

26 **Abstract**

27 Domestic violence and abuse (DVA), mental ill-health (MH), and substance misuse (SU) are
28 inter-related public health problems negatively impacting families. Improved support requires
29 an understanding of key stakeholders' perspectives and experiences of current UK service
30 provision. We conducted a qualitative research study to explore service users', service
31 providers', and senior leadership/commissioners' experiences of service provision for
32 responding to parental DVA, MH, and SU in one locality. Six service users participated in
33 individual, semi-structured interviews and ten service providers and senior
34 leadership/commissioners attended two separate focus groups. We analysed data using
35 reflexive thematic analysis. Five themes captured participants' experiences: *'it's hard to get*
36 *the support I need, when I need it'*; *'almost all services come together around a family'*; *'it's*
37 *all about the right relationships'*; *'addressing upstream drivers'*; and *'it's difficult providing*
38 *support for multiple needs'*. These highlighted the importance of: early support; a relational
39 response; and addressing needs beyond parental DVA, MH, and SU. They also emphasised
40 the barriers presented by siloed specialisms and overwhelmed practitioners. Our study is one
41 of the first to consider multiple stakeholders' perspectives on current UK service provision
42 for co-occurring parental DVA, MH, and SU. It highlights key challenges for working at the
43 intersection of these problems and suggests system-level change is needed to create the
44 conditions to support families with multiple needs.

45

46 **1. Introduction¹**

47 Parental domestic violence and abuse (DVA), mental ill-health (MH), and substance misuse
48 (SU) are three global public health problems that co-occur at the household-level and
49 negatively impact parents, parenting capacity, and children (Allen et al., under review;

¹ Abbreviations used throughout include: DVA (domestic violence and abuse); MH (mental ill-health); SU (substance misuse); EH (Early Help); and TAF (team around the family).

50 Bacchus et al., 2018; Cleaver et al., 2011; Devries et al., 2013; EMCDDA, 2015). Within the
51 UK, 3.6% of children live in households with all of these problems (Chowdry, 2018), while
52 serious case reviews and epidemiological research indicate these children are at increased risk
53 of maltreatment (Brandon et al., 2020; Kelley et al., 2015; Rodriguez, 2006). The historically
54 siloed nature of UK services presents barriers to support for families experiencing co-
55 occurring needs (Mason & O'Rinn, 2014). Consequently, improving prevention and
56 intervention to address parental DVA, MH, and SU in combination is a policy and practice
57 priority (HM Government, 2017, 2019; Safe Lives, 2019).

58

59 In the absence of evidence-based interventions that address parental DVA, MH, and SU in
60 combination (Allen et al., 2022), developing an understanding of ways to better support
61 families at the intersection of these problems is essential. This requires an epidemiological
62 understanding of these families' needs and an understanding of key stakeholders' experiences
63 of current service provision for co-occurring needs including if, and how, this might be
64 improved.

65

66 Qualitative work has considered parents' and children's experiences of risk-dyads (i.e., a
67 combination of two of parental DVA, MH, or SU), the relationships between these risk-
68 dyads, and what useful support might comprise (Galvani, 2015; Humphreys & Thiara, 2003;
69 Macy et al., 2013; Templeton et al., 2009). These studies have highlighted key components of
70 effective support to include: *early*, pro-active support; *non-judgemental* support from
71 someone who *listens* and works with families' needs; education about healthy relationships
72 and the inter-relationships between DVA, MH, and/or SU; and recognising and addressing
73 DVA, including a focus on safety (Galvani, 2015; Humphreys & Thiara, 2003; Macy et al.,
74 2013; Templeton et al., 2009). Despite the common co-occurrence of these problems, studies

75 focusing specifically on families' experiences of service provision for parental DVA, MH,
76 and SU are rare, particularly within the UK. In a Canadian study, Lessard et al. (2020)
77 examined mothers', fathers', and young people's experiences of the inter-relationships of
78 parental DVA, MH, and SU but did not consider participants' views on current service
79 provision or how this might be improved. When considering the perspectives of professionals
80 delivering services for families with multiple needs, there is more evidence available but the
81 focus is often on implementation of specific interventions/approaches rather than what we
82 can learn from current service provision and inter-agency working (Bailey et al., 2020;
83 Healey et al., 2020).

84

85 Isobe et al. (2020) recommend that useful treatment approaches for co-occurring parental
86 DVA, MH, and SU are likely to include: keeping the perpetrators behaviours and actions in
87 mind; recognising and building on the ways in which mothers try and resist the violence;
88 providing supportive responses that do not induce fear of child removal/replicate abusive
89 tactics; and listening to and engaging with children. In terms of interagency working, helpful
90 facilitators could be: co-convened case planning meetings; regular interagency
91 communication, training, and events; the development of strong informal and formal links
92 between services; support for practitioners; and support from leadership could be helpful
93 facilitators (Isobe et al., 2020; Townsend et al., 2020). However, we know little about
94 whether these suggestions resonate with families, service providers, and senior
95 leadership/commissioners in the UK, where many localities already have systems in place to
96 promote inter-agency working (see [https://www.gov.uk/government/collections/supporting-](https://www.gov.uk/government/collections/supporting-families)
97 [families](https://www.gov.uk/government/collections/supporting-families)).

98

99 Our study aimed to develop an understanding of whether, and how, current service provision
100 supports families experiencing multiple problems including parental DVA, MH, and SU. We
101 did this by addressing the following research questions, which were co-developed alongside
102 service providers and senior leadership/commissioners: 1) how do service users experience
103 service provision for co-occurring parental DVA, MH, and SU?; 2) what are service users’
104 perspectives of helpful and unhelpful support for co-occurring parental DVA, MH, and SU?;
105 and 3) what are service providers’ and senior leadership/commissioners’ perspectives of the
106 system-level barriers and facilitators to providing support at the intersection of co-occurring
107 parental DVA, MH, and SU? While our study focused on a specific service locality within
108 England (UK), the locality shares a similar service provision landscape for parental DVA,
109 MH, and SU as other settings, both nationally and internationally (i.e., provision that is
110 challenged by the historically siloed nature of provision). Therefore, we believe our study has
111 the potential to provide important insights that may be transferable beyond the current service
112 context.

