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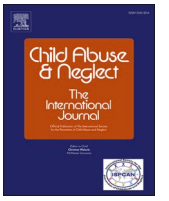

"They had clothes on their back and they had food in their stomach, but they didn't have me": The contribution of parental mental health problems, substance use, and domestic violence and abuse on young people and parents☆

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ABSTRACT

Background: The parental risk factors of mental health problems, substance use, and domestic violence and abuse each individually negatively impacts children's health and developmental outcomes. Few studies have considered the lived experience and support needs of parents and children in the real-world situation where these common risks cluster.
Objective: This study explores parents' and young people's lived experiences of the clustering of parental mental health problems, parental substance use, and domestic violence and abuse.
Methods: Semi-structured interviews were conducted with 18 mothers, 6 fathers, and 7 young people with experiences of these parental risk factors. Transcribed interviews were analysed using reflexive thematic analysis.
Results: Four themes were developed, 1) cumulative adversity, 2) the impact of syndemic risk, 3) families navigating risk, and 4) family support. Parents and young people described family situations of stress wherein they experienced cumulative impact of multiple parental risk factors. Parents sought to navigate stressors and parent in positive ways under challenging conditions, often impeded by their own childhood trauma and diminished confidence. Parents and young people spoke of the need for, and benefits of having, support; both as a family and as individuals, to successfully address this trio of parental risks and the related impact.
Conclusions: This study highlights the high level of stress families experience and the efforts they go to mitigate risk. Services and interventions need to reflect the complexity of multiple needs and consider both the whole family and individuals when providing support.

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1. Introduction

Estimates suggest that between 2.1 and 5.4 million children in England live in homes with at least one parental risk factor of mental illness, substance use, or domestic violence and abuse (DVA) (Children's Commissioner, 2018). Increasing evidence points to a range of harms to adults associated with these risk factors (Rehm & Shield, 2019; World Health Organization, 2013), with those impacted by substance use and mental illness at a greater risk of physical comorbidities and early mortality compared to the general population (Hjorthøj et al., 2015; Šprah et al., 2017). Further, fathers who perpetrate DVA and have substance use problems exhibit more hostile and aggressive parenting (Stover et al., 2013).

Many families demonstrate resilience (Masten & Monn, 2015), wherein families have the capacity to adapt well to adversity. However, when problems such as parental mental ill-health, substance use, and DVA combine with economic disadvantage and deprivation (Adjei et al., 2022), it can be more difficult for parents to provide a supportive and nurturing environment. This can then lead to intergenerational cycles of stress and adversity (Bridgett et al., 2015). Impacts upon children include accidental injury (Yang et al., 2020), poor health, barriers to appropriate health care (Artz et al., 2014) and lower educational attainment (Cleaver et al., 2011). Children exposed to these adversities within the family are more likely to experience mental health problems themselves (McGovern et al., 2023), as well as trauma symptoms (Evans et al., 2008; Grip et al., 2012), and are more likely to engage in health compromising behaviours such as substance use and anti-social behaviour (McGovern et al., 2018; Whitaker et al., 2006). Further, these common risk factors interact to exacerbate the overall effect within families. For example, in violent households the probability of child-to-parent domestic violence increases by 71 % compared to those children that have not been exposed (Gallego et al., 2019). The cumulative impacts (Whitaker et al., 2006) are themselves driven and exacerbated by structural risk factors such as poverty (Adjei et al., 2022) and related housing instability and overcrowding (Coulton et al., 2007). One conceptual framework relevant to the nature of these trio of risks is syndemics, which describes the interplay and adverse impact between health conditions and the social, economic, environmental, and political context (Sharma, 2017). The syndemic interaction between these trio of common risk factors, and their interaction with other illnesses and conditions, results in accumulated risk, which is enhanced by experienced inequities (Sharma, 2017).

Previous qualitative studies have typically focussed on a single risk factor (e.g., (Arai et al., 2019; Maina et al., 2021; Yamamoto & Keogh, 2018)), which while provides an important understanding of their experience and impact, lacks the understanding of how these risks cluster and exacerbate adversity. Fewer studies have investigated the perspectives of parents and children where there are co-occurring risk factors, or the impact these factors have on family function (Lessard et al., 2021). One study which sought to investigate how these risk factors co-occur demonstrated the circular nature of these risks. For example, mothers and adolescents frequently perceived that mental health problems and substance use were a consequence of the mother experiencing DVA (Lessard et al., 2021). While this study contributes to the understanding of the complex relationship between these risk factors, further research is needed to understand how families manage and mitigate these risks in conjunction with experiences of support.

