to clarify roles and responsibilities. A service level agreement should clearly state what services are to be provided and how this will be measured or ensured. For example, a domestic violence service could offer to run an afternoon of outreach in a mental health service. In order for this to occur, an agreement, inclusive of associated costs, may have to be devised.

What works? Linking abuse and recovery through advocacy [4]

The LARA (Linking abuse and recovery through advocacy) project is the first pilot domestic violence intervention involving reciprocal training between mental health and domestic violence services, and a direct referral pathway to domestic violence advocacy for psychiatric service users. Between May 2009 and May 2011 five Community Mental Health Teams (CMHTs) in a South London borough participated in a randomized control trial to assess the impact of an integrated response to domestic violence. Two CMHTs offered care as usual to identified survivors of domestic violence. Three CMHTS were provided with 4 hours of domestic violence training, a domestic violence manual for clinicians, a direct referral pathway to domestic violence advocates (seconded to the teams from local

domestic violence voluntary sector organisations) and an information campaign was run. The domestic violence advocates received 6 hours mental health training. In the three CMHTs that received the training and specialist support, the evaluation found significant improvements in clinicians' domestic violence knowledge, attitudes and behaviours. Service users reported significant reductions in violence and unmet needs at follow-up.

6. Information sharing

Confidentiality and limits on information sharing is cited as a key barrier to partnership working. Unfortunately progress towards developing effective multi-agency information-sharing protocols has, overall, been slow,[5] particularly in relation to health.

6.1 Reasons to share information

In many instances, agencies will be able to obtain a service user's consent to share information with another service – as part of the referral process or in jointly supporting a service user.
In other cases, you may have to consider sharing personal information, possibly without the individual's consent, because of:

- concerns for the safety of a vulnerable adult, particularly in cases where the person does not have capacity,
- evidence or reasonable cause to believe that a child is suffering, or is at risk of suffering, significant harm, or
- the need to prevent a crime, including acts of domestic and sexual violence, towards a named person.

When considering whether to share information without consent, you must ensure that your decision to share is based on necessity and proportionality "i.e. whether the proposed sharing is likely to make an effective contribution to preventing the risk and whether the public interest in sharing information overrides the interest in maintaining confidentiality".[6]

"Despite considerable progress in interagency working, often driven by Local Safeguarding Children Boards and multi-agency teams who strive to help children and young people, there remain significant problems in the day-to-day reality of working across organisational boundaries and cultures, sharing information to protect children and a lack of feedback when professionals raise concerns about a child." [7]

This does mean that in some cases, particularly if there are no children involved, professionals should not share information or make referrals (even to MARACs) without the survivor's consent.

It is advisable that agencies develop protocols with partner agencies with whom they need to share personal data. AVA has produced guidance on writing a multi-agency domestic violence information sharing protocol which can be accessed here: http://tinyurl.com/c28nbvo.

Remember always share information to protect the safety of a survivor and their child(ren). If it is not for this reason, do not share it. Information should not be shared for the sake of sharing information.

6.2 What information to share

You should only share sufficient personal information that will enable another agency to work safely to support a survivor and their child(ren). This means balancing the need for survivors not to have to repeat their details over and over again with partner agencies and, in the case of multi-agency fora such as the MARAC, providing sufficient information for agencies to manage risk with the need to respect survivors' entitlement to privacy. Practitioners should therefore only:

- share personal data on a need to know basis

AND

- share relevant information.

This requires considerable judgement, and will often be specific to the context. At a MARAC, for example, an alcohol worker may choose not to share information about injuries a service user had reported received from falling down the stairs whilst under the influence of alcohol. If, however, during the MARAC, it was reported that the perpetrator's previous partner had

suffered a miscarriage as a result of falling down stairs, then details of the current survivor's injuries may need to be shared.

Similarly, the rights of perpetrators need to be upheld, with only relevant information being shared with the purpose of increasing the safety of survivors and their child(ren). Whilst it may not seem necessary or relevant to share information that a perpetrator has entered into a drug treatment programme, drugs workers should be aware that a perpetrator's abusive behaviour may increase as his substance use changes and the survivor may be at greater risk of harm. It could therefore be appropriate to share this information at a MARAC.