113

114 **2. Methods**

115 **2.1 Study context**

116 Our study examined services located within a UK Early Help (EH) system in a culturally
117 homogenous area in southern England. EH is an approach implemented by service localities
118 across the UK (<https://www.gov.uk/government/collections/supporting-families>) aiming to
119 bring together service support for families where there are multiple problems (including, but
120 not limited to, parental DVA, MH, and SU). Practitioners are encouraged to suggest the
121 suitability of an EH approach where multiple family needs have been identified. Families can
122 also self-refer and have to consent for an EH approach to be adopted. EH support involves a
123 lead practitioner working with the family to assess family needs, develop a plan for support,

124 and bring in services around the family. This includes holding ‘team around the family’
125 (TAF) meetings (involving the family and all practitioners) to set goals, review progress, and
126 identify additional needs. EH practitioners are encouraged to provide a relational response to
127 families (i.e., a response that involves building a relationship with the family), ensuring
128 families feel listened to, cared about, and understood (Department for Levelling Up Housing
129 & Communities & Department for Education, 2022). The adoption of EH systems is
130 encouraged by the UK Government, with local authority, National Health Service (NHS), and
131 third sector organisations committed to providing EH support across the country (Department
132 for Levelling Up Housing & Communities & Department for Education, 2022).

133

134 **2.2 Participants**

135 *2.2.1 Interviews*

136 We conducted individual, semi-structured interviews with six service users (mothers, fathers,
137 and young people aged 16+) who had experienced, or were currently experiencing, parental
138 DVA, MH, *and* SU, and were supported by EH services in one southern England locality.

139

140 Service users were identified and initially approached by EH service providers between June
141 and September 2022. Service providers provided eligible service users with an invitation
142 sheet (one-page summary of the study) and participant information leaflet, which were
143 developed with service providers. If the service user was interested in participating, service
144 providers sought their consent to pass on their contact details to KA, who contacted them
145 within two days to discuss the study, answer any questions, and ask whether they would
146 participate. KA arranged a setting and time for the interview with service users and sought
147 informed written consent on the day of the interview. Participants were informed of: the

148 voluntary nature of the study; how we would keep data secure and confidential; and how we
149 would use the data.

150

151 Twelve service users were approached, of whom 11 consented to be contacted by KA. Of
152 these 11, one did not respond, one withdrew on the day of the interview due to concerns
153 about resurfacing uncomfortable feelings, two discussed participation but did not commit to
154 participating, and one said they were too busy. The remaining six completed an interview, all
155 of whom were from different families. We use pseudonyms and do not report service users'
156 demographic characteristics, or whether they were mothers, fathers, or young people, to
157 maintain anonymity.

158

159 *2.2.2 Focus groups*

160 We conducted two online focus groups: one with five service providers and one with five
161 senior leadership/commissioners. Service providers and senior leadership/commissioners had
162 to have worked in services for families experiencing DVA, MH, and/or SU to participate.

163

164 Service providers and senior leadership/commissioners were identified in conjunction with
165 the local authority and third sector organisations in the locality and emailed in June 2022. KA
166 arranged calls/meetings with those interested in participating to discuss the study and seek
167 consent prior to the focus group.

168

169 Seven service providers expressed interest in participating in the first focus group. Of these,
170 one did not respond to KA's contact and one withdrew due to work commitments. The
171 remaining five were from a mixture of local authority, public health, and third sector
172 organisations specialising in DVA (n=2), SU (n=2), and family focused (n=1) support. Eight

173 senior leadership/commissioners expressed interest in the second focus group. Of these, two
174 did not respond and one could not attend. The remaining five had backgrounds in DVA
175 (n=1), public health (n=1), children and families (n=2), and SU (n=1).

176

177 **2.3 Data collection**

178 *2.3.1 Interviews*

179 Semi-structured interviews followed a topic guide designed with EH to address our
180 aims/research questions while providing useful feedback for services (see Appendix A). The
181 topic guide started with open questions about family context and strengths before moving
182 onto questions about helpful and unhelpful aspects of service provision, and ways to improve
183 future support for families. Probes were informed by the wider literature, and conversations
184 with service providers and commissioners.

185

186 Interviews were conducted by KA between June and September 2022. Service users were
187 offered the choice of face-to-face (at a service location of their choice), video call, or
188 telephone interviews. Interviews lasted approximately one hour and ended with the
189 opportunity for questions, discussion, and signposting to services.

190

191 *2.3.2 Focus groups*

192 Focus groups started with introductions, an emotions check-in (using one word to describe
193 how you are feeling), and the co-development of ground-rules which included participant
194 confidentiality. The semi-structured topic guide was developed with service providers and
195 started with questions about how current services supported families experiencing parental
196 DVA, MH, and/or SU, before moving onto questions about system-level barriers and
197 facilitators to providing support at the intersection of parental DVA, MH, and SU (see

198 Appendix B). Focus groups concluded with discussion of ways to improve provision for
199 families experiencing multiple problems.

200

201 Focus groups were conducted online by KA (researcher-moderator) and VB (facilitator) in
202 July 2022 to enhance accessibility. The first (service providers) lasted two hours and the
203 second (senior leadership/commissioners) lasted ninety minutes.

204

205 *2.3.3 Interviews and focus groups*

206 Both interviews and focus groups were audio-recorded and transcribed for analysis.

207 Participants were offered £25 as reimbursement for their time (in addition to travel expenses,
208 where applicable).

