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

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Claire Powell, Emma Howarth, Gene Feder, Ruth Gilbert, Sigrun Clark, Lauren Herlitz, Shabeer Syed, Jessica Deighton, Laura Howe, Rebecca Lacey
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?
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
Emerging findings: work in progress
## Participants (N=38)

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