Partnerships: survey respondents' perceptions of inter-professional collaboration to address alcohol-related harms in England

Abstract

Tackling alcohol-related harms crosses agency and professional boundaries, requiring collaboration between health, criminal justice, education and social welfare institutions. It is a key component of most multi-component programmes in the USA, Australia and Europe. Partnership working, already embedded in service delivery structures, is a core mechanism for delivery of the new UK Government Alcohol Strategy. This paper reports findings from a study of alcohol partnerships across England. The findings are based on a mix of open discussion interviews with key informants and on semi-structured telephone interviews with 90 professionals with roles in local alcohol partnerships. Interviewees reported the challenges of working within a complex network of interlinked partnerships, often within hierarchies under an umbrella partnership, some of them having a formal duty of partnership. The new Alcohol Strategy has emerged at a time of extensive reorganisation within health, social care and criminal justice structures. Further development of a partnership model for policy implementation would benefit from consideration of the incompatibility arising from required collaboration and from tensions between institutional and professional cultures. A clearer analysis of which aspects of partnership working provide 'added value' is needed.

Keywords: alcohol, partnerships, professional collaboration

Introduction: partnership working 1997-2011

Responding to alcohol-related harms poses problems for policy formation and implementation because the issue crosses agency and professional boundaries and requires collaboration between a wide range of professional, trade and civic organisations. This paper charts the emergence of new forms of partnership working as a pragmatic response to implementing alcohol policy at local levels. It focuses on partnerships between health, social welfare and criminal justice professionals as these groups are in the foreground of local alcohol policy. The paper examines the assumptions underpinning the partnership model and highlights the continuing challenges to partnership working.

Over the past two decades, partnership working has become the accepted approach to addressing complex health and social problems which require complex solutions. This is not a new idea and has appeared at various times and under different labels – as multi-agency collaboration, joint working, joined up thinking, inter-professional collaboration. Partnerships are a core feature of most multi-component programmes in health and social care, emerging, for example, from community health approaches in the United States (e.g. Mitchell and Shortell 2000) as well as from community and population interventions aiming to tackle poverty, inequality and health issues in Europe (e.g. Geddes 2000) and in the UK (e.g. Elston 2000).

In the UK, with the election of New Labour in 1997, partnerships became a key mechanism for the delivery of central policy at local levels, underpinning a large number of health and

social care initiatives as part of the de-centralisation, or localisation, agenda (Peckham 2007, Smith *et al*. 2009, Perkins *et al*. 2010). Seen as a way of tackling what has been called 'wicked issues' – problems which are complex and cross traditional organisational boundaries (Wildridge *et al*. 2004, p.6) - partnerships have become accepted and normalised as necessary and inevitable across programmes aimed at improving health and reducing health inequalities as well as in other policy areas (Health Development Agency 2000, Smith *et al.* 2009, Beatty *et al*. 2010). The briefing paper, *Health Improvement Programmes: research into practice* (Marks and Hunter 2000) and Elston's (2000) analysis of 50 HImPs, indicates the extent to which such initiatives had spread during the 1990s and the extent to which partnership working had already become a requirement. According to Elston (2000, p. 9):

> *Partnership working represents a crucial development in local health improvement planning and all HImPs are required to list the partners involved in producing the programme. The majority of partnerships include: NHS trusts, PCG/PCTs or general practitioners (GPs), some local authority representation, and a voluntary sector umbrella group. However, within these groupings there is considerable variety: ranging from almost total NHS dominance to the involvement of different local authority tiers and departments, voluntary sector groups, the police, the probation service, a university and the private sector (such as the local chamber of commerce). Professional NHS committees – such as local medical, dental and prescribing committees – are also common partners. In some areas, groups with particular interests are linked to the HImP – such as organisations representing black and minority ethnic groups and carers' forums*.

As might be gathered from Elston's comment, there is no clear definition of partnership although some core elements can be distinguished from the literature. Writing somewhat later, Peckham (2007, pp.2-3) suggests that:

> *Partnerships are formal structures of relationships among individuals or groups, all of which are banded together for a common purpose. It is the commitment to a common cause – frequently purposive change – that characterises these partnerships, whether the partners are organizations or individuals, voluntary confederations of independent agencies or community assemblies developing multi-purpose and long term alliances.*

Peckham's observation draws attention to a defining feature of the development of partnerships over the past decade - the shift from more organic, loose forms of collaboration to more structured, strategically directed and regulated relationships between different organisations, professional groups and a whole range of other stakeholder groups. As Wildridge *et al*. (2004) noted, *The New NHS: Modern Dependable* (1997), placed a formal duty of partnership between the National Health Service, local authorities, local voluntary and for-profit organisations. In their study of partnerships in public health (2007-10), Hunter and Perkins (2012) confirm the shift towards more regulated, monitored and statutory relationships which, they argue, may not be the best model to address complex health and social issues. The trend was equally pronounced in criminal justice where New Labour imposed a duty of partnership on some organisations, for example Crime and Disorder Reduction Partnerships (CDRPs), which have mandatory partners (Crawford 1997).