209

210 **2.4 Analysis**

211 We analysed data from the interviews and focus groups using reflexive thematic analysis
212 (Braun & Clarke, 2022) from a critical realist standpoint, as it provides theoretical flexibility
213 while also allowing exploration of shared patterns of meaning across the data. The analysis
214 involved six phases (Braun & Clarke, 2022) conducted in an iterative and cyclical manner.

215 KA: 1) familiarised herself with the data by re-reading the transcripts and creating sketches to
216 capture initial reflections; 2) systematically coded the data with our research questions in
217 mind using inductive and deductive codes as well as semantic (descriptive) and latent
218 (interpretive) codes; 3) used these codes to generate initial candidate themes by arranging
219 these into shared patterns of meaning, visually mapping these candidate themes and the
220 relationships between them; 4) discussed candidate themes with VB, further refining these
221 and testing their utility by going back to the original data; 5) discussed the utility of the
222 themes with CB and worked to refine, define, and name them, writing short ‘abstract’

223 summaries for each theme; and 6) began the writing process which helped her further engage
224 with the themes and their meaning. KA coded data from the interviews and focus groups
225 separately in stage two (systematic coding of the data), bringing codes together in stage three
226 to generate themes representing shared patterns of meaning across the *whole* dataset (Miles &
227 Huberman, 1994). We highlight where themes are predominately driven by specific
228 stakeholder perspectives.

229

230 Throughout the analysis, KA kept a record of reflexive notes which allowed her to critically
231 interrogate her position and role in co-constructing the findings. For example, KA considered
232 how her role as a researcher, prior experiences, lack of pre-established relationships with
233 service users, eagerness to conduct interviews where service users felt comfortable and
234 listened to, and relationships with service providers may have influenced the design, conduct,
235 and interpretation of the study. This reflexive process meant KA was able to take active steps
236 to mitigate some of these issues (e.g., taking time to meet with service users prior to the
237 interview, empowering service users to exercise control over the time, date, and setting of the
238 interview, conducting the interview in a way that reduced any power differentials, enhancing
239 integrity of analysis by discussing interpretation with co-authors), while also acknowledging
240 the role she played in shaping the design and conduct of the study.

241

242 **2.5 Ethics**

243 Our study obtained ethical approval from the University of Exeter Medical School Research
244 Ethics Committee (ethics number: 51147).

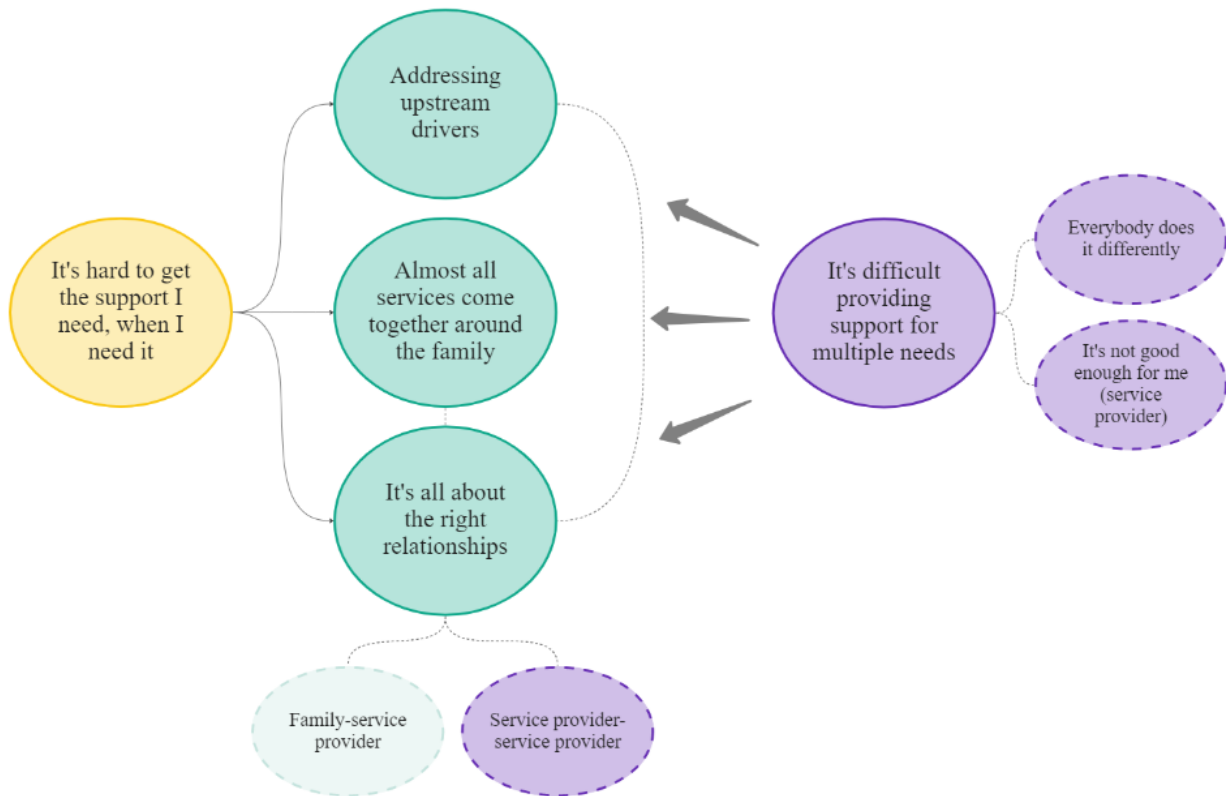
245

246 **3. Results**

247 Participants described a service response to parental DVA, MH, and SU that involved
248 identifying families' needs and referring to, or bringing in, support from multiple, specialist
249 services. Many specialist services were involved, with families' needs often extending
250 beyond support for DVA, MH, and SU to children's social care, housing, and finances. We
251 constructed five themes which captured shared patterns of meaning across the data. The first
252 theme, *'it's hard to get the support I need, when I need it'*, reflects the challenges service
253 users faced in accessing support for co-occurring problems. The second, third, and fourth,
254 *'almost all services come together around a family'*, *'it's all about the right relationships'*,
255 and *'addressing upstream drivers'*, highlight service users' experiences of support and the
256 importance of a relational response, as well as addressing needs that extend beyond support
257 for DVA, MH, and SU. In discussion of the final theme, *'it's difficult providing support for*
258 *multiple needs'*, we report some of the difficulties service providers face with providing
259 support to families at the intersection of parental DVA, MH, and SU. These themes and the
260 data informing them are illustrated in Figure 1.

