Experiences of current UK service provision for co-occurring parental domestic violence and abuse, mental ill-health, and substance misuse: a reflexive thematic analysis

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Abstract

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

1. Introduction

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

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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).

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

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

Qualitative work has considered parents’ and children’s experiences of risk-dyads (i.e., a combination of two of parental DVA, MH, or SU), the relationships between these risk-dyads, and what useful support might comprise (Galvani, 2015; Humphreys & Thiara, 2003; Macy et al., 2013; Templeton et al., 2009). These studies have highlighted key components of effective support to include: *early*, pro-active support; *non-judgemental* support from someone who *listens* and works with families’ needs; education about healthy relationships and the inter-relationships between DVA, MH, and/or SU; and recognising and addressing DVA, including a focus on safety (Galvani, 2015; Humphreys & Thiara, 2003; Macy et al., 2013; Templeton et al., 2009). Despite the common co-occurrence of these problems, studies
focusing specifically on families’ experiences of service provision for parental DVA, MH, and SU are rare, particularly within the UK. In a Canadian study, Lessard et al. (2020) examined mothers’, fathers’, and young people’s experiences of the inter-relationships of parental DVA, MH, and SU but did not consider participants’ views on current service provision or how this might be improved. When considering the perspectives of professionals delivering services for families with multiple needs, there is more evidence available but the focus is often on implementation of specific interventions/approaches rather than what we can learn from current service provision and inter-agency working (Bailey et al., 2020; Healey et al., 2020).

Isobe et al. (2020) recommend that useful treatment approaches for co-occurring parental DVA, MH, and SU are likely to include: keeping the perpetrators behaviours and actions in mind; recognising and building on the ways in which mothers try and resist the violence; providing supportive responses that do not induce fear of child removal/replicate abusive tactics; and listening to and engaging with children. In terms of interagency working, helpful facilitators could be: co-convened case planning meetings; regular interagency communication, training, and events; the development of strong informal and formal links between services; support for practitioners; and support from leadership could be helpful facilitators (Isobe et al., 2020; Townsend et al., 2020). However, we know little about whether these suggestions resonate with families, service providers, and senior leadership/commissioners in the UK, where many localities already have systems in place to promote inter-agency working (see https://www.gov.uk/government/collections/supporting-families).
Our study aimed to develop an understanding of whether, and how, current service provision supports families experiencing multiple problems including parental DVA, MH, and SU. We did this by addressing the following research questions, which were co-developed alongside service providers and senior leadership/commissioners: 1) how do service users experience service provision for co-occurring parental DVA, MH, and SU?; 2) what are service users’ perspectives of helpful and unhelpful support for co-occurring parental DVA, MH, and SU?; and 3) what are service providers’ and senior leadership/commissioners’ perspectives of the system-level barriers and facilitators to providing support at the intersection of co-occurring parental DVA, MH, and SU? While our study focused on a specific service locality within England (UK), the locality shares a similar service provision landscape for parental DVA, MH, and SU as other settings, both nationally and internationally (i.e., provision that is challenged by the historically siloed nature of provision). Therefore, we believe our study has the potential to provide important insights that may be transferable beyond the current service context.

2. Methods

2.1 Study context

Our study examined services located within a UK Early Help (EH) system in a culturally homogenous area in southern England. EH is an approach implemented by service localities across the UK (https://www.gov.uk/government/collections/supporting-families) aiming to bring together service support for families where there are multiple problems (including, but not limited to, parental DVA, MH, and SU). Practitioners are encouraged to suggest the suitability of an EH approach where multiple family needs have been identified. Families can also self-refer and have to consent for an EH approach to be adopted. EH support involves a lead practitioner working with the family to assess family needs, develop a plan for support,
and bring in services around the family. This includes holding ‘team around the family’
(TAF) meetings (involving the family and all practitioners) to set goals, review progress, and
identify additional needs. EH practitioners are encouraged to provide a relational response to
families (i.e., a response that involves building a relationship with the family), ensuring
families feel listened to, cared about, and understood (Department for Levelling Up Housing
& Communities & Department for Education, 2022). The adoption of EH systems is
encouraged by the UK Government, with local authority, National Health Service (NHS), and
third sector organisations committed to providing EH support across the country (Department
for Levelling Up Housing & Communities & Department for Education, 2022).

2.2 Participants

2.2.1 Interviews

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

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

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

2.2.2 Focus groups

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

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

Seven service providers expressed interest in participating in the first focus group. Of these, one did not respond to KA’s contact and one withdrew due to work commitments. The remaining five were from a mixture of local authority, public health, and third sector organisations specialising in DVA (n=2), SU (n=2), and family focused (n=1) support. Eight
senior leadership/commissioners expressed interest in the second focus group. Of these, two
did not respond and one could not attend. The remaining five had backgrounds in DVA
(n=1), public health (n=1), children and families (n=2), and SU (n=1).

