How Effective are Current Joint Working Practices between Children and Family Social Workers and Mental Health Care Coordinators, in Supporting Families in which there is a Primary Caregiver, with a Diagnosis of Emotionally Unstable Personality Disorder?

Abstract

Emotionally Unstable Personality Disorder is a complex and often stigmatising diagnosis. Although falling under the remit of mental health services, it is not always seen as a mental health need and research suggests that, if parents or carers are not provided with more holistic support, parental mental health will deteriorate with children likely to have poorer outcomes, placing them at an increased risk of harm. This likelihood of harm increases with compounding factors such as substance misuse and domestic abuse. One organisation alone cannot effectively address the complex difficulties that people with this diagnosis may experience, thus interagency working is necessary. This paper explores the barriers and facilitators to interagency working to support parental caregivers with a diagnosis of Emotionally Unstable Personality Disorder between Children's Social Care and a Community Mental Health Team within the same English area. Five mental health care coordinators and two children and families social workers who had experience working with this client group were interviewed. Participants identified challenges and benefits to working with their partner agency around communication, knowledge, stigmatisation and resources. The research provides suggestions to develop current interagency working relationships and to enhance care and support available to people experiencing the diagnosis.

Teaser Text

Emotionally Unstable Personality Disorder is a complicated diagnosis, that can lead to people being treated in negative ways. Parents with this diagnosis often receive support from mental health services. However, their needs are not always seen as mental health needs and research suggests that when parents or carers are not provided with effective all-round

support, this is likely to lead to poorer outcomes for their children. One organisation on its own cannot effectively support parents who have complex needs covering different areas of their lives and working with other organisations is important to provide people with a wide range of support that meets their needs both as people and as parents. In this research, five mental health care coordinators and two children's social workers, working in the same area of England, were interviewed about their experience of cooperating with other professionals to work with parents with Emotionally Unstable Personality Disorder. They identified ways of working together which were helpful and unhelpful linked to communicating, specialist knowledge, negative views of people with this diagnosis and the resources they had to do their jobs. From this, the research suggests ways to improve how different services work together to give better support.

Literature Review

Parental mental health and child development and wellbeing are closely interrelated. The University of Essex Institute for Social and Economic Research (2022) identified that in England, around 1 in 3 children lived with at least one parent reporting emotional distress. The Office of National Statistics (2022) highlights that children whose parents experienced mental health difficulties were more likely to have a mental disorder in comparison to children whose parents did not exhibit symptoms of a mental disorder. mason (2020) found that when a child was exposed to severe and long term parental distress, this led to these children reporting higher levels of personal distress in later life. In an analysis of 175 child safeguarding practice reviews Sidebotham et al. (2016) found that 53% of reviews involved parents with mental health difficulties. Nevertheless, living with a parent/care giver with mental health difficulties does not automatically lead to negative outcomes for children; circumstantial factors need to be considered such as protective factors, if the person is in a crisis, substance misuse, domestic abuse, and access and engagement with support services (Mason et al. 2018; Fledderjohann et al. 2021).

 Emotionally Unstable Personality Disorder (EUPD) features prominently in narratives around the impact of parental mental health on parenting. Although this research positions EUPD

within the mental health remit, the debate around whether EUPD can or should be treated as a mental health disorder is complex and longstanding (see, for example, Lester et al, 2020; Campbell et al, 2020; RITB, 2019) and this positioning should not be accepted uncritically. It has been established that there is no clear explanation as to how EUPD develops however genetics, maladaptive parenting and traumatic life events experienced during childhood are identified as potential triggers (MIND, 2022; Steele, Townsend and Grenyer, 2019). The difficulties individuals may experience such as emotional dysregulation, impulsivity, suicidal ideation, self-harm, and challenges in managing relationships are considered to likely have an effect on parenting capacity, and impact on the child's attachments and hence have a ripple effect on the lived experiences of children (Laulik et al., 2013, Petfield et al. 2015; Laporte, Paris and Zelkowitz, 2018). It is important to acknowledge that the research discussed is conducted predominantly in Western countries, raising the possibility of variation in experiences across cultural and gender boundaries.