Strategies to address the impacts of ACEs on children centre upon preventing or reducing harm to children from exposure to ACEs. To achieve this goal, recommendations include fostering safe, stable, and nurturing relationships within families; promoting parental resilience to current stressors, including mental health problems, substance abuse, DVA, social isolation, financial difficulties, and parenting difficulties; and encouraging effective parenting practices and healthy expectations about child development in culturally-sensitive ways. To mitigate the effects of ACEs, improving accessibility to evidence-based practices to promote positive parenting and children's socioemotional competence and resilience is one such strategy (Centers for Disease & Prevention, 2019; Harper Browne, 2014; Sege et al., 2017).

Interventions which integrated parenting skill and family functioning content with a substance use component are suggested to be the most effective at reducing parental substance use (McGovern et al., 2021), and there is promising evidence for a variety of effective interventions for reducing child mental health problems or improving children's behavioural or developmental outcomes, whether delivered to children directly or to parent-child dyads or families (Havinga et al., 2021; Leijten et al., 2019; Loechner et al., 2018; Marie-Mitchell & Kostolansky, 2019).

Evidence indicates the need for longer term interventions to support families affected by adversity which allow the necessary time to build up trust (Lester et al., 2019), and previous research has called for intervention development to be informed by people with lived experience of these adversities to ensure it addresses their ongoing and multi-faceted needs (Lorenc et al., 2020). Understanding how parents and children interact with adversity (both as a protective and risk factor) is necessary to ensure appropriate response and an important element of addressing the intergenerational cycle of adversity (Woods-Jaeger et al., 2018) and improving outcomes for affected families.

1.1. Study aims

The current research explores parents, and young people's lived experiences of the clustering of parental mental health problems, parental substance use, and DVA. We examine the needs of parents, and young people and their experiences of seeking and receiving support for these risks.

2. Methods

Data was drawn from the exploratory phase of a mixed-method study, which aimed to develop an intervention to support families affected by parental mental health, substance use, and DVA. We conducted semi-structured qualitative interviews with parents, and

young people across England.

2.1. Participants

We recruited participants from a wide range of community services, including organisations that provide services and support to individuals and families experiencing mental health problems, substance use, and DVA. We partnered with a national charity that has strong networks with multiple community services who advertised our study on our behalf, and we directly approached services within our local areas and wider networks.

Mothers, fathers, and young people were eligible for the study if they met the following criteria: a) having at least one of the risk exposures: parental mental health issues, substance use, DVA and b) being in a position where involvement in the research would be feasible and appropriate (e.g., families not in immediate crisis). Practitioners provided potential participants with participant information sheets and requested consent to share their contact details with the research team. A member of the research team then contacted the parents and young people to explain the study and invite participation.

We purposively sampled individuals with a myriad of experiences, with diverse genders, socio-economic factors, and geographic locations across England. We intended to recruit 20–25 parents and 10–15 young people to reach data saturation and to capture diverse experiences and demographic factors (Hennink & Kaiser, 2022). A broad age range was considered for inclusion for children and young people (ages 5–19 years); however, all participating young people were 14 years or above. One participant was recruited when she was aged 19 years and was interviewed when she had recently turned 20 years.

Participants received a £10 'thank you' e-voucher for their time.

2.2. Data collection

A total of 31 semi-structured one-on-one interviews were conducted, 18 with mothers, 6 with fathers, and 7 with young people. See Tables 1 and 2 for characteristics and risk profiles of parents and young people, respectively. Three researchers (SK, SB, CM) conducted the interviews. Separate topic guides were developed for parents and young people; however, both examined significant life events, the participant's experience of the risk factor(s), the impacts upon them and their family, and their experiences of support. Parent interviews were on average 60 min (range 30–153 min), and young people interviews averaged 32 min (range 10–64 min). All interviews were audio-recorded with participant's consent and transcribed verbatim. Each researcher generated field notes following the completion of an interview, notes included additional demographic details provided by participants, and reflections including common themes.

Interviews were conducted between March and October 2022 in-person, via telephone, and via video conferencing depending upon participant preference. Young people were provided with the option of having a support person of their choice present during their interview. Five chose to do so, with support people including teachers and support workers.

Table 1
Parent characteristics.