Partnerships had become a policy tool in the increasing devolution of policy and service delivery from central government to local levels.

In the alcohol field, efforts to stimulate collaborative working to tackle alcohol related problems pre-dated the rising popularity of the concept of partnership (Thom *et al*. 2011) and reflected the more organic model characteristic of earlier times. From the start, collaborative working in alcohol was seen to cross the disciplinary boundaries and to require inter-agency and inter-professional commitment from across health, criminal justice and social welfare spheres. Alcohol Forums had typically brought together probation, specialist alcohol services, the police, youth workers and, to a lesser extent, health professionals (Thom *et al*. 2011). A network of 14 Regional Alcohol Misuse Co-ordinators in 1990, under the guidance of the Health Education Authority, was another push towards fostering collaboration between statutory health services, social care agencies and voluntary organisations and towards initiating strategy to support inter-sectoral working at local level (Means 1990).

The consensus surrounding the adoption of a partnership model for the development of policy, strategy and service delivery at local level was reflected in the Department of Health's recent Alcohol Improvement Programme where partnership was specified as a key facilitating element for the delivery of a number of 'high impact' interventions to address rising rates of alcohol-related hospital admissions (ALC 2012). It is reinforced in the UK Alcohol Strategy (HM Government 2012) which endorses a number of developments such as Health and Wellbeing Boards, Joint Strategic Needs Assessment, and giving directly elected Police and Crime Commissioners (PCCs) commissioning powers and funding to enable them

to work with partners to cut crime and ant-social behaviour. Partnership working has, therefore, emerged as a key policy mechanism for local intervention and service delivery.

The acceptance of partnership has grown despite the fact that we know very little about how effective partnerships are as a method of developing and implementing local policy and the possibility that persistent policy support for the concept is largely faith based (Smith *et al*. 2009, p. 212). As in other policy areas, issues of developing common goals, setting agreed priorities for resource allocation and managing institutional and professional cultures are likely to present considerable barriers to successful partnership working, especially when cooperation is expected between a wide range of partnership networks, some of which have more mandatory underpinnings than others. (Wildridge *et al*. 2004, Zacocs and Edwards 2006, Perkins *et al*. 2010). In particular, previous studies have documented the resistance of professional 'tribes' to the behaviour changes needed for collaborative working (Beatty *et al*. 2010) and have highlighted the complications for partnerships arising from members' involvement in competing markets and hierarchies within and between their organisations. Thus, to think of partnerships as operating separately from the more traditional governance forms is unrealistic and may set partnerships to fail (Rowe and Devanney 2003).

The research on which this paper is based focussed on partnerships between health and criminal justice professionals; these were seen as the dominant groups driving local policy and intervention. A much wider range of stakeholders – the alcohol trade, youth workers, groups concerned with children and young people, users and voluntary groups – overlapped with the partnerships which we studied but were not central to their membership and were not covered in this study.

While theoretically, there are good arguments for a policy emphasis on partnerships, the observation that failure to move from policy to implementation happens because the model is not based on the realities of existing organisational structures, professional practices and relationships (May *et al*. 2005), indicates the value of drawing on experiential evidence from the field. As partnership working expands and, possibly, shifts towards more formal and contractual approaches to governance and management, evidence from practice becomes increasingly important (Hunter and Perkins 2012).

This paper provides a critical overview of alcohol partnerships in England, based on professionals' perceptions of the effectiveness of their partnerships, the barriers to successful collaboration and how they met the challenges.

The specific issues reported here, address the following questions:

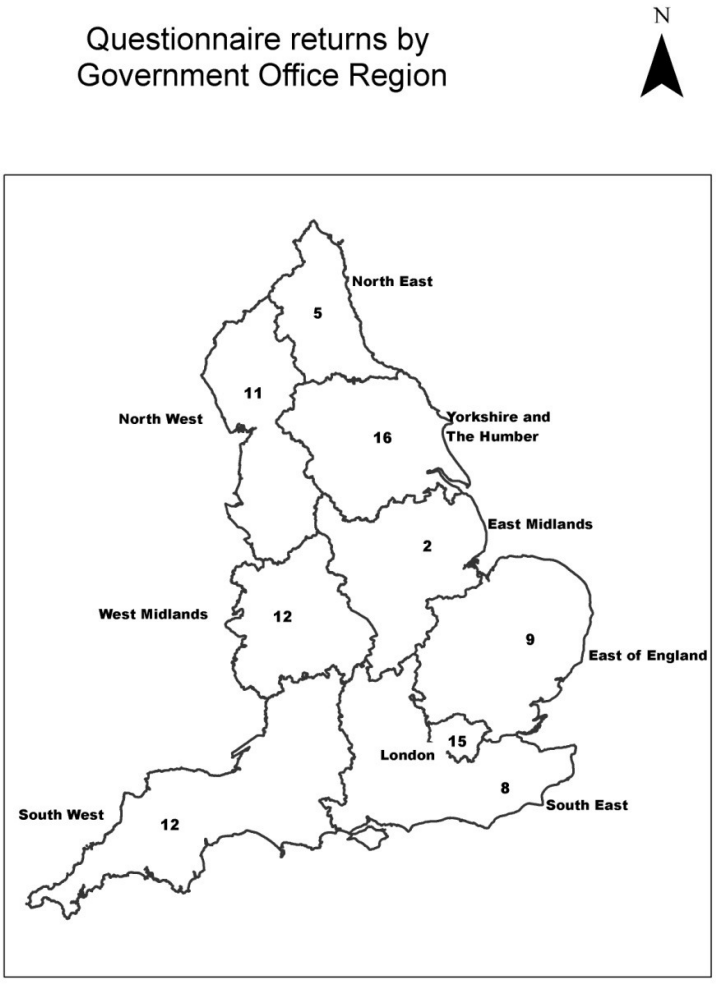
- What kinds of partnerships are there and how is their effectiveness assessed by a sample of professionals involved in their operation?
- What do partners see as the challenges in partnership working?
- What can we learn from informants' accounts about the dynamics of partnership working: in particular the need to break down professional and institutional silos?

Methods

The research aimed to provide an overview of partnerships in England based on the accounts and perceptions of professionals who were asked to describe their main partnership and reflect on its role, functioning and barriers to effective working. Seventeen key informants at national or regional policy level were interviewed to explore themes highlighted in the literature and to identify emerging issues. Interviewees were chosen to provide insights into the development of partnership approaches over the previous two to three decades (a historical perspective), perspectives from individuals working at national and regional levels, and individuals coming from a range of different professional backgrounds within health and criminal justice agencies predominantly.

These interviews informed the development of a semi structured telephone interview with alcohol co-ordinators/ leads. Appropriate respondents were contacted through lists from Regional Alcohol Managers (mainly those in health), Home Office lists of individuals involved in Community Safety Partnerships (CSP), and lists of alcohol co-ordinators from previous work conducted by the research team. Initial email contact was followed by telephone interview, resulting in 90 responses. Respondents included professionals working at local level in different areas in England and from different professional backgrounds and institutional locations. As the map of the Regions shows, there were survey replies from each Region although the number varied from 16 in Yorkshire and The Humber to 2 in the East Midlands.

Questionnaire returns by
Government Office Region



Based on their job titles and information given about their roles, respondents included directors or assistant directors in public health and services, heads of community safety partnership and commissioning, as well as staff heading up projects at less senior levels. The vast majority (90%) worked in full-time posts, although alcohol was not always the sole focus of their job. Just under half (44%) were alcohol co-ordinators/managers or Drug and

Alcohol Action Team (DAAT) co-ordinators/managers or had roles relating to local alcohol strategy. Commissioning, either wholly or as a joint responsibility, was reported by12%; about half of these were alcohol/substance misuse co-ordinators and commissioners, while the remainder were mostly lead commissioners for either: alcohol, alcohol and drugs or substance misuse. Within the health field, roles included nursing consultants, public health consultants/managers and shared roles such as mental health and social care service managers, commissioning managers, and service managers for substance use and homelessness. Respondents also came from other fields including community safety, community planning and licensing and policy. Clearly, the job titles reflect the range of people we approached for information; but equally, they indicate the multiplicity of functions and roles represented in the partnerships.

Interviews with these respondents consisted of largely structured questions but included open questions to help capture respondents' reflections and experiences.

A further 20 individuals in two case study areas were interviewed, using open ended schedules to examine examples of partnership dynamics from multiple perspectives and to elaborate some specific issues emerging from the survey (see Box 1).

Box 1: Case study informants

Five members of a police/ councillors group
A county council policy officer
Three informants from public health
A youth worker
A rural development officer
A representative from a service users' forum
Two planning/ service commissioners
A drug and alcohol community team leader
A Primary Care Trust (PCT) alcohol lead
A local authority officer
A strategic consultant
Two alcohol service managers

The findings reported in this paper are drawn largely from the telephone interview data but include some illustrative material from the key interviews and case studies.