More details about information sharing at MARACs is detailed in *Striking the Balance*, the Department of Health's guidance on applying the Caldicott Principles to domestic violence. The document can be accessed from http://tinyurl.com/cjfjyev.

Seven golden rules of information-sharing [8]

1. Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.

2. Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

3. Seek advice if you are in any doubt, without disclosing the identity of the person where possible.

4. Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgment, that lack of consent can be overridden in the public interest. You will need to base your judgment on the facts of the case.

5. Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.

6. Necessary, proportionate, relevant, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.

7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

6.1 How to share information

Sharing personal information is not difficult. What is important is to share information safely. So what does this mean in practice?

- It means encrypting emails if you are sending personal data.
- It means password protecting electronic files that you share so that only the other worker with whom you need to share the information obtains access to it.
- Avoid faxing information whenever possible but if you need to send information by fax take precautions to ensure it does not get intercepted by someone who should not have access to the information.
- When speaking on the telephone, make sure you are not being overheard by someone who does not have a need to know that information. Be careful where you talk about individual cases to ensure you are not overheard.
- Mark post "Personal and Confidential - to be opened by the recipient only".
- Do you need the consent of individuals in order to share their personal data with another agency?

- A consent-based approach (i.e. asking the service user) is ideal.

However, there may be occasions when workers need to assess whether sharing information would jeopardise a survivor and their child(ren)'s 'vital interests' (as the law defines it) or if it is in the public interest to share that information (for example, there is a high risk that the perpetrator is about to attack the woman or child or another person). Workers are advised not to seek consent and to share relevant information with relevant partner agencies who have 'a need to know' in these instances.

Support and guidance should be sought from your supervisor/line manager or the Data Controller within your agency if you are unclear on how to proceed.

6.1 Dealing with consent

A service user is entitled to withdraw their consent to you sharing their information at any point.
You must tell the service user that they can exercise this right and that, should they do so, you will inform them of any impact on the service they will receive from you.

In the event that an individual:

- withdraws their consent for their personal information to be shared, or:

- wishes to subsequently place/ amend restriction upon the personal information to be shared,

your agency should immediately inform all other agencies who are, or may be, affected by this request and you should record the details of the request on the individual's file.
Where consent is withdrawn, no further personal information should be disclosed unless there are legal reasons for doing so. As before, these may include: a threat to the 'vital interests' of a survivor, their child(ren) or another person or where there is a 'public interest' to share this information. It may also include situations in which the survivor does not have capacity.
For information about capacity and consent, see p.117 and p.129.

Remember to inform survivors if you intend to share information about them with other services, even if consent is not forthcoming.

The information in this section was drawn primarily from AVA's Basic Guide to Domestic Violence Information Sharing. The guide can be downloaded from http://tinyurl.com/cydqe2b.

7. Effective referral procedures

It might seem unnecessary to consider how to make an effective referral but, in practice, many service users report being referred between agencies without knowing why and without sufficient support to contact the second agency or attend the first appointment, which reduces the likelihood that the survivor will engage and get the support they need.

Next time you make a referral, ask yourself the following questions:

- How much do you know you do about the service – what actually do they offer? Is your client likely to meet the referral criteria? What is the referral procedure? Do they have a waiting list?
- Does your client know what the service does and why you are referring them on?
- Is your client okay with you sharing information between the two organisations?
- Have you given the receiving organisation as much information as possible in your referral to minimise the amount of information the client has to repeat?
- Is the client able to go by themselves? Do they have a named contact when they arrive at the meeting place?
- Does the client understand what happens next?

After making a referral, don't forget to follow it up. Find out:

- How did it go? Is your client engaging?
- If not, you might want to speak to the client about why they are not engaging – they could give you useful feedback about the other service, or maybe it just wasn't the right time for the client.

- If the client does engage, ask for the client's consent to talk to the worker in the partner organisation – find out what are they helping the client with? What are they struggling with? How can you help one another?

- Where possible, organise joint meetings with the client to reduce the number of appointments the client has to attend, to present a united front and reduce the need for duplication of work

A sample referral pathway can be found on p.219 which outlines the process for making a successful referral.

Figure 10 - Sample referral pathway[9]