Participant	Gender	Ethnicity	No. of children	MH	SU	DVA victim/ survivor	DVA perpetrator	(Ex-) partner MH	(Ex-) partner SU
1	Female	White British	3		x	x			x
2	Female	White British	5	x					x
3	Female	White British	Multiple			x			x
4	Female	White British	7	x					x
5	Female	African	3	x		x			
6	Female	White British	3	x		x			x
7	Female	NA	3	x		x			
8	Female	NA	1	x					
9	Female	White British	2	x		x			x
10	Female	Indian	3			x			
11	Female	White British	2	x	x				x
12	Female	White British	1	x	x				
13	Female	White British	5	x					
14	Female	Latvian (own words)	1			x			x
15	Female	White British	5	x		x			
16	Male	Sikh (own words)	3	x				x	
17	Male	White British	Multiple	x	x		x		x
18	Female	White British	3	x		x			x
19	Male	White British	3		x		x		x
20	Male	White British	1		x				
21	Male	White British	1	x	x				
22	Male	White British	2	x			x		
23	Female	Pakistani	2	x		x			
24	Female	NA	1			x			

MH = mental health, SU = substance use, DVA = domestic violence and abuse, NA = not available.

Table 2
Young people characteristics.

Participant	Gender	Ethnicity	Living situation	MH	Behavioural problems	Parental DVA	Parental MH	Parental SU
CYP1	Male		Relatives home	x			x	x
CYP2	Male		Family home		x			
CYP3	Male		Care home	x	x			
CYP4	Male		Family home		x	x		
CYP5	Female	White British	Relatives home			x	x	x
CYP6	Female	White British	Family home	x			x	x
CYP7	Female	White British	Supported living					x

MH = mental health, SU = substance use, DVA = domestic violence and abuse.

2.3. Data analysis

Reflexive thematic analysis was undertaken based on Braun and Clarke's six-step process (Braun & Clarke, 2021), which afforded the flexibility needed to explore the diverse family experiences of risk exposures. The analysis was guided by a social constructionist epistemology, where meaning and realities are a product of social processes and interactions (Braun, 2013).

Three researchers (SK, SB, CM) familiarised themselves with the data by checking the transcripts for accuracy and re-reading the transcripts. Following familiarisation, an inductive approach was used for generating codes (Fereday & Muir-Cochrane, 2006). The transcript data was uploaded to shared spreadsheets (one for parent data, one for young people data), which allowed the researchers to code simultaneously and provide an overview of the dominant codes. Initial themes were generated from the parent data through examining the coded data and discussion among the research team (led by RM). Codes were assigned to each generated theme, and the themes and subthemes were further refined through an iterative process.

Young people interviews were coded, the codes were mapped to the same themes and subthemes as the parent data to illustrate similarities and differences in groups' perspectives (Lindsay, 2018; Peterson, 2010).

2.4. Ethics

Full ethical approval for the study was granted by King's College London Health Faculties Research Ethics Subcommittee (HR/DP-21/22-21189). Additional organisational approvals were sought when required by gatekeeping organisations.

3. Results

Four main themes were constructed within the data: cumulative adversity, the impact of syndemic risk, families navigating risk, and family support. Three themes comprised of multiple subthemes (Table 3), which illustrate the lived experiences of adversity among parents and young people.

3.1. Cumulative adversity

The parents and young people who participated in our study described experience of multiple and longstanding family adversity. Parents often described traumatic experiences in their own childhood, which they associated with their development of problems with substance use, mental health, and/or abusive relationships. These difficulties typically emerged in adolescence and persisted into adulthood and becoming a parent. Parents typically described personally experiencing these risks concurrently or in combinations between multiple family members. For example, many of the mothers had experienced mental health problems in combination with DVA, and either had a current or ex-partner with substance use problems. Parents described the interaction between risk factors including examples of how one risk factor would develop into or exacerbate others. Parental mental health problems were considered a common consequence of DVA (both as victim and perpetrator) and substance use, while substance use was often described by parents as a means of coping with being a victim to DVA and their own mental health problems.

Table 3
Overview of themes and subthemes.

Main theme	Subthemes
1. Cumulative adversity	
2. The impact of syndemic risk	2.1 Behavioural impacts
	2.2. Emotional impact and social isolation
3. Families navigating risk	3.1. Strategies to navigate risk
	3.2. Children as motivation
4. Family support	4.1. Ineffective support
	4.2. Characteristics of good support

Obviously me (sic) *ex-husband was abusive like emotionally, financially and sexually. So, like me confidence was just on the floor.* [*but drinking*] *pushed all my feelings down, pushed all the emotions down. I could be, like confident, I could talk to people – P12* (*Mother, MH, SU*)

This complex nature of risk within families extended beyond the parent-child relationship to other family members. Siblings who experienced problems with substance use, mental health or were violent within the home were also described as increasing a situation of extreme stress within the family. One young person discussed the cumulative impact upon her due to her brother's substance use and her mother's mental health.