Laporte, Paris and Zelkowitz (2018) found that children with mothers with EUPD were more likely to be involved in children and families social care and youth offending teams. Whilst this research does not consider caregivers who identify as male, or children looked after by other family members with EUPD it raises an interesting point in relation to involvement with reactive statutory services. Steele, Townsend and Grenyer (2019) assert that more support and preventative interventions need to be implemented for parents experiencing EUPD to promote protective factors and avoid maladaptive parenting. Eyden et al. (2016) importantly highlight that it is not a case of mothers experiencing EUPD not wanting to effectively parent their children, their systematic review indicated that mothers experiencing EUPD considered themselves to be overprotective especially in relation to the health and safety of children. Nevertheless, the authors state that at times individuals with EUPD may lack the necessary strategies to effectively parent which is why early intervention and support is important particularly within the perinatal period to encourage secure attachments and emotional regulation. Dearden and Alridge (2010) and Steele, Townsend and Grenyer (2019) concur that if services are implemented to holistically support families this will increase outcomes for families with parental mental illness.

The National Institute of Clinical Excellence (NICE) (2009) recommends that individuals who have moderate to severe symptoms of EUPD should be referred to Community Mental Health Teams (CMHTs) and recommend Dialectical Behaviour Therapy (DBT). The aim of DBT is to assist individuals to explore, recognise and understand emotions, and to develop healthy strategies to manage emotions. Despite this, individuals experiencing EUPD often do not receive support until they reach a crisis point (Warrender et al. 2020). Depending on the severity of mental ill-health, individuals may be allocated a Mental Health Care Coordinator (MHCC) under the Care Programme Approach (NHS, 2022). Theoretically, the Care Programme Approach appears to put the individual at the centre of their care and involve carers, but this makes one question whether consideration is given to the potential implications on children particularly if they play a caring role as this is not specifically stated within policy (Department of Health, 2006). Cooklin (2013) proposes that mental health staff may consider their primary focus to be on their adult service user and the role of supporting children is not necessarily within their remit. Mechling (2011) suggests that often mental health clinicians do not ask individuals whether they have children and children's needs were often overlooked. This raises concerns in relation to what support is available for children experiencing parental mental health difficulties. The Care Act (2014) and the Children and Families Act (2014) have since legislated the need for young carers to receive regular assessments which should give consideration to the effects of the caring responsibilities on them. However, the primary focus appears to be on the adult experiencing mental ill-health and the consideration of how they support and care for their child appears to be secondary.

The Children Act (1989) stipulates that the child's welfare is paramount, and the child's voice should be promoted. In practice, Local Authority children and families' social workers take the lead on child protection enquiries (SCIE, 2022). Nonetheless, the Children Act (s. 10, 2004) highlights that agencies should make arrangements for cooperation to improve children's wellbeing. Whilst mental health services may cooperate and work with social workers their priority is not necessarily the child (Mechling, 2011; Cooklin, 2013). MHCCs can be from various disciplines such as nurses, occupational therapists and social workers and it is important to consider how different training and professional standards may inform their

practice without assuming that all MHCCs work homogeneity. It is apparent that there are competing demands which perhaps lead to ethical tensions for practitioners dependent on their professional background, responsibilities and organisational context.

Roughley et al. (2021) stipulate that practitioners should adopt a trauma-informed approach when supporting individuals experiencing EUPD, focusing on therapeutic relationships, being empathetic, and warm to encourage engagement. However, it has repeatedly been established that in practice, individuals with EUPD may experience negative attitudes from professionals which impacts on individuals' willingness to engage in support (Barr et al. 2020; Ring and Lawn, 2019; Knaack et al. 2015; Versey, 2014). Individuals reported more positive experiences when their workers were specialised in working with personality disorders (Barr et al. 2020), or had a relationship with their mental health worker that had traits of a real-life friendship (Zaccharia et al. 2021). Adwok and Nightingale (2021) found that when doctors received training on EUPD which was co-delivered with an individual with lived experience of the condition, it was positively received, and they suggest that it could be a tool for reducing negative perceptions of EUPD held by professionals.