261

262 *Figure 1. Themes, sub-themes, and relationships between themes [PRINT IN COLOUR]*



263

264 NB. Yellow = predominately service user perspectives; Green = mixture of service user, service provider, and senior
265 leadership/commissioner perspectives; Purple = predominately service provider and senior leadership/commissioner
266 perspectives.

267

268 **3.1 Theme 1 – It’s hard to get the support I need, when I need it**

269 Service users reported that it was hard to get the support they needed, when they needed it, an
270 issue also recognised by service providers and senior leadership/commissioners. Service
271 users said it was hard to access services because they: did not know whom to go to, what
272 support was available, or how services could help; feared child removal (or being separated
273 from parents); or had previously experienced poor relational practice:

274

275 *“I didn’t know how to go about it. Obviously, I’d been to the doctors a couple of times to try*
276 *and explain my situation with me. I just didn’t think they were going to hear what I had to*

277 *say, Ben's mental sadness, do you know what I mean? [...] I didn't want to go to Social*
278 *Services because I didn't want my kids taken off me because of the way I am and stuff and I*
279 *didn't... the primary school didn't get on with that anyway, so I didn't really know what to*
280 *do." (Service user 1)*

281

282 This was compounded by users' experience of multiple problems, which meant that it could
283 take additional strength and courage to reach out for support. Attempts to access support were
284 described by service users as a constant battle. Service users reported chasing services to get
285 support, services being unavailable or having long waitlists (particularly for MH services), a
286 lack of tailored support, long procedures to get support, needs not being 'great enough' to
287 warrant support in the context of overwhelmed services, and being denied access to support
288 due to co-occurring problems:

289

290 *"I can't get any contact with any mental health because they won't even look at me. And it is*
291 *actually ridiculous. It's just absurd because all my mental health was way, way, way before I*
292 *started drinking. [...] No. They won't... I can't do it because they will just turn around and*
293 *say, "because she drinks"."* (Service user 6)

294

295 Service users were aware that they needed to be constantly making progress and attending
296 sessions to retain support if successfully accessed. Although they understood the reasons for
297 this, both service users and service providers considered this unreasonable:

298

299 *"Two [missed] appointments and then you get kicked off. I mean that's ridiculous. You know,*
300 *we're talking about young people and adults, where they're struggling with that, you know,*

301 *confidence to engage with services and that kind of thing. So you do need to be a bit more*
302 *kind of understanding of a serv... of somebody.” (Service provider)*

303

304 The difficulty in accessing timely, consistent, tailored support was something all participants
305 recognised as a key issue that meant some service users believed there was “*no point*”
306 (*service user 4*) in seeking support, while others reported that lack of early support just
307 aggravated problems, allowing co-occurring problems to become more entrenched.

308

309 **3.2 Theme 2 – Almost all services come together around a family**

310 Once ‘in’ the service system, the *ideal* collaborative response to multiple needs was described
311 by service providers and senior leadership/commissioners as identifying the families’ needs
312 and bringing in multiple, specialist services around a family. This response often involved
313 holding regular, multiagency meetings with the family and practitioners to discuss progress,
314 assess safety, discuss concerns, and co-develop family goals. These multiagency meetings
315 were useful for some service users, helping them to ‘keep on track’, identify and address any
316 problems, and develop relationships with service providers and wider family who attended:

317

318 *“We felt very supported [...] I knew that if anything happened with Steve relapsing, then it*
319 *would... we were in a position where we had regular check-ins, we were regularly like... I*
320 *felt very looked after... we had safety plans in place and it, although it was probably one of*
321 *the worst times for the family, we felt that secure in the services that were being provided that*
322 *we were... that... that’s probably where I felt most supported” (Service user 5)*

323

324 For others, multiagency meetings were not happening, were happening less frequently than
325 promised, or had been arranged poorly by services who failed to communicate and

326 collaborate effectively. This confused some service users, given that EH was meant to
327 facilitate communication between services. Service providers and senior
328 leadership/commissioners also acknowledged that bringing in support around the family was
329 not always happening well enough in practice, leading to inconsistent provision. Service
330 providers attributed this to bureaucratic barriers to collaboration, not knowing to *whom* to
331 speak in order to facilitate collaboration, and service-level differences in commitment to
332 collaborative working.

333

334 Bringing in support from MH services was highlighted as a particular challenge. Although
335 MH services could be relied on where cases were ‘high-risk’, for low-risk cases MH services
336 were described as absent or inadequate, with unreasonably long waitlists. Service providers
337 described various attempts to bring in MH support for families, which were often
338 unsuccessful, leaving some to feel it was pointless trying to collaborate with MH services.
339 Barriers for collaborative working included deliberate gatekeeping, not being allowed contact
340 details of the families’ MH worker, and difficulties getting hold of MH services. This is not
341 something service providers experienced with other specialist services:

342

343 *“I’ve got a mum at the moment that is daily having suicidal thoughts and hasn’t seen her*
344 *community mental health worker for maybe three months. Not even a phone call! So I can’t*
345 *contact her worker to say ‘look, could you just give her a ring or could you pop in?’ I’ve got*
346 *go through the secretary and then the secretary passes it on. But... like, with that family, I’ve*
347 *never ever had a reply from her worker, which is like, I know we’re all busy, but takes 2*
348 *minutes for a reply [...]. It’s just quite frustrating and that’s... I don’t find that with any of the*
349 *other services.” (Service provider)*

350

351 This lack of support resulted in patchy provision. Service providers reported numerous ways
352 in which they tried to fill this gap in provision, including contacting other services about MH
353 support (e.g., GPs and local/national charities) or providing their own stopgap MH support.
354 Service providers often felt uncomfortable with this, believing it insufficient to meet needs
355 for specialist MH support.

