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Co-ordinating support for families experiencing IPV and mental health concerns: Preliminary qualitative findings with a focus on CAMHS

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Background

- Previous work indicates that the response and confidence of professionals around IPV and its mental health impacts can vary greatly
- There is often a lack of co-ordination between health and social care services for this group of families

Research questions

- How do services recognise and address child mental health, parental/carer mental health, and domestic abuse in families where these may be co-occurring vulnerabilities?
- **How do services co-ordinate support for families experiencing mental health difficulties and domestic abuse?**

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Methods

Qualitative approach:

- Multi-site interview study
- Recruited professionals from primary care, child mental health care, and specialist domestic abuse services
- From three contrasting areas in England

PPI: survivor-led domestic abuse lived experience advisory group to consult on study design and analysis

Advisory groups: local working groups of professionals for each area in the study to consult on study design, support with recruitment and feedback on findings

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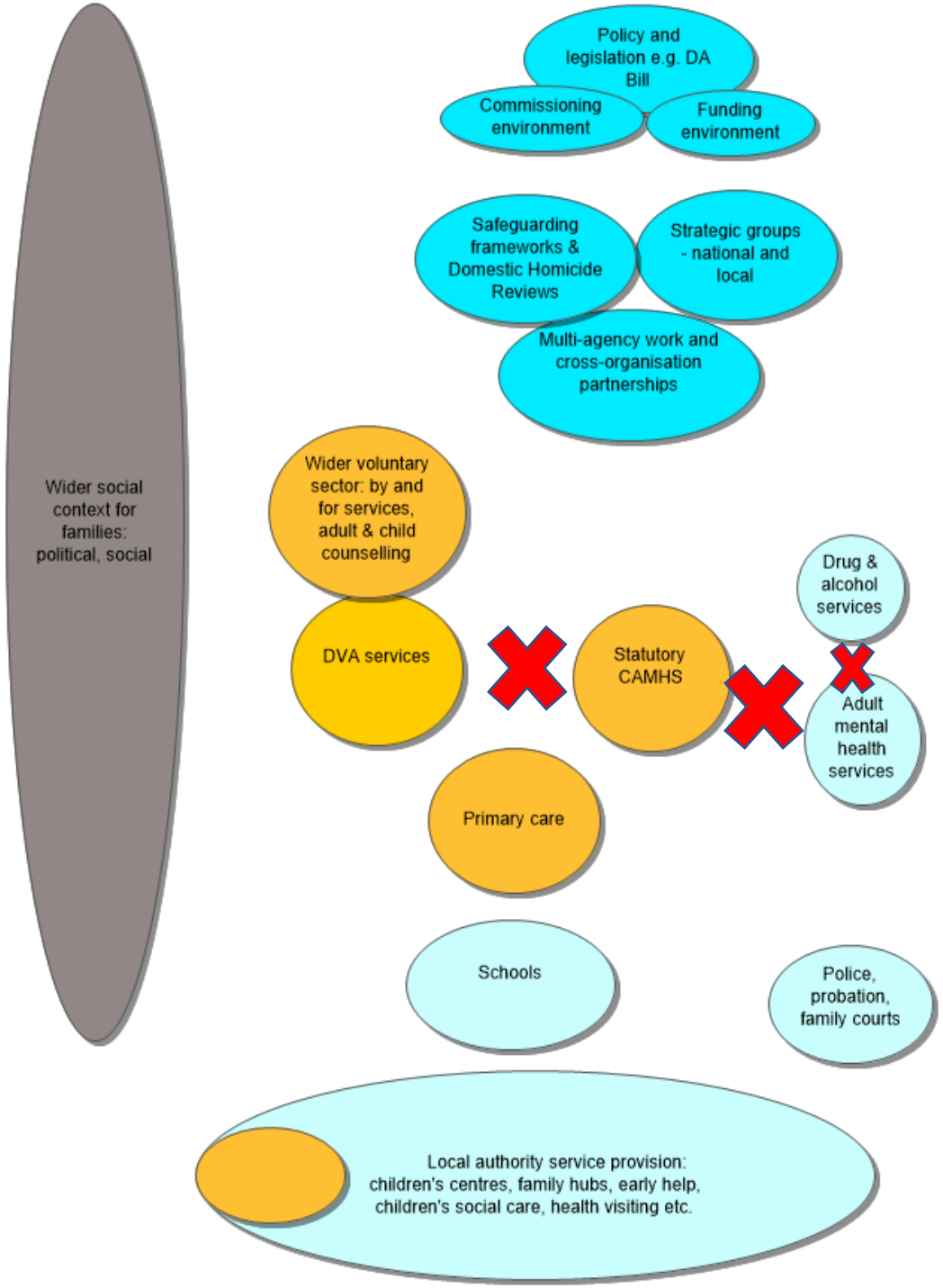
Emerging findings: work in progress

Participants (N=38)