McCusker and Jackson (2016) found that social work students on placement in children's services observed negative attitudes and a lack of confidence of supporting caregivers experiencing mental illness. Despite this, there was reluctance in contacting CMHTs which correlates with Zacharia et al (2020) findings that both social workers and mental health practitioners lacked a holistic understanding of parenting with EUPD. This raises concerns in relation to practitioners potentially being inadequately trained and under knowledgeable about EUPD.

On a national level, there are legislation and guidelines depicting what support should be provided and how practitioners should be working with individuals with EUPD; yet, on an individual level, ultimately practitioners' attitudes and understanding of EUPD appear to be a pivotal factor in what actual support people with the diagnosis experience.

Research highlights that a single organisation in isolation cannot thoroughly address all of the complex issues that families involved with CFSC may experience such as; mental health, financial difficulties and safeguarding concerns; hence the literature stipulates that interagency working is essential (Webber et al. 2011. Peckover and Golding, 2017; Baginsky

et al. 2022). Walker (2018, p. xiv) describes interagency working as "to mean at least two workers from different agencies (or services) who carry out essentially different roles and who are engaged in joint work." To effectively meet a service user with EUPD's care needs, NICE (2009) promote the importance of interagency working; they illustrate that clear and robust multidisciplinary care plans with each professional having a specific role should be implemented. They recognise that people experiencing EUPD require support during transitions, thus clear systems of information sharing with other agencies is essential in care planning, especially when support from one agency ends.

Nonetheless, Glasby and Dickinson (2014) argue that despite interagency working being on the political agenda, agencies working together is not strongly implemented in practice. Child safeguarding practice reviews indicate that professionals do not share information with other agencies effectively, and often the child is not spoken too (Precey, Gretchen and Unnamed safeguarding children partnership (2022). Doherty (2017) and Murphy and Richardson (2017) identified that professionals did not share information appropriately or understand the role of other professionals involved in a family's care. This contributed to poor parenting and mental health assessments as individual practitioners did not have a holistic understanding of a family's presenting situation; workers were unable to identify and reduce all risk factors. Thus, despite legislative changes, interagency working opportunities still do not seem to be utilised.

Further barriers to interagency working include MHCCs feeling unable to share information with children and families social care due to a lack of understanding of information sharing legislation (Garcia et al. 2015). twinin et al. (2017) highlights the difference in theoretical frameworks between both children and families social care and mental health services resulting in them working in silos. Brettig and White (2015, p. 40) state "child focussed services need to become 'parent' sensitive and adult focussed services need to become both 'parent' and 'child' sensitive." This would suggest that there is a training issue in relation to practitioners understanding of effective interagency working. Brettig and White (2015) stipulate that clear information sharing policies and procedures are necessary to facilitate effective collaborative working. Sidebotham et al (2016) advances that multidisciplinary training and good quality supervision was necessary to enhance understanding on parental difficulties on children which contributed to improved assessments and intervention.

Whilst there appears to be literature identifying potential barriers and facilitators to interagency working, there appears to be little research specifically exploring how agencies work together when supporting people with EUPD. This paper will explore how effective are current interagency working practices between children and family social workers (CFSWs), and adult mental health care coordinators (MHCCs), in supporting families known to their services, in which there is a primary care giver (parent/carer), with a diagnosis of EUPD.

Research Aims

- To explore both the barriers and facilitators to interagency working between CFSWs, and MHCCs, when supporting a primary care giver with EUPD.
- To consider how well joint working protocols are being implemented by CFSWs and MHCCs when supporting a primary care giver with EUPD.
- To consider if current interagency working procedures and practices need to be further developed.

<u>Methodology</u>

Study Design

The researcher used qualitative methodology as literature suggests it is best suited to explore views and experiences from an individual's perspective (Taylor et al. 2016). Semi-structured interviews were chosen as they allow the interviewer time to plan, prepare and design the interview guide to ensure that questions are open ended whilst, still focussing on the specific research aims (Jamshead, 2014). Interviews were chosen as they provided participants with the option of speaking freely about a potentially contentious subject without causing damage to working relationships and reduced the risk of social desirability bias which may have arisen from a focus group discussion. Open ended questions were incorporated as they provide the participant with opportunities to share their experiences (Galletta, 2013). The interview guide was developed to consider the apparent gaps in research which have been previously evidenced in the literature review.