356

357 **3.3 Theme 3 – It’s all about the right relationships**

358 *3.3.1 Family-service provider*

359 The family-service provider relationship influenced service users’ experience of service
360 provision. Positive service experiences were characterised by the development of a trusting
361 and supportive relationship with a service provider who understood the service users’ needs,
362 cared, and worked with the service user to bring in support. This helped service users
363 navigate services (which was difficult for them to do alone) and access support. In these
364 instances, service providers were described as being “*more like a friend than a professional*”
365 (*service user 5*), always being there when they needed them:

366

367 “*She makes you feel like she’s got all the time in the world for you. That’s really good. So,*
368 *she’ll come around and she... she’s really friendly. It’s very... it feels informal but it’s got*
369 *that formal sort of side to it. You know? That she’s paying attention and taking notes and*
370 *listening and that she’s... she’s really acting on what you’re saying. But you don’t feel like*
371 *intimidated, or like you’re in a formal setting.*” (*Service user 5*)

372

373 Conversely, negative experiences were characterised by the absence of a relational response
374 from service providers who were described as not listening, not understanding their needs,

375 being judgemental, not acting on promises, or generally not communicating well with the
376 service user:

377

378 *“[they] just score you on a survey; it’s really inhumane and mechanical, it doesn’t do*
379 *anything for helping people. [...] I was feeling really low I just got given and survey and I*
380 *said, “This is ridiculous. Is this what you’re going to do every time you call me, you know,*
381 *just keep asking me surveys and then scoring out of 10?” Not a human thing to do. No help*
382 *so I discharged myself from them and I didn’t bother with them again.” (Service user 3)*

383

384 High staff turnover within services created problems in this regard, with some service users
385 describing being ‘left in the dark’ after building a trusting relationship:

386

387 *“I think my mum already had problems sort of when she had Zoom meetings and that and she*
388 *would have one person and would like sort of get to know them, sort of trust them and then*
389 *they would just leave without even like sort of telling us.” (Service user 2)*

390

391 The importance of developing a trusting family-service provider relationship was also
392 recognised by service providers and senior leadership/commissioners. There were two
393 essential ingredients: time for service providers to read and familiarise themselves with the
394 families’ notes, and permission to work alongside the family to provide long-term, consistent,
395 tailored support. This was important given families’ co-occurring needs were often
396 conceptualised as ‘hidden’, and only identified and addressed over time. Furthermore, one
397 senior leadership/commissioner suggested choice was important, which chimed with service
398 users’ comments on it being about *who* provided the support and whether that person was
399 genuine, trustworthy, and someone they got on with.

400

401 3.3.2 Service provider-service provider

402 The relationships between service providers were also key. Service providers talked about
403 working around bureaucratic barriers to collaboration, which hindered their ability to support
404 families, by developing informal relationships with other service providers. These informal
405 relationships were described as useful for service providers *and* families, allowing them to
406 skip time-consuming, formal procedures and get the support families needed, quickly:

407

408 *“I just think it's having... and it's probably not the right answer... but having good contacts*
409 *in all these services, that you can ring, you know, I've got a few in Social Services, a few in*
410 *CAMHS [Child and Adolescent Mental Health Services] where I just bypass everyone and*
411 *just go “I've got this problem”. [...] I've been in the service for 20 years, I've made lots of*
412 *contacts over that time so... it's like my little black book, you know, so I find that helpful for*
413 *my families because, actually, if they were sometimes put in the system, it's a lot slower and*
414 *that's an awful thing to say, but that's the reality.” (Service provider)*

415

416 However, service providers recognised that this was not necessarily sustainable. High staff
417 turnover meant that it was difficult to maintain informal links and, given that this way of
418 working was not systematised, new staff coming into the service would struggle to provide
419 quality support. Furthermore, service providers called upon by many to bypass bureaucratic
420 procedures were likely to become overwhelmed themselves.

421

422 **3.4 Theme 4 – Addressing upstream drivers**

423 Service providers recognised that families' needs often extended beyond support for DVA,
424 MH, and SU to issues such as housing, finances, and employment. Where these needs were

425 identified, this was something service providers focused on before focusing on the specialism
426 of their service. Service users valued this type of support. When asked about what ‘helpful’
427 support looked like, they often gave examples of being provided with financial support,
428 whether that was support to move house, access food, help with debt, access benefits, attend
429 therapy sessions, or send children on day trips:

430

431 *“I was panicking about, like, enforcement agents coming to the door because of the debt and*
432 *all these other things that were bugging me, she, sort of, took collectively all the problem and*
433 *tried to find a resolve for them. So she’s actually like an occupational therapist in some*
434 *sense and it’s the... the greatest support that I’ve... I’ve probably ever had.” (Service user 3)*

435

436 Sometimes this support was provided in the context of couples who remained together or in
437 the context of relative safety from the perpetrator. At other times, it was linked with moving
438 to a safe environment (away from the perpetrator) and was support that service users felt they
439 wouldn’t have been able to access themselves:

440

441 *“When I got my house [...] I was really grateful and happy for the services then because they*
442 *got me help. They got... paid for my van, a van...the removal van. They paid for that and it*
443 *was really good because the hill I had to climb up, it was ridiculous... so, that was really*
444 *good. And then, he got me a cooker” (Service user 6)*

445

446 **3.5 Theme 5 – It’s difficult providing support for multiple needs**

447 *3.5.1 It’s not good enough for me (service provider)*

448 All participants emphasised that individual service providers were not to blame for
449 inadequate support at the intersection of parental DVA, MH, and SU. Instead, the problem

450 was system-level; the current system was insufficient for families and service providers.
451 Several factors contributed, including overwhelming need, lack of time, the complexity of
452 families' needs, lack of training and knowledge, and inconsistent support from line managers.
453 Service providers were aware that these pressures meant they were often unable to provide
454 the support families needed, further adding to their sense of being overwhelmed. In turn, this
455 led to high staff turnover which created further problems for services.