	Child Mental Health	Domestic Abuse services	Primary Care
Definition	Any role focusing on CYP's mental health or wellbeing in statutory or voluntary sector, includes CYP primary mental health	Frontline service provision of core services (i.e. refuge, advocacy etc.) and wider support (counselling, advice); relevant commissioners	Either GP-based, relevant strategic role or adult primary mental health, includes IRIS (GP-based domestic abuse advocacy)
Total (n)	15	19	6
Example roles recruited	Clinical psychologist, psychiatrist, primary mental health worker, counselling manager	CEO, refuge manager, IDVA, children's services manager, perpetrator group facilitator, commissioner	GP, safeguarding lead, advocate educator, mental health peer support worker

Service ecosystem for families experiencing IPV and MH

- Participants identified service provision/co-ordination as part of a complex system:
  - from policy
  - to individual level practice
- Interviewees from a focused set of services gave us a picture of the whole system
- Key gaps identified between services that affects the provision of co-ordinated support:
  - DVA-CAMHS
  - CAMHS-adult services
  - Between adult services
- Positive connections highlighted with:
  - Schools
  - Early Help
  - Family Hubs



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Key challenge: mental health service boundaries

- Professionals were empathetic and understanding of the resource and capacity limitations in their colleagues' sectors
- However, some families seen to fall through the gaps of current service provision for mental health support:
    - Children **living with parental IPV** (i.e. not considered to be living in a safe situation)
    - Parents and children **between** IAPT/primary mental health ('too complex') and not meeting secondary mental health service thresholds ('don't fit criteria')
    - Children **not meeting** social care or risk thresholds
    - High-needs mothers **with custody** of their children

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Key challenge: mental health service boundaries

- MH service thresholds were seen to have an impact both on families but also on other services:
    - Children **deteriorate** on the waiting list and then no longer meet the criteria for the service
    - Women are unable to access support at the time they need it, so they **return** to perpetrators
    - Families are **bounced around** different services, or **disengage** while waiting, or some professionals **won't refer** out of concern the referral will be unsuccessful
    - Voluntary sector and primary care try and **fill the gap**

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Key challenge: mental health funding

General impact of under-funded mental health services

Costs: lack of funding for timely support and intensive, long-term and individual work

- Only peer support and groups are offered
- Refuges unable to offer level of MH support needed
- People can't access MH support when needed -> can't leave perpetrator

Responsibility: MH related to IPV falls through gaps because LA doesn't have responsibility to fund it

Funding restrictions: can't fund services for identified needs, e.g. post-refuge

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Key challenge: conflicting perceptions amongst professionals

Who is responsible for what support when?

- CAMHS don't see themselves as specialist enough to support DVA so refer automatically to vol sector
- DVA services see their role as referring out for MH support
- CAMHS want more links with DVA services but sequencing of support means doesn't happen

What MH support can be offered when the family situation is unstable?

- Can't do trauma work while still experiencing it or living in refuge
- Can't leave perpetrator if MH too poor
- Basic anxiety and mood interventions don't work
- Focus on safety excludes children from support

DVA sector perceptions:

- MH services see current DVA as a safeguarding issue only
- MH services focus on diagnosis and historic trauma only
- CAMHS less likely to think about DVA, lack knowledge
- Short term interventions unhelpful for trauma
- CYP don't 'fit' diagnoses

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How does primary care fit in?

- DVA is '**on the radar'** although can be lower priority than physical health. Some GPs felt asking about DVA is **'opening a can of worms'** so avoid it. Others were aware it can involve asking multiple times over a period of time (challenging when don't see same GP). GPs need reminding to have **'professional curiosity'** (from DHRs).
- Coding challenges, inflexible IT systems, lack of time and capacity = multi-disciplinary meetings, information access and communication with other services challenging.
- HVs mean younger children more easily identified, but older children less likely to be flagged to GP. Challenges linking up with refuges.
- Impact of fragmented services (especially MH & addiction) and waiting lists (MH) on primary care – want to fill the gap through additional consultations, linking with wider primary care practitioners/other services. GPs perhaps less likely to refer to wider voluntary sector services.
- GPs as **'holders of the information'**

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Examples of positive service co-ordination

Although the most common relationship amongst services is by referral, we heard examples in each area of positive partnerships and effective multi-agency working

Embedded workers: CAMHS staff embedded in LA service provision; domestic abuse advocates embedded in health services

Second tier support: LA domestic abuse team supporting all health and social professionals in the area

Co-location: being based in the same building, often Family Hubs or with Early Help team

Staff moving sectors: staff moving from voluntary sector to statutory sector (and vice versa)

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Factors that promote positive service co-ordination

Behind every successful partnership lies governance, relationships and a shared vision. Three factors were highlighted by participants:

Joint: funding streams, commissioning, contracting, case management systems

Relationships: local authority and health trust; cross-commissioning

Cross-sector focus on public health approach: prevention, widespread knowledge and education for professionals and public, need for healthy relationships education

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Summary

- **Funding and commissioning** are central to successful service co-ordination
- There are **pockets of 'best practice'** across the country
- But these are **not widespread**
- There are some **key areas** on which professionals **disagree** (what should happen when, and by whom) but there is also widespread **agreement** on taking a public health approach to IPV

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