Sample

Holloway and Galvin (2014) suggest that homogeneous, purposive sampling is beneficial if research is interested in participants who share a particular characteristic or experience. This method was applied as the research aimed to interview participants who were; a professional who was registered with their professional regulatory body, to be practicing in a CMHT or a Children and Families Social Care team (CFSC), and to have experience of or who were currently supporting a parent or carer who has EUPD.

Sample Size:

The study aimed to collect in-depth data from a small number of participants within a single geographic area to ensure comparability of experience across both services. A sample size of ten was chosen because it was practicable with time and resource constraints and enabled a reasonable balance and diversity of views from the two teams:

- Five MHCCs (mental health care coordinators).
- Five CFSWS (children and family social workers).

Recruitment

Managers employed in CFSC and a CMHT in the same London borough were approached by email informing them of the study. Each manager was sent a recruitment pack (invitation to participate letter and participant information sheet) and was asked to disseminate the packs to practitioners who had experience of or who were working with caregivers who had EUPD. Two weeks later managers were asked to resend the email to their staff due to an initial low response rate. Practitioners who were interested in participating contacted the researcher via email and arranged a time to conduct an interview.

Interviews

Participants were asked to sign a consent form with the option of being audio recorded prior to interviews. The researcher and participant met in a private interview room at the interviewer's place of work; interviews lasted between 35 and 60 minutes. Observational notes were also documented which noted participants' intonation. Phillippi and Lauderdale (2018) stipulate that this is an important component of qualitative research and support the interviewer to observe environment, body language and provide context to the interviews

which subsequently inform data analysis. All interviews were audio recorded to support data analysis.

Both interview guides for the CFSWs and MHCCs followed the same structure: firstly, personal information such as, professional background, length of experience and length in their current roles were discussed. Next, questions explored participants understanding and knowledge of EUPD along with interventions. Finally, interviews focused on experiences of interagency working with the other organisation including, attitudes towards working with the other agency, the steps they would take if they had concerns of an adult with EUPD who is caring for a child, what are the facilitators and barriers to interagency working and any recommendations to improve current service.

Analysis

A thematic approach to data analysis was applied; this involves highlighting, examining, categorising, describing and reporting themes (Nowell et al. 2017). Braun and Clarke's (2006) analysis framework was applied; the researcher listened to and then transcribed interview audio recordings. Interview transcripts were read several times to ensure that vital information was not missed when analysing the findings. The researcher highlighted similar and dissimilar responses along with new insights, and subsequently identified initial key codes and themes. Themes were reviewed, modified and developed and then defined. Braun and Clarke (2014) indicate that this technique is advantageous, especially when undertaking applied research which could contribute to service and policy development. They argue that the approach is robust yet, a simple and clear method; it is particularly useful in that thematic findings are easily presentable to people not in the academic arenas.

Ethics

Ethical approval was granted from the Health Research Authority and from the University of York's ethics board. Permission to conduct the research was obtained from the NHS trust and local authority who participated in the study.

Results

Seven practitioners were recruited in total, with five MHCCs and two CFSWs participating in the study. After interviews the following themes were identified:

Communication

The overall consensus from participants was that interagency working when supporting a caregiver with EUPD is only effective when agencies communicate and share information. In practice one MHCC stated, *"mental health services need to be inviting children and families' social workers to CPAs (Care Programme Approach) meetings and equally, care coordinators should be attending children and families social care meetings."* One MHCC stipulated that communication alone is insufficient and instead agencies need to be clear on roles and tasks in order to effectively support a service user. This suggests that there is more to communication than simply talking to each other which could be explored.

Even though there was agreement amongst professionals that communicating is pivotal in interagency working, CFSWs voiced that in practice, practitioners were not talking to each other frequently, and not doing the tasks agreed in multi-disciplinary meetings. It was identified that people did not always seem to be working towards the same goal; one CFSW stated, *"sometimes information sharing with mental health agencies is not transparent…I do not think we are always given the full story from adult services and I think this is needed to inform the risk assessment."* Similarly, one MHCC highlighted that they did not feel that CFSWs needed to attend the full CPA meeting due to the service user's rights and confidentiality. Yet, he also voiced that as a MHCC, he felt psychologists should share full information with him as this would inform his practice however, this does not happen often. This suggested that organisations could explore effectiveness of internal communication between different teams within their own organisations as well as examining interagency communication.