456

457 All service providers stressed they did not have enough time to do face-to-face therapeutic
458 work with families. With changes in service remits, service providers were not only expected
459 to work within their specialism (e.g., DVA, MH, SU, children, and families) but also support
460 families with multiple needs. This was difficult and sometimes frustrating for service
461 providers, with time being taken up with attempting to overcome bureaucratic barriers to
462 collaboration, as well as increasing paperwork, additional meetings, managing
463 'unmanageable' caseloads, or simply working within the remit of their specialism:

464

465 *"[Talking about EH] I know there are two practitioners that felt like completely and utterly*
466 *dedicated to it and were really fully involved in it. That's it though. The rest of the team*
467 *couldn't do it cos it wasn't seen as their job and also, they're inundated with the other*
468 *demand of their specialism... of doing, getting through the volume of work of their*
469 *specialism."* (Senior leadership/commissioner)

470

471 Combined with long waitlists, service providers described pressure to close cases quickly.
472 This undermined the development of strong, trusting relationships with families, which were
473 essential (see *'it's all about the right relationships'*). This was difficult for service providers,

474 who recognised that closing cases too quickly created a “*revolving door*” (*service provider*)
475 for families:

476

477 *“We're getting real pressure to quickly turn these families around. So like one in one out*
478 *because we've got such a long waiting list at the moment. [...] we're not going to get to the*
479 *root of the problem because it takes time to build a trusting relationship. [...] And if you've*
480 *got to close people too early, close that family when you've only addressed Billy not going to*
481 *school but you haven't addressed why Billy's not going to school. It's just gonna be a*
482 *revolving door. They're gonna get referred back because Billy's behaviours going to present*
483 *in a different way. [...] we all want to give 110% to our families and you don't always feel*
484 *like you're able to do that because of the pressure to close.” (Service provider)*

485

486 Service providers described feeling overwhelmed by the complexity of families’ needs and
487 the responsibility to support them. There were different ways in which service providers tried
488 to manage this: from using self-assessment tools (designed to identify family needs) to reduce
489 needs to a manageable amount, to discussing cases with one another to facilitate shared
490 decision-making (and responsibility). In addition, many service providers discussed the
491 protective benefit of sticking to their specialist service remit. This was often encouraged by
492 line managers, giving the service provider permission to move away from attempting to
493 address the complexity of families’ needs themselves (and the sense of overwhelm that
494 comes with this) towards a narrower focus on a specific, specialist need. However, not
495 everyone felt comfortable with this, recognising that while sticking to the service remit
496 helped the service, it did little to help families:

497

498 *“I get the feeling that sometimes things are kind of just ‘sssh, move it on to somebody else,*
499 *crack on, you can get on with that, can't you?’. Umm and that's not right, you know? Its*
500 *people's lives we're dealing with here.” (Service provider)*

501

502 Service providers noted they were not always able to stick to their service remit and were
503 often required to be a *“Jill of all trades”* (service provider) in order to provide support for
504 families across multiple needs. Service providers supported one another in this by sharing
505 ideas and discussing cases. However, they often felt they lacked adequate skills and expertise.
506 Increasing staff skills was something senior leadership/commissioners recognised as
507 important:

508

509 *“We haven't got the training in order to do the stuff that we're doing and its responsibility.*
510 *And you're there like, just like, ‘I don't know!’, well, I'll go... it's almost sometimes like I'll*
511 *come home and I'll go on Google and I'll try and research it myself. And that's not good*
512 *enough, you know, but it's all that we have to do. It's that or nothing.” (Service provider)*

513

514 Service providers reported that changes in service remit, and increasing workloads and
515 responsibilities, were not reflected in their pay or the way they were treated. Good strong
516 leadership, with line managers who understood the unrealistic expectations placed on service
517 providers and the work they do, was key to ensuring service providers felt supported. Service
518 providers who had this support from line managers felt lucky, with many lacking this.
519 Combined, these issues left service providers feeling overworked, overwhelmed, and uneasy
520 in the knowledge that the support they were providing was not meeting families' needs:

521

522 *“I just think... [sigh] you know, I do find it times it's like, you know, have I been able to do*
523 *enough there? That's how I feel. Have I done enough there? And, you know and I [...] just*
524 *think it comes back to having not enough people really to kind of cover all bases in terms of*
525 *what supports required at the time for the specific needs.” (Service provider)*

526

527 3.5.2 Everybody does it differently

528 The other difficulty in providing support for multiple needs stemmed from diversity of
529 practices between agencies. Although EH encourages collaborative working between
530 services, senior leadership/commissioners highlighted that this is operating within a system
531 that is predominantly segregated into specialisms, designed to address singular adversities.
532 This creates challenges for working at the intersection of parental DVA, MH, and SU:

533

534 *“I think we, as services, have been commissioned in silos... so around domestic abuse,*
535 *mental health, substance misuse... and whilst the practitioners will recognise that these*
536 *people have complex needs, they not necessarily equipped or given permission to work with*
537 *that whole person, they work with their specialist element and the specialist interventions and*
538 *then refer to another agency to do their specialist bit... in a sort of simplistic term. I think*
539 *there's creativity out there where practitioners want to do a better job, want to make sense of*
540 *services themselves. But that's driven by them, that individual practitioner, not by the system.*
541 *The system puts constraints on it. It doesn't free them up to do that.” (Senior*
542 *leadership/commissioner)*