2.3 Data collection

2.3.1 Interviews

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

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

2.3.2 Focus groups

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

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

2.3.3 Interviews and focus groups

Both interviews and focus groups were audio-recorded and transcribed for analysis. Participants were offered £25 as reimbursement for their time (in addition to travel expenses, where applicable).

2.4 Analysis

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

KA: 1) familiarised herself with the data by re-reading the transcripts and creating sketches to capture initial reflections; 2) systematically coded the data with our research questions in mind using inductive and deductive codes as well as semantic (descriptive) and latent (interpretive) codes; 3) used these codes to generate initial candidate themes by arranging these into shared patterns of meaning, visually mapping these candidate themes and the relationships between them; 4) discussed candidate themes with VB, further refining these and testing their utility by going back to the original data; 5) discussed the utility of the themes with CB and worked to refine, define, and name them, writing short ‘abstract’
summaries for each theme; and 6) began the writing process which helped her further engage
with the themes and their meaning. KA coded data from the interviews and focus groups
separately in stage two (systematic coding of the data), bringing codes together in stage three
to generate themes representing shared patterns of meaning across the *whole* dataset (Miles &
Huberman, 1994). We highlight where themes are predominately driven by specific
stakeholder perspectives.

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

2.5 Ethics

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

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

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

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

“I didn’t know how to go about it. Obviously, I’d been to the doctors a couple of times to try and explain my situation with me. I just didn’t think they were going to hear what I had to
say, Ben’s mental sadness, do you know what I mean? [...] I didn’t want to go to Social Services because I didn’t want my kids taken off me because of the way I am and stuff and I didn’t... the primary school didn’t get on with that anyway, so I didn’t really know what to do.” (Service user 1)

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

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

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

“Two [missed] appointments and then you get kicked off. I mean that’s ridiculous. You know, we’re talking about young people and adults, where they're struggling with that, you know,
confidence to engage with services and that kind of thing. So you do need to be a bit more kind of understanding of a serv... of somebody.” (Service provider)

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

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

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

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

For others, multiagency meetings were not happening, were happening less frequently than promised, or had been arranged poorly by services who failed to communicate and
collaborate effectively. This confused some service users, given that EH was meant to facilitate communication between services. Service providers and senior leadership/commissioners also acknowledged that bringing in support around the family was not always happening well enough in practice, leading to inconsistent provision. Service providers attributed this to bureaucratic barriers to collaboration, not knowing to whom to speak in order to facilitate collaboration, and service-level differences in commitment to collaborative working.

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

“I've got a mum at the moment that is daily having suicidal thoughts and hasn't seen her community mental health worker for maybe three months. Not even a phone call! So I can't contact her worker to say ‘look, could you just give her a ring or could you pop in?’ I've got go through the secretary and then the secretary passes it on. But… like, with that family, I've never ever had a reply from her worker, which is like, I know we're all busy, but takes 2 minutes for a reply […]. It's just quite frustrating and that's... I don't find that with any of the other services.” (Service provider)
This lack of support resulted in patchy provision. Service providers reported numerous ways in which they tried to fill this gap in provision, including contacting other services about MH support (e.g., GPs and local/national charities) or providing their own stopgap MH support. Service providers often felt uncomfortable with this, believing it insufficient to meet needs for specialist MH support.

### 3.3 Theme 3 – It's all about the right relationships

#### 3.3.1 Family-service provider

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

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

Conversely, negative experiences were characterised by the absence of a relational response from service providers who were described as not listening, not understanding their needs,
being judgemental, not acting on promises, or generally not communicating well with the service user:

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

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

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

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

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

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

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

3.4 Theme 4 – Addressing upstream drivers

Service providers recognised that families’ needs often extended beyond support for DVA, MH, and SU to issues such as housing, finances, and employment. Where these needs were
identified, this was something service providers focused on before focusing on the specialism of their service. Service users valued this type of support. When asked about what ‘helpful’ support looked like, they often gave examples of being provided with financial support, whether that was support to move house, access food, help with debt, access benefits, attend therapy sessions, or send children on day trips:

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

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

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

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

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

All participants emphasised that individual service providers were not to blame for inadequate support at the intersection of parental DVA, MH, and SU. Instead, the problem
was system-level; the current system was insufficient for families and service providers.

Several factors contributed, including overwhelming need, lack of time, the complexity of families’ needs, lack of training and knowledge, and inconsistent support from line managers. Service providers were aware that these pressures meant they were often unable to provide the support families needed, further adding to their sense of being overwhelmed. In turn, this led to high staff turnover which created further problems for services.