The CFSWs interviewed highlighted that at times, they found it difficult to get in contact with MHCCs, and therefore often they were unable to invite them to meetings regarding their service users. Nevertheless, four MHCCs interviewed spoke positively of working with CFSWs; *"it's always good to get joined up, it's like a puzzle, I have part of the puzzle, you have part of the puzzle, and we need to connect to see the picture."* Conversely, the remaining MHCC stipulated that she avoided working with CFSWs due to previous negative interagency working experiences; it was felt that parental mental health needs were often neglected, and

support was not provided to the caregivers by CFSWs. Therefore, although there was agreement amongst all participants that talking to each other and sharing information was necessary, on a practical level, there appeared to be competing variables affecting interagency working which may require further exploration.

Knowledge

All respondents identified that knowledge of supportive ways of working with an individual with EUPD was necessary when interagency working. They recognised that people with EUPD could experience difficulties in emotional regulation and could find it hard to maintain stable relationships. Several suggestions were made by respondents including, implementing and maintaining boundaries, modelling prosocial behaviour and using strengths-based models.

Nonetheless, despite knowledge being considered effective in interagency working, all respondents highlighted that they had received no formal training of EUPD; instead, MHCCs described having to learn from work-based experience, whilst CFSW were reliant on MHCCs knowledge. One MHCC commented, *"I have been chasing personality disorder training for over a year and still there is none! I just feel like I am winging it to be honest!"* Hence, practitioners were voicing that they lacked an awareness and understanding of how to effectively support people with EUPD and therefore are identifying a training need.

In addition, whilst discussing risk escalation processes, all respondents interviewed were unable to identify who the safeguarding children or adults lead were within their organisations. Respondents attributed not knowing who the relevant person was due to high staff turnover. Two MHCCs stated that their team had a mental health *"link worker"* who liaised with children and families social care; however, they were unable to describe exactly what this role entailed or times in which they had used this resource. The remaining three MHCCs did not mention a link worker. One MHCC did not know who to send the referral to if they had a concern about a child. Similarly, a senior MHCC reported that she did not know what paperwork she needed to complete if she needs to do a referral to CFSC. This demonstrated that some MHCCs were not familiar with current interagency working protocols with CFSC.

Stigma

All MHCCs interviewed provided examples of discriminatory comments made toward service users with EUPD from professionals working within their organisation. A MHCC provided an example of attending a ward round and disclosed that a psychiatrist introduced himself as *"I am [service user's] consultant unfortunately,"*. He also described witnessing staff talking to individuals who wanted to end their lives respond with *"well you have capacity; you know what you are doing."* Likewise, CFSWs provided examples of witnessing stigmatising attitudes towards service users during CPA meetings although they did not mention any discriminatory behaviour from within their own organisation.

Furthermore, four MHCCs stipulated that they did not feel that EUPD was considered as serious by professionals within their own organisation and by external agencies such as benefits services and social housing. They did not feel that individuals were fully supported if they demonstrated suicidal ideation. All MHCCs advanced that the name of the diagnosis attributed blame to the individual and pointed to a distortion in their personalities and they felt that it needed rebranding; one MHCC suggested *"mood and personality disorder service."* If stigmatising attitudes towards people with EUPD were apparent in the organisations meant to be supporting them, this raises questions about the effectiveness of interagency working and the quality of holistic support. Therefore, further research is needed to explore stigmatising attitudes and methods in which this could be reduced.

Reductions in Resources

All respondents reported that interagency working was currently ineffective due to a reduction in resources and services. One MHCC voiced that mental health was evidently on the political agenda through initiatives such as the *"Time to Change"* campaign however, there was not enough resources and services for the increase in demand for the service. All MHCCs highlighted that psychological services had lengthy waiting lists, there was a lack of EUPD therapists, the assertive outreach team was no longer in place and MHCCs did not feel that they had the time, skill or confidence in themselves to effectively support someone with EUPD. It was emphasised that this coupled alongside difficulties in accessing support from other agencies such as housing and benefits agencies led to negative outcomes for people with EUPD.