Results

Respondents and their partnerships

The 90 telephone survey respondents reflected the range of agencies and professionals in the field; 46% were employed by local authorities and county councils; 29% by health services; 9% were employed solely by the DAAT; joint appointments (local authorities/ PCTs; DAATs/ drug and alcohol advisory services) accounted for 14%; and the police employed 2 of the respondents (2%).

The figures in Table 1 indicate that many of the partnerships were relatively new, reflecting the growth of partnership working; 52% were formed less than five years ago while 40% had been in existence for more than five years. The extent to which the older partnerships had evolved and changed over the years was commented on by respondents so that, in some cases, the current partnership bore little resemblance to its origins. Most respondents (56%) had been in their jobs for less than 3 years.

Table 1 here

The composition of partnerships was reported as: a combination of health and criminal justice (67%); health and other areas such as education, employment, social services (8%); only three respondents (3%) stated that health alone was the focus of their main partnership and criminal justice alone was mentioned by 14%. These findings suggest that alcohol and health

is now firmly on the agenda, possibly embedded within broader agendas such as community safety. However, there were frequent comments regarding the continuing dominance of drugs where alcohol was included in DAATs or as part of CSPs. There was considerable concern about poor inclusion of children and young people partnerships; and there were criticisms of the continuing health and criminal justice divide.

Tables 2 and 3 show that the majority of partnerships overlapped with at least one other and in many cases the partnership was nested within a bigger umbrella group.

Table 2 here

Table 3 here

Working with multiple organisations and partnerships within the same area increased the partnership network and complicated lines of responsibility and accountability. A philosophy of localism, which devolved responsibility to local areas (and entailed more local level partnerships) meant that co-ordination of priorities and goals across the different partnership levels became increasingly time consuming and difficult. As mentioned by one alcohol lead in a large metropolitan area:

> *So to be honest, each one of these* (*members of the three top level strategic boards*), they have their own Met-area wide meetings, but they also have their local meetings. So if I was just to go to the three meetings there, that's another three meetings in my*

diary that I can't fit in, but if we were actually trying to get these all on board, we'd have to go to each one of these on a local level, to try and get them on board… so that's 33 meetings that I've got to go to. It's physically impossible. There is only me…, I can't go to each one of these meetings across all the boroughs. (alcohol lead) *author clarification added

Perceptions of partnership structures, processes and effectiveness

Initial interviews with key informants indicated a range of issues around the structure, processes and effectiveness of partnerships which warranted further exploration. Telephone survey respondents were asked, therefore, to rate the structure of their main partnership, the processes involved in partnership working, and the effectiveness of their partnerships on a scale from 5 (highest) to 1 (lowest) satisfaction. They were also allowed space to comment freely.

Figure 1 shows that respondents felt that their membership was relevant and representative of the appropriate agencies.

Figure 1 here

It would appear, therefore, that the basic foundation for partnership working – a representative, relevant membership - was seen to be in place. However, views on the process of working in partnership were more mixed.

Scores shown in figure 2 below indicate that between 5% and 20% of respondents gave a low score (2) on all dimensions and, unlike the ratings on structure, a few people scored each dimension as 1.

Figure 2 here

Survey respondents were asked to rate three process outcomes: effectiveness in achieving partnership working; effectiveness in action planning to meet objectives; and effectiveness in obtaining financial support/resources from member agencies. The mean scores for these dimensions were 3.67, 3.58 and 2.55 respectively showing that respondents were less satisfied with outcomes than with the structural aspects of their partnership. While effectiveness of working as a partnership and planning actions to meet objectives were rated comparatively highly, not surprisingly obtaining financial support and resources from member agencies appeared to be most challenging. This can be seen in figure 3 where the lowest scores of 2 and 1 are given by comparatively high proportions of respondents.

Figure 3 here

Challenges

Despite perceived satisfaction with many aspects of partnership working, respondents spoke at length about the difficulties and barriers they had encountered, with financial constraints, not surprisingly, frequently mentioned (Table 4).

Table 4 here

Challenges in developing the partnership, such as getting and maintaining commitment, particularly at the appropriate level were also reported. Although respondents felt that their partnerships comprised agencies which were representative and relevant, securing the commitment of agencies and members to continuing, long term relationships was difficult. Problems included:

- gaining top level buy in from senior people working in member organisations and agencies
- retaining individual members who were at the right level to access resources and take decisions within their own agencies
- securing agency commitment to shared goals and priorities
- sustaining a viable group over a period of time

The problems were well summed up by one key interviewee:

> *partnerships will go through cycles, but in my view if you've got meetings - … the only reason they continue to attend partnership meetings is either if they are getting something from it, or if they're contributing something to it, ideally both. But if they don't feel that either is happening, then either they stop coming, or the people that do come are those that are just wanting a quiet afternoon sitting having to do nothing.* (Key informant)