543

544 The challenges were believed to arise because specialist services were fundamentally
545 different from one another, with differences in: underpinning theoretical models;
546 commissioning and funding; performance indicators and outcomes; prevention or treatment

547 focus; commitment to ‘think family’; and commitment to collaborative working. Although
548 senior leadership and commissioners recognised some benefits to this system (e.g., keeping
549 line of sight on, and listening to, children), some expressed concerns that this created tensions
550 for collaborative working and led to variations in response depending on how families first
551 engaged with the system:

552

553 *“So I think, for me, what I see currently... is that it is the need that... it's the lens from which*
554 *the service that is most triggered sees it. So if a mental health practitioner is working with*
555 *somebody then they may not necessarily think about the needs of the children. If it comes to*
556 *social care because of someone's mental health, then it might. If it comes to the police*
557 *because of DVA, it may be about separating that couple.”* (Senior leadership/commissioner)

558

559 There were also differences in providers’ ways of working. Discussing whether or not they
560 used specific models of care to inform their practice, service providers emphasised that
561 *“everybody just freestyles”* (service provider), with everyone doing this differently (between
562 and within service specialisms) depending on their own skills and expertise, and what they
563 thought worked or might be most useful for a particular family. This was also recognised by
564 senior leadership/commissioners, who emphasised that although there were shared models of
565 care that were encouraged across services (e.g., trauma-informed practice), these were often
566 applied differently across the system. Adopting shared goals across services was seen as key
567 to overcoming some of these challenges. Others suggested it would be useful to create a
568 system where there is one key worker able to address multiple complex needs.

569

570 **4. Discussion**

571 Our study analysed service users', service providers', and senior leadership/commissioners'
572 experiences of service provision for parental DVA, MH, and SU in an EH service system in
573 one locality in southern England. It is one of the first to explore multiple stakeholders'
574 experiences of current UK service provision. Based on data from six service users, and ten
575 service providers and senior leadership/commissioners, we constructed five themes which
576 captured shared patterns of meaning across the data. These themes highlight some of the
577 difficulties that families face in accessing timely support, the absence of MH services, the
578 importance of relational practice and addressing needs beyond those relating to parental
579 DVA, MH, and SU, and the challenges that service providers face in providing support for
580 families with multiple needs.

581

582 Service users reported difficulty in accessing services for co-occurring parental DVA, MH,
583 and SU. They described not knowing what support was available or to whom to speak, not
584 wanting service involvement due to fear of child removal or previous poor relational practice,
585 or having to battle for support amid long waitlists that prioritised those at crisis point. Given
586 the potential bi-directional relationships between parental DVA, MH, and SU (Bacchus et al.,
587 2018; Devries et al., 2013), failure to address problems early is likely to result in these
588 problems becoming more entrenched and multifaceted over time. Consequently, receiving
589 early, timely support is essential. Although the UK EH system is designed to bring in support
590 for a family where there are co-occurring needs, a number of family members reported being
591 denied access to specialist services recommended to them *because* of co-occurring needs.
592 This is one of many factors disadvantaging those with co-occurring needs (Fox, 2020; Mason
593 & O'Rinn, 2014; Public Health England, 2017; Safe Lives, 2019) and our findings highlight
594 that it remains an issue even within an EH approach encouraging interagency working

595 (Department for Levelling Up Housing & Communities & Department for Education, 2022;
596 Ministry of Housing Communities and Local Government, 2021).

597

598 Service users found it particularly difficult to access support for MH; NHS-provided MH
599 services were often described as absent, difficult to access, or inflexible. Service providers
600 also highlighted issues with working collaboratively with these MH services, emphasising
601 lack of responsiveness, failure to attend multiagency meetings, or deliberately gatekeeping
602 support. Similar difficulties have been highlighted elsewhere both within the UK and other
603 context such as Australia (Healey et al., 2020; Moreton et al., 2022). Although DVA, MH,
604 and SU services have seen increased demand recently (NSPCC, 2022), it may be that this is
605 particularly so in terms of MH, affecting the support they are able to provide. The number of
606 adults and children seeking NHS-provided MH support has drastically increased in the last
607 year; with around 1.07 million adults and 395,000 children currently in contact with MH
608 services (British Medical Association, 2022). NHS funding for MH services has, however,
609 failed to keep up with demand and, combined with a depleted MH workforce, services are
610 increasingly overwhelmed (British Medical Association, 2022). We suggest this is one reason
611 why it might be difficult for MH services to engage effectively in EH. Furthermore,
612 fragmentation of MH provision may mean families with multiple needs often fall through the
613 gaps, with needs too complex for services such as Improving Access to Psychological
614 Treatment (IAPT) but not meeting the thresholds for specialist support such as CAMHS or
615 Community Mental Health Teams (Appleton et al., 2021; Moreton et al., 2022). Future
616 research should seek to explore MH professionals' experiences.

617

618 Consistent with previous research exploring families' experiences of risk-dyads (Galvani,
619 2015; Humphreys & Thiara, 2003; Macy et al., 2013; Templeton et al., 2009), our study

620 emphasises that the most helpful support for families experiencing co-occurring problems
621 involves a consistent, relational response from a service provider. Whereas service providers
622 who were judgemental, did not listen, or did not tailor support to the families' needs were
623 deemed unhelpful, those that took the time to listen, work with families' needs, and were
624 more like a 'friend' than a professional were crucial for ensuring families felt supported.
625 Families gave multiple examples of where this was happening within the EH context, which
626 is unsurprising given that this is a key aspect of the EH approach (Department for Levelling
627 Up Housing & Communities & Department for Education, 2022; Ministry of Housing
628 Communities and Local Government, 2021). However, there were also examples where
629 service providers were experienced as judgemental or not listening, renegeing on promises, or
630 communicating poorly. High staff turnover was recognised as an issue in this regard, as well
631 as system-level barriers. For example, many service providers reported that they lacked the
632 time, permission, and support from managers to develop the consistent relationships with
633 families which were needed to build trust and identify co-occurring needs. Although this
634 varied across services, most services were described as 'overwhelmed', resulting in pressure
635 to close cases early and stick to the service remit despite knowing that families' needs were
636 only partially being met.