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

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

Combined with long waitlists, service providers described pressure to close cases quickly. This undermined the development of strong, trusting relationships with families, which were essential (see ‘it’s all about the right relationships’). This was difficult for service providers,
who recognised that closing cases too quickly created a “revolving door” (service provider) for families:

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

Service providers described feeling overwhelmed by the complexity of families’ needs and the responsibility to support them. There were different ways in which service providers tried to manage this: from using self-assessment tools (designed to identify family needs) to reduce needs to a manageable amount, to discussing cases with one another to facilitate shared decision-making (and responsibility). In addition, many service providers discussed the protective benefit of sticking to their specialist service remit. This was often encouraged by line managers, giving the service provider permission to move away from attempting to address the complexity of families’ needs themselves (and the sense of overwhelm that comes with this) towards a narrower focus on a specific, specialist need. However, not everyone felt comfortable with this, recognising that while sticking to the service remit helped the service, it did little to help families:
“I get the feeling that sometimes things are kind of just ‘sssh, move it on to somebody else, crack on, you can get on with that, can't you?’ Umm and that's not right, you know? It's people's lives we're dealing with here.” (Service provider)

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

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

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

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

3.5.2 Everybody does it differently

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

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

The challenges were believed to arise because specialist services were fundamentally different from one another, with differences in: underpinning theoretical models; commissioning and funding; performance indicators and outcomes; prevention or treatment...
focus; commitment to ‘think family’; and commitment to collaborative working. Although
senior leadership and commissioners recognised some benefits to this system (e.g., keeping
line of sight on, and listening to, children), some expressed concerns that this created tensions
for collaborative working and led to variations in response depending on how families first
engaged with the system:

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

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

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

Service users reported difficulty in accessing services for co-occurring parental DVA, MH, and SU. They described not knowing what support was available or to whom to speak, not wanting service involvement due to fear of child removal or previous poor relational practice, or having to battle for support amid long waitlists that prioritised those at crisis point. Given the potential bi-directional relationships between parental DVA, MH, and SU (Bacchus et al., 2018; Devries et al., 2013), failure to address problems early is likely to result in these problems becoming more entrenched and multifaceted over time. Consequently, receiving early, timely support is essential. Although the UK EH system is designed to bring in support for a family where there are co-occurring needs, a number of family members reported being denied access to specialist services recommended to them because of co-occurring needs. This is one of many factors disadvantaging those with co-occurring needs (Fox, 2020; Mason & O’Rinn, 2014; Public Health England, 2017; Safe Lives, 2019) and our findings highlight that it remains an issue even within an EH approach encouraging interagency working.
Service users found it particularly difficult to access support for MH; NHS-provided MH services were often described as absent, difficult to access, or inflexible. Service providers also highlighted issues with working collaboratively with these MH services, emphasising lack of responsiveness, failure to attend multiagency meetings, or deliberately gatekeeping support. Similar difficulties have been highlighted elsewhere both within the UK and other context such as Australia (Healey et al., 2020; Moreton et al., 2022). Although DVA, MH, and SU services have seen increased demand recently (NSPCC, 2022), it may be that this is particularly so in terms of MH, affecting the support they are able to provide. The number of adults and children seeking NHS-provided MH support has drastically increased in the last year; with around 1.07 million adults and 395,000 children currently in contact with MH services (British Medical Association, 2022). NHS funding for MH services has, however, failed to keep up with demand and, combined with a depleted MH workforce, services are increasingly overwhelmed (British Medical Association, 2022). We suggest this is one reason why it might be difficult for MH services to engage effectively in EH. Furthermore, fragmentation of MH provision may mean families with multiple needs often fall through the gaps, with needs too complex for services such as Improving Access to Psychological Treatment (IAPT) but not meeting the thresholds for specialist support such as CAMHS or Community Mental Health Teams (Appleton et al., 2021; Moreton et al., 2022). Future research should seek to explore MH professionals’ experiences.

Consistent with previous research exploring families’ experiences of risk-dyads (Galvani, 2015; Humphreys & Thiara, 2003; Macy et al., 2013; Templeton et al., 2009), our study
emphasises that the most helpful support for families experiencing co-occurring problems involves a consistent, relational response from a service provider. Whereas service providers who were judgemental, did not listen, or did not tailor support to the families’ needs were deemed unhelpful, those that took the time to listen, work with families’ needs, and were more like a ‘friend’ than a professional were crucial for ensuring families felt supported.