Providing strategic direction, getting alcohol issues on to local agendas and helping to secure top level buy in were all seen to benefit from having a local alcohol champion. Champions needed to be good communicators, able to facilitate networks and collaboration, and able to keep alcohol on agendas:

> *So people like X, constantly, constantly, never letting it go away…..even without the political will…It was drip, drip and if there's political will now, then things could start improving.* (DAAT, team leader*)*

Poor communication and a failure to share information exacerbated the problems of coming to an agreement about goals and priorities. In the end, what was seen as important – and often lacking – was the development of trust, which could be difficult to achieve in large groups consisting of diverse agencies and professions. Indeed, a major issue running through the

interviews was the problem of changing professional behaviour. This was linked to issues of institutional and organisational context which embedded individuals within particular occupational or institutional cultures with their associated values and ways of working. There was doubt about the extent to which partnership working could overcome long established behaviours:

> *I am not convinced as to how far the partnership will be able to influence behaviour and action of partners, especially if this means changing what they do now. However time will tell!* (Survey respondent, alcohol lead)

Arising from the restrictions of institutional and professional pressures was a strong tendency towards 'silo' working. Many comments reflected the view that current systems and structures for the delivery of policy still channelled individuals and agencies in ways which made collaboration difficult. In addition, it emphasised the need to find a supportive institutional base for alcohol partnerships. Three examples of the problems and attempts to solve them came from interviewees' accounts.

Example 1: countering 'silo' working

The first account describes a partnership between the local council and police at electoral ward level. Interviewees in this partnership spoke of a sea change in how issues were identified and how partnership working fostered the acceptance of joint responsibility for problems within the partnership as a whole, in contrast to the blame culture which had historically prevailed. Eradicating a blame culture **a**llowed commitment and mutual trust to

develop more readily and this was needed to foster effective joint working. Training offered one approach to breaking down silos. The principles of partnership working at neighbourhood level, for example, were now embedded in routine police training.

> *Whereas new recruits always previously went to the response job - which is the 24/7 answering the 999 calls - new recruits now come into a neighbourhood policing team….. they come here to get embedded in the neighbourhood policing team principles and ethos before anything else. And that whole partnership thing, which is really difficult to grasp isn't it, that thing about 'oh so what's our responsibility?' and it's actually about partnerships and that is kind of something that you do at training. It's embedded. I mean, for 22 years I was a response officer at differing ranks and I probably had never spoken to anybody from X council, to try and sort out anything, I had just gone to 999 calls.* (Case study, police inspector).

Nevertheless other respondents who were part of the same partnership noted that the rigidity of their own agency's agendas and close monitoring procedures hindered their ability to be flexible and responsive and this prevented greater commitment to working in partnership

Example 2: countering 'power' in professional cultures

Another example highlights the issue of managing the imbalance of power (or perceived power) between professional groups. Although rarely mentioned directly, partnerships were faced with countering traditional professional hierarchies and the possible dominance of some professional groups over others. In the rural area discussed below, partnership working

required shifts in the balance of power between senior police officers – responsible for securing resources -and youth workers, responsible for delivering the project.

In order to work sensitively and effectively in engaging young people in a local project, the police needed to relinquish their traditional ways of working based on an enforcement perspective and take the lead from youth services. Working within a youth centred approach evolved progressively and required adaptability on their part. Through trying to establish common ground, the project afforded partners the opportunity to develop more effective working relationships. Building up mutual trust was essential and took considerable time to allow for increasing understanding of each agency's work ethos, roles and responsibilities. Several participants noted that attitudes had changed as understanding of perspectives had improved, protocols had been established and compromises and their impacts were explored. The dilemmas faced in marrying very different models and working practices were commented on by a youth worker on the project:

> *Initially I think when the project was set up ..... both staff and young people were very sceptical because- how can you work with enablers and enforcers together? … but because of the work, I suppose, and the commitment of the partners in terms of actually going outside of our briefs a little bit (the problems were overcome), in terms of when the PCSO (Police Community Support Officer) is there, they are actually working under the direction of youth work principles and under the direction of youth workers. They are not in their PCSO capacity for example. And so that's taken quite a bit of time for us to work that out and trust each other, do you know what I mean? Because initially the police were kind of directing people to this space - then the*

young people almost felt corralled - which then creates issues and tension. (Case study, youth worker)

Example 3: the importance of institutional embedding

The third account points to questions of ownership of the problem. Because of the continuing strength of professional and agency cultures, the emphasis placed on alcohol issues and the level of priority accorded to alcohol was at least partly dependent on the institutional embedding of the partnership. Finding the right home for alcohol and negotiating ownership was important:

…. so it took a long time to write it (alcohol strategy) because of partnership difficulties really and where was the ownership? We were part of the Drug Action Team, but to be honest that never really worked because there was something on the DAT Agenda each time for alcohol but it never got to that bit. .... Although the individual DAT members would have said alcohol is a more serious issue than drugs for us but our remit has to be this and that's what we have to spend our money on. … When the Alcohol Harm Reduction Strategy was published, which said you should have Drug and Alcohol Action Teams, then I took it back to them and said look this says.. and they said, well we'd like to be a DAAT, but to be honest we don't want to do that because that would assume we were going to be able to do something and we cannot see any way to spend any money on alcohol, so we think that would be a deception…….So we shifted it to the newly formed CDRP which then became Safer XTown and there were people in public health who were concerned about that move, seeing it as a very crime orientated organisation. I took the

proposal to the CDRP before it became Safer XTown and looked at all these policemen around the table and said look if we are going to do this then I have to say that health is really our major concern and we must not lose this from the agenda and they agreed that. (Key informant)

Discussion

Across the studies undertaken in different policy arenas and in different countries, there is a high degree of consensus regarding the types of factors which are important in setting up and developing partnership approaches. These include features of the national and local policy contexts and local socio-economic settings; they include process factors – such as ensuring the effectiveness of leadership and the engagement of senior level members, information sharing and developing clear aims and objectives, access to sufficient time and resources to initiate and sustain change, as well as overcoming professional and organisational differences in priorities, power and culture. Partnerships are, therefore, very much a product of wider political, socio-economic determinants operating at both national and local levels (Geddes 2000, Wildridge *et al*. 2004, Zacocs and Edwards 2006, Perkins *et al*. 2010).

This study did not set out to measure the extent to which partnerships were successful in achieving their aims or delivering their targets. Indeed, reviewers have found few studies which attempt to measure effectiveness using change in the target population as outcome measures (e.g. Smith *et al.* 2009, Perkins *et al.* 2010). More commonly, partnerships have been assessed by indicators of the success of their initiation, operation and stability.

Similarly, we were interested in how those involved in partnership working judged the success of formation and process aspects of their partnerships and what they considered to be the obstacles in their way.

The above sections illustrate well the hurdles partners face in trying to achieve the aim of effective collaboration in responding to alcohol related harm. Partnerships have grown and become more formally structured, creating complex networks of partnerships, organised hierarchically. Although the ideal of partnership goes largely unquestioned, issues of trust, tensions over responsibility and accountability to the employing agency and to the partnership, and the diverse training and professional experiences of members continue to prevent fully integrated partnership working, even where there are good intentions to move in that direction.

Respondents were clearly well aware of the problems and many questioned, especially, the growing size and complexity of the partnerships which made management much more difficult. The *requirement* to work in partnership and the role of some people to foster and build partnership working is part of the policy drive towards establishing partnership working as a primary vehicle for service delivery but one which may exacerbate rather than mitigate existing tensions between professional groups and reduce the chances of changing professional behaviour. Similar reservations regarding formal, strategic partnerships in public health in England have been reported by Hunter and Perkins (2012). This trend was also noted by Mitchell and Shortell (2000) in relation to community health partnerships in the United States. They illustrated how voluntary forms of collaboration raised very different governance and management issues from contractual coordination or more formal

collaboration. The partnerships we studied appeared to be in a transition stage between voluntary and 'required' status which may reflect the relative fluidity and frequently changing nature of health and criminal justice structures during New Labour's period of office and again under the new coalition government of 2010. This research was conducted at a time when partnerships were increasing in importance and number, when the local infrastructure for service delivery was becoming more structured, co-ordinated and regulated and, at the same time, when the ideals of de-centralised government and 'localism' were setting expectations that partnerships were the appropriate vehicle for ensuring that local needs were addressed by strategically coordinated action. This meant the emergence of a diverse range of partnership types, processes and targets in different areas. As the study reported here, and other research, has shown, when disparate groups are required to provide a co-ordinated response which may not always accord with their own professional priorities or occupational cultures, the assumption that consensus can be achieved and partnerships established can be challenged.

Conclusion

Despite the widespread belief in partnership working – which crosses political and policy divides - there is no good evidence to suggest that partnerships work or to indicate which aspects of partnership approaches are providing added value. The new UK Alcohol Strategy (HM Government 2012) will be implemented amidst widespread re-organisation of the structures for the delivery of policy at local level. Partnerships have barely had time to settle down within the old service frameworks and the challenges are unlikely to be any less as new alliances replace, or are added to, existing partnerships and partnership networks. There is a

considerable bank of knowledge regarding the challenges faced by partnerships and the principles of good partnership working but more rigorous assessment of the role of partnerships is needed especially at the current time when partnerships have become a key mechanism in policy delivery. This is particularly pertinent in policy domains addressing complex issues such as alcohol, where collaboration crosses health, criminal justice, education and youth services, where there is increasing size and complexity of partnership networks and hierarchies and where there is increasing potential for incompatibility arising from what Crawford (2003) has called 'consent by coercion'.