637
638 Our findings also highlight that helpful support involves addressing upstream drivers (and
639 potential consequences) of parental DVA, MH, and SU such as housing, finances, and
640 employment. Several studies have linked poverty and wider socio-economic factors to the
641 experience of parental DVA, MH, and SU using national and international samples (Allen et
642 al., under review; Lacey et al., 2020; Walsh et al., 2019), and previous work in the U.S. has
643 highlighted that those experiencing DVA, MH, and SU often require support across multiple
644 domains (Moses et al., 2004). Therefore, it is unsurprising that families in our study valued

645 service providers who listened and acted to provide support with debt, employment, housing,
646 and finances. After establishing safety, addressing these basic financial needs is likely to be
647 important to create the conditions in which families can feel able to focus on and attend to co-
648 occurring parental DVA, MH, and SU.

649

650 Ways to improve support for co-occurring parental DVA, MH, and SU include training
651 service providers, increasing communication and collaboration between services through
652 inter-agency training, events, and meetings, and increasing knowledge about co-occurring
653 DVA, MH, and SU (Isobe et al., 2020; Townsend et al., 2020). However, our findings
654 suggest that these strategies are unlikely to be sufficient or sustainable in the long term.

655 Although these strategies would facilitate collaborative working within EH, services remain
656 siloed in terms of their theoretical underpinnings, funding, provision, remits, and
657 performance indicators. This creates barriers to integrated working and tensions for service
658 providers who are overwhelmed and struggling to meet the needs of their specialism, let
659 alone support families with multiple needs. Others have reported similar difficulties
660 internationally (Healey et al., 2020; Kertesz et al., 2022; Moses et al., 2004), raising the
661 question as to whether more fundamental system-level change is needed. For example,
662 commissioners could encourage more joined up working by setting performance indicators
663 focused on more holistic outcomes and rewarding collaborative working rather than work
664 within specialisms. Furthermore, funding for services that address multiple problems in
665 combination, including parental DVA, MH, and SU, are likely to be useful. Such services
666 might be provided by more generalised providers with skills across DVA, MH, and SU. Such
667 funding models have been set up across the UK (see <http://lhalliances.org.uk>; Knight et al.,
668 2017; Lowe & Plimmer, 2019).

669

670 This study benefited from including the perspectives of service users, service providers, and
671 senior leadership/commissioners. The study also benefited from employing reflexive thematic
672 analysis, allowing us to enhance the conduct and integrity of our study and acknowledge the
673 role we, as researchers, have played in the design, conduct, and interpretation of the findings.
674 However, it has several limitations. First, we were only able to recruit six service users,
675 which fell short of our target of twelve derived using the concept of information power (see
676 Malterud et al., 2015) and limited the depth of resultant data. Second, we were unable to gain
677 the perspectives of father perpetrators who are likely to experience differential support and
678 intervention from services. There are several reasons for this, including difficulties
679 identifying service users experiencing parental DVA, MH, and SU within specialist services
680 (which ordinarily focus on only one of these issues) and practitioner concerns about the
681 vulnerability of service users. Furthermore, it may be that some service users did not respond
682 to KA's invitation to participate due to anxiety around engaging with a researcher (whom
683 they had no pre-existing relationship with) or fear of child removal. Future work should work
684 closely alongside a broader array of services for longer to overcome these challenges. Third,
685 we did not recruit service users through MH services and MH practitioners were not present
686 within the focus groups as we only had University college-level ethical approval (not health
687 research authority approval). The need to acquire additional health research authority
688 approval to involve the MH sector in research remains a barrier to collaboration (from a
689 research perspective) and this limitation may have heightened the sense of MH services being
690 'absent' within the interviews and focus groups. However, provision of integrated support has
691 been noted as a challenge for MH services elsewhere (Healey et al., 2020; Moreton et al.,
692 2022). Future research should seek to examine MH professionals' perspectives of the barriers
693 and facilitators to working across parental DVA, MH, and SU to develop an understanding of
694 the challenges MH services might face. Fourth, this study was only designed to provide a

695 snapshot of an English localities service provision. However, the findings are likely to
696 provide valuable insights for other contexts, both nationally and internationally, who share
697 similar service provision or similar tensions in provision which challenge working at the
698 intersection of needs. Future research could use more in-depth qualitative methods to explore
699 nuances in service users', service providers', and senior leaderships/commissioners'
700 experiences, developing theory about the mechanisms likely to be important in addressing
701 parental DVA, MH, and SU in combination.

702

703 **4.2 Conclusions**

704 Our study aimed to develop an understanding of service users', service providers', and senior
705 leadership/commissioners' experiences of current service provision for co-occurring parental
706 DVA, MH, and SU, helpful and unhelpful aspects of support, and the system-level barriers
707 and facilitators to providing support at the intersection of families' needs. The findings
708 suggest families' experiences of service provision are mixed, with families often finding it
709 difficult to access timely support that addressed all aspects of their needs. Relational
710 responses for parental DVA, MH, and SU were important, as were responses that addressed
711 the underlying determinants of these problems. However, there were a number of system-
712 level barriers to providing this support, underpinned by the siloed nature of services and
713 overwhelmed and under-funded providers. Supporting services to work collaboratively to
714 provide support at the intersection of parental DVA, MH, and SU is likely to require more
715 fundamental system-level change.

716

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722

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