Scope for Change

All respondents suggested strategies to improve interagency working. Suggestions included; a universal computer system and co-located teams to facilitate information sharing, developing the link worker role, and a MHCC being seconded into CFSC that would be able to be an active bridge between services. All respondents highlighted that they felt spending time shadowing each other and completing joint training would be helpful in building relationships, developing an understanding of the role of the other agency and developing their skills. A further consideration was the development of a specialist EUPD team in which practitioners had enhanced training, smaller caseloads and more time to spend with service users.

One CFSW and one MHCC who had been qualified for a similar amount of years reflected on their initial social work training and felt that more generic training was needed when students were completing their social work training. They felt that their own placements led to specialist roles in which they had spent their careers with a lack of awareness and understanding of other types of social work.

Discussion

As already identified in previous research communicating with external agencies was considered a facilitator of effective interagency working (Jahans-Baynton and Grealish, 2021; Mason et al. 2018; Garcia et al. 2015). Concerns regarding confidentiality, data protection and service users' rights appear to have impacted on some practitioners' willingness to share information. Even so, unlike Garcia et al. (2015), the current research considers the two-way working relationship between CFSWs and MHCCs when supporting people with EUPD; whereas, Garcia et al. (2015) focuses solely on CFSWs perceptions towards working with mental health services. The findings support Canadian research by Mason et al. (2018) in which CFSWs appeared to instigate communication and MHCCs showed some reluctance to share information. Therefore, the current research has illustrated that even when practitioners do want to liaise with each other, confusion and a lack of understanding towards legislation and organisational policies such as information governance seem to be affecting some practitioners' willingness to collaboratively work together.

Nevertheless, when practitioners do wish to communicate, there is a lack of knowledge regarding organisational risk escalation and safeguarding procedures. It is apparent in child safeguarding practice reviews such as Doherty (2017) that children have experienced serious

harm when organisations fail to share information or do not take appropriate safeguarding action. In addition, there is also statutory legislation and guidance which places a duty on organisations to work together to safeguard children (HM Government, 2018; The Children and Social Work Act, 2014; The Children Act, 2004; The Children Act, 1989; NICE, 2009). Yet still, some practitioners lack an understanding of risk escalation procedures, which may contribute to missed opportunities. This information will be beneficial for senior management and the Local Authority's Safeguarding Partnership to have an awareness of particularly as it consists of the Local Authority, Clinical Commissioning group and the police. They also formulate safeguarding procedures and training which are informed by statutory legislation and guidance (HM Government, 2018). It needs to be considered whether practitioners understand and know where to obtain relevant policies, whether they have opportunities to complete training, the quality of the training received and whether local joint working arrangements need to be reviewed.

Interestingly, all of the MHCCs interviewed were professionally registered Social Workers, with the same educational background as the CFSW respondents. Yet, the findings suggest that the team and area that practitioners specialise in can steer their focus particularly when working within multi-disciplinary teams, and the mental health participants demonstrated a different perspective on children safeguarding to their children's service counterparts. Practitioners within NHS trusts need to complete mandatory safeguarding training and must have knowledge of policies and relevant legislation particularly in relation to safeguarding children (NHS England, 2022a), however, the findings suggest that they were unfamiliar with current safeguarding partnership policies and procedures and could be hesitant in sharing information which again draws focus to the availability and quality of training and also the quality and frequency of supervision. This disagrees with Cooklin's (2013) idea that children are secondary to adults within mental health settings, with the issue around lack of knowledge rather than lack of priority.