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Tables

Table 1: Length of time respondent in post and when post created

Length of time respondent in post	**%**	**When post created**	**%**
Less than a year	20	Less than a year ago	22
1 year – less than 3 years	36	1 year – less than 3 years ago	22
3 years – 5 years	24	3 years – 5 years ago	19
More than 5 years	20	More than 5 years ago	27
Total	**100**	Don't know	10
		Total	**100**
Based on number answering	85	Based on number answering	78

Table 2: Number of partnerships connected to main partnership

Overlap:	No
None	2
Overlaps with 1 other partnership	7
Overlaps with 2 others	21
Overlaps with 3 others	14
Overlaps with 4 others	2
Overlaps with 5 others	2
Overlaps with more than 5 others	7
All overlap with others	5
Many overlaps	3
Not applicable	1

Based on 64 responses

Table 3: Umbrella groups

Umbrella group:	No
None	9
Local strategic partnership/Local Area Authority	24
CDRP; Safer Communities; Community Safety; Safer/Stronger Partnership/Communities; Stronger Communities etc	19
DAAT board	6
Health and Well-Being/Health and Social Care/Healthy area Partnership/NHS area board	8
Council executive	3
Various themed children's boards	3
Public Service Board	2

Based on 74 responses

Table 4: Main challenges faced by partnerships in past 12 months

Main challenges:	**%**
Funding/securing funding for developing services / meeting needs/managing cuts	38
Lack of/safeguarding resources / human resources	35
Developing partnership e.g. getting commitment at right level, maintaining commitment, improve working etc	20
Lack of strategic direction / competing priorities / developing / implementing strategy	20
Performance managing /performance improvements	9
None	1

Based on number answering: 82

Figures

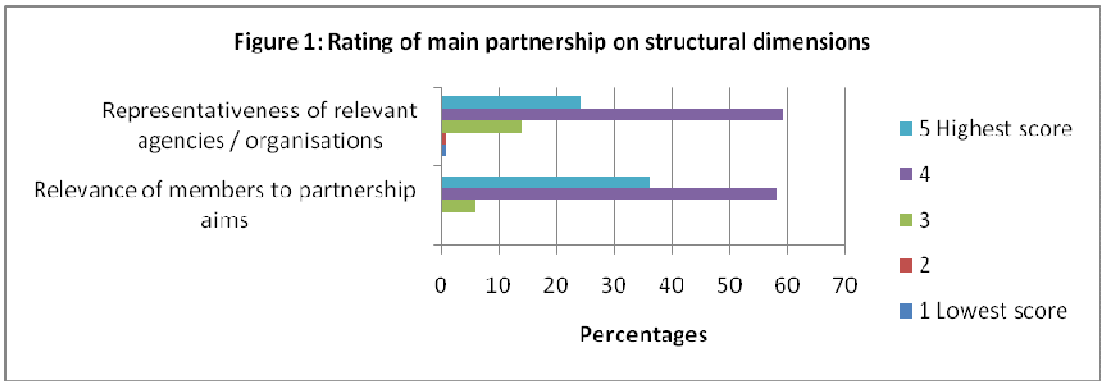
Figure 1: Rating of main partnership on structural dimensions
Representativeness of relevant agencies / organisations
Relevance of members to partnership aims
0
10
20
30
40
50
60
70
Percentages
5 Highest score
4
3
2
1 Lowest score