Families gave multiple examples of where this was happening within the EH context, which is unsurprising given that this is a key aspect of the EH approach (Department for Levelling Up Housing & Communities & Department for Education, 2022; Ministry of Housing Communities and Local Government, 2021). However, there were also examples where service providers were experienced as judgemental or not listening, reneging on promises, or communicating poorly. High staff turnover was recognised as an issue in this regard, as well as system-level barriers. For example, many service providers reported that they lacked the time, permission, and support from managers to develop the consistent relationships with families which were needed to build trust and identify co-occurring needs. Although this varied across services, most services were described as ‘overwhelmed’, resulting in pressure to close cases early and stick to the service remit despite knowing that families’ needs were only partially being met.

Our findings also highlight that helpful support involves addressing upstream drivers (and potential consequences) of parental DVA, MH, and SU such as housing, finances, and employment. Several studies have linked poverty and wider socio-economic factors to the experience of parental DVA, MH, and SU using national and international samples (Allen et al., under review; Lacey et al., 2020; Walsh et al., 2019), and previous work in the U.S. has highlighted that those experiencing DVA, MH, and SU often require support across multiple domains (Moses et al., 2004). Therefore, it is unsurprising that families in our study valued...
service providers who listened and acted to provide support with debt, employment, housing, and finances. After establishing safety, addressing these basic financial needs is likely to be important to create the conditions in which families can feel able to focus on and attend to co-occurring parental DVA, MH, and SU.

Ways to improve support for co-occurring parental DVA, MH, and SU include training service providers, increasing communication and collaboration between services through inter-agency training, events, and meetings, and increasing knowledge about co-occurring DVA, MH, and SU (Isobe et al., 2020; Townsend et al., 2020). However, our findings suggest that these strategies are unlikely to be sufficient or sustainable in the long term. Although these strategies would facilitate collaborative working within EH, services remain siloed in terms of their theoretical underpinnings, funding, provision, remits, and performance indicators. This creates barriers to integrated working and tensions for service providers who are overwhelmed and struggling to meet the needs of their specialism, let alone support families with multiple needs. Others have reported similar difficulties internationally (Healey et al., 2020; Kertesz et al., 2022; Moses et al., 2004), raising the question as to whether more fundamental system-level change is needed. For example, commissioners could encourage more joined up working by setting performance indicators focused on more holistic outcomes and rewarding collaborative working rather than work within specialisms. Furthermore, funding for services that address multiple problems in combination, including parental DVA, MH, and SU, are likely to be useful. Such services might be provided by more generalised providers with skills across DVA, MH, and SU. Such funding models have been set up across the UK (see http://hlalliances.org.uk; Knight et al., 2017; Lowe & Plimmer, 2019).
This study benefited from including the perspectives of service users, service providers, and senior leadership/commissioners. The study also benefited from employing reflexive thematic analysis, allowing us to enhance the conduct and integrity of our study and acknowledge the role we, as researchers, have played in the design, conduct, and interpretation of the findings. However, it has several limitations. First, we were only able to recruit six service users, which fell short of our target of twelve derived using the concept of information power (see Malterud et al., 2015) and limited the depth of resultant data. Second, we were unable to gain the perspectives of father perpetrators who are likely to experience differential support and intervention from services. There are several reasons for this, including difficulties identifying service users experiencing parental DVA, MH, and SU within specialist services (which ordinarily focus on only one of these issues) and practitioner concerns about the vulnerability of service users. Furthermore, it may be that some service users did not respond to KA’s invitation to participate due to anxiety around engaging with a researcher (whom they had no pre-existing relationship with) or fear of child removal. Future work should work closely alongside a broader array of services for longer to overcome these challenges. Third, we did not recruit service users through MH services and MH practitioners were not present within the focus groups as we only had University college-level ethical approval (not health research authority approval). The need to acquire additional health research authority approval to involve the MH sector in research remains a barrier to collaboration (from a research perspective) and this limitation may have heightened the sense of MH services being ‘absent’ within the interviews and focus groups. However, provision of integrated support has been noted as a challenge for MH services elsewhere (Healey et al., 2020; Moreton et al., 2022). Future research should seek to examine MH professionals’ perspectives of the barriers and facilitators to working across parental DVA, MH, and SU to develop an understanding of the challenges MH services might face. Fourth, this study was only designed to provide a
snapshot of an English localities service provision. However, the findings are likely to provide valuable insights for other contexts, both nationally and internationally, who share similar service provision or similar tensions in provision which challenge working at the intersection of needs. Future research could use more in-depth qualitative methods to explore nuances in service users’, service providers’, and senior leaderships/commissioners’ experiences, developing theory about the mechanisms likely to be important in addressing parental DVA, MH, and SU in combination.

4.2 Conclusions

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

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