The findings support Heller and Garran (2014), Barr et al. (2020) and Zacharia et al. (2020) arguments that practitioners must have sufficient knowledge of EUPD and to be skilful and respectful in order to effectively engage and support an individual with EUPD. Despite practitioners voicing what they feel is helpful such as boundaries, participants highlighted that they did not receive any training in relation to how to effectively support people with EUPD;

MHCCs appear to be learning from work-based experience whilst, CFSWs indicated that they are reliant on the knowledge of MHCCs. Thereby, if individuals are not being provided with opportunities to develop their knowledge and skills around EUPD, this questions not only how effectively agencies are working together, but also the quality of the service being provided by singular organisations and the contribution this has on the outcomes and recovery of individuals and their families.

A dominant theme was an issue of stigma towards individuals with EUPD. The results enhance Knaack et al. (2015) quantitative research on professionals' negative thoughts and attitudes towards people with EUPD. Whilst Knaack et al. (2015) employed questionnaires and indicated that professionals demonstrated greater stigmatising beliefs towards EUPD in comparison to other mental illnesses, the present research not only confirms this, but the qualitative approach adds a further deeper dimension. Despite none of the respondents personally disclosing stigmatising attitudes, some did disclose examples of discrimination that they had observed from mental health professionals. This again raises questions how interagency working arrangements between CFSWs and MHCCs can be effective, when entrenched, discriminatory beliefs held by individuals employed from within the services that are funded to support people in their mental health recovery have been identified. Versey (2014) and Zaccharia et al. (2020) highlighted from a service user perspective that stigmatising attitudes deter individuals from engaging with support. Therefore, further research may wish to explore the prevalence of stigma and discrimination held by employees within mental health services and to also ascertain the views of individuals who have lived experiences of mental health services.

A further consideration is a lack of resources contributing to difficulties in collaborative working; with respondents proposing information sharing systems as central. Nevertheless, this is not the first time such changes have been proposed. Following systemic failings identified after the death of Victoria Climbie, the Department for Education and Skills (2003) anticipated a universal electronic system for sharing information, several years later this has still not transpired (Department for Education, 2014). Logistically this may be difficult to implement in practice due to the number of organisations, policies, and resources it would need in order to be implemented across the country, nevertheless now twenty years later and subsequent technological advances this may be worth revisiting. Similarly, respondents

felt co-location would be effective in assisting interagency working however, again this was suggested two decades ago (Department for Education and Skills, 2003). Even so, Frederico et al. (2014) highlight that co-location encourages joint working, develops knowledge, and has been considered effective, and therefore is instigated in some parts of Australia. Nevertheless, even with the development of Multi-Agency Safeguarding Hubs (MASH) in the UK, and statutory guidance which highlights key standards for information sharing (HM Government, 2018a) and emphasises agencies duties to work with each other (HM Government, 2018b), there are still misunderstandings among practitioners as to what information can be shared and children and families' teams seem predominantly child focussed (Home Office, 2014). This implies that professionals' suggestions correspond with historic proposals to implement change, but that sustained change has not been made as the same barriers to interagency working persist.

Limitations

The research sample is relatively small; and there is an under representation of CFSWs, thus MHCCs appear to dominate the findings. As only two CFSWs participated, both of whom had similar lengths in service and demographic characteristics, this research does not adequately reflect the potentially diversity of perspectives and the extent to which wider understanding should be assumed from this is limited.

The researcher was a MHCC practicing in the CMHT in the study and thus, the possibility of the interviewer effect and respondent bias require consideration. Relationship dynamics between researcher and participant may have impacted on the trustworthiness of the findings (Galdas, 2017). The influence of bias was minimised as participants were not approached directly by the researcher, professionalism was maintained throughout interviews, questions were read from the interview guide and anonymity was maintained.

<u>Conclusion</u>

It is evident that there are currently a combination of both individual and national level factors which impact on the ability of agencies to effectively work together to support a primary care giver with EUPD and their family. On an individual level, practitioners' understanding of EUPD, knowledge of policies and legislation, personal opinions on what should be shared with

agencies, and their previous experiences of working with the agency, appear to have had a negative impact on their willingness to work collaboratively. This coupled alongside wider national level issues such as reductions in resources, a lack of training, technological issues, along with stigma in systems meant to support people with EUPD, again limits the effectiveness of interagency working when supporting someone with the diagnosis. Nevertheless, scope for change has been identified by those working on the front line in which it is acknowledged that there is sufficient room for improvement.

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