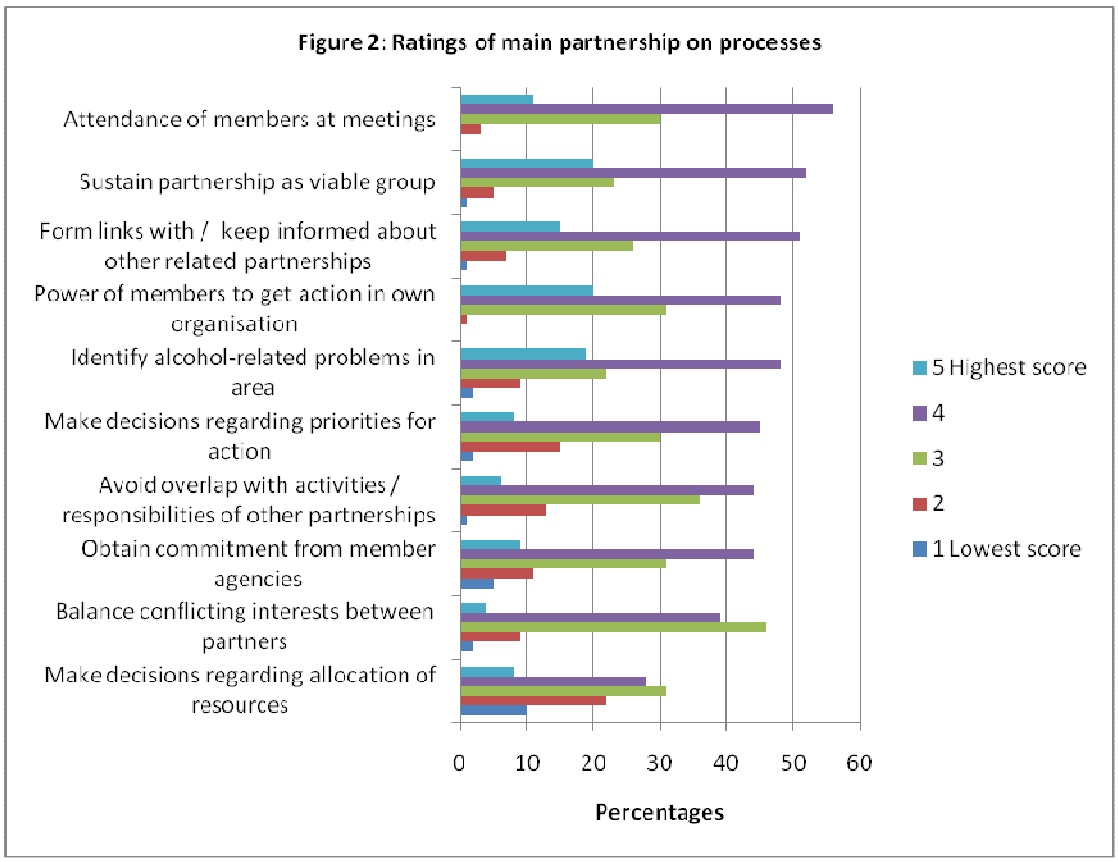
Figure 2: Ratings of main partnership on processes
Attendance of members at meetings
Sustain partnership as viable group
Form links with / keep informed about other related partnerships
Power of members to get action in own organisation
Identify alcohol-related problems in area
Make decisions regarding priorities for action
Avoid overlap with activities / responsibilities of other partnerships
Obtain commitment from member agencies
Balance conflicting interests between partners
Make decisions regarding allocation of resources
0
10
20
30
40
50
60
Percentages
5 Highest score
4
3
2
1 Lowest score

FIGURE 3

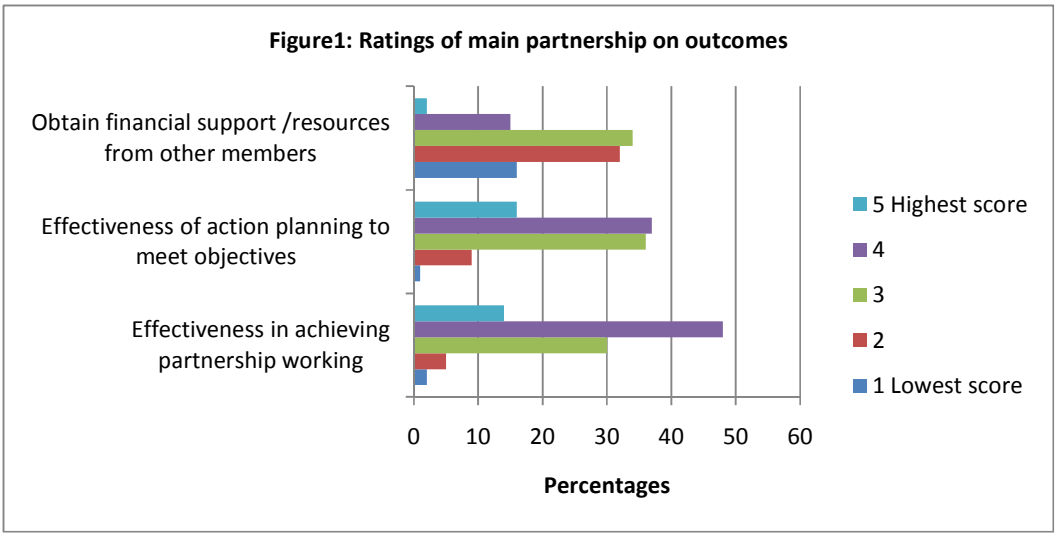
Figure1: Ratings of main partnership on outcomes
Obtain financial support /resources from other members
Effectiveness of action planning to meet objectives
Effectiveness in achieving partnership working
0
10
20
30
40
50
60
Percentages
5 Highest score
4
3
2
1 Lowest score