Dealing with my brother's alcohol abuse is probably the worst. Because he – it's not like an alcohol problem where you just drink every day, it's like bingeing, withdrawing, having a seizure, ending up in hospital. He's really damaged his pancreas, and he doesn't eat either, so it's like, just a constant worry. My mam's mentally ill, so it sometimes comes across as like she's a bit mentally abusive and manipulative. I think it's more so because she couldn't control what my brother does, so she tries to control me. – CYP6 (*Young person, female, 20 years, parental MH; co-occurring sibling MH & SU*)

The context in which these families lived was frequently characterized by instability, including financial insecurity, inappropriate housing, and disruption related to family movements and separation. Mothers described how structural and interpersonal factors greatly impacted upon their ability to care for their children and keep them safe. This included high levels of financial and food insecurity or inability to access accommodation to take their children away from a situation they considered to be high risk, for example to leave a household that included a substance using or violent partner. Where alternative accommodation was offered, this was often temporary accommodation, and perceived to be poor quality housing in neighbourhoods which they deemed unsafe for children or within close vicinity to an abusive ex-partner. Although several mothers sought out and acquired private rentals, the processes involved provided additional stress due to financial constraints, and in some instances, mothers were required to pay six months of rent in advance to secure accommodation.

I got this privately rent property because I don't want my kids to live somewhere I don't find it safe. Or where there is drug use or alcoholic people live there. So I got this privately property for myself and for my kids. – P10 (*Mother, DVA victim/survivor*)

3.2. The impact of syndemic risk

3.2.1. Behavioural impacts

The cumulative and interacting nature of family stressors was described by participants as making daily life difficult. Parents discussed struggling to manage their own health needs and the needs of their children. The following quotation from a lone mother illustrates the hard work of, and struggle with, self-care and parenting of many of the parents in our study.

I suppose, because I feel like I'm constantly trying to, I have to work hard to manage my own mental health, that of three children's hard work anyway, but having a stroppy 15-year-old who's having counselling, and then a three year old who's sort of got quite severe separation anxiety and selective mutism, on your own with like the basic, basic income, it's really tough. – P6 (*MH, DVA victim/survivor, ex-partner SU*)

Parents reported that children and young people displayed a range of behavioural issues and attributed these to the family adversity they experienced. Parents often discussed how their children would struggle with anger, either within the school environment or within the home. This included being violent towards siblings and peers, threatening behaviours towards teachers or punching walls out of frustration. One mother described her son as having an:

"*Overwhelming sense of feeling powerless, and vulnerable* [*and*] *struggling with anger and needing to feel like he is powerful when he's in control*" – *P6* (*Mother, MH, DVA victim/survivor, ex-partner SU*).

The association between parental risk factors and child behavioural problems was also discussed by young people. The majority reflected on their aggression and the rationale behind it, with one young person stating that his aggression was "*just 'cause of my emotional insecurities*" – CYP3 (Young person, male, MH, behavioural problems).

Moreover, some parents and young people reported that children used substances or self-harmed to cope with the emotional impacts of family adversities. For example, one young person described her experience of using alcohol to cope with the household dysfunction she experienced. This young person's episodic binge drinking resulted in hospitalization on numerous occasions.

I would go out and get mortal [intoxicated] *just to forget everything. Which I obviously from childhood I knew that wasn't a good idea. But I saw the effect that it had on my stepdad at the time, and I just kind of needed that relief. So that's what I would do. Which got out hand, I would end up in hospital off nights out. Even ended up in a ditch one time, passed out mortal drunk. So that was kind of my coping mechanism, which obviously wasn't a very good one. – CYP5* (*Young person, female, 15 years, parental DVA, MH, SU*)

3.2.2. Emotional impact and social isolation

Parents and young people both frequently discussed the emotional impact of family adversity. Parents often reported experiencing high levels of guilt when reflecting on what their children had witnessed. This guilt remained and often intensified after the risk factor was no longer present, especially when becoming aware of the extent of the impact on their children.

Because [*ex-partner*, *son's father*] *used to hit on my son as well, which I never knew about until afterwards. When I went out he would pick on him for whatever reason, I don't know, he couldn't do anything right in his eyes. So that was kind of hard to hear, very hard to hear. My son never told me. – P9* (*Mother*, *MH*, *DVA victim/survivor*, *ex-partner SU*)

Experiences of guilt were consistent across parental risk factor(s) for both mothers and fathers. Guilt was attributed to their children being exposed to harm and the subsequent impact this had on their children. Fathers additionally reported feeling guilt for not being able to provide for the needs of their children or build relationships with them. For some, this was related to their reported transient presence in their children's lives. Feelings of guilt were not exclusive to parents. Young people reported feeling responsible for their parent's difficulties, especially concerning their parents' behaviours associated with mental health problems and substance use.

Emotional impacts upon children were felt to vary by age, with parents often reporting that their older children were impacted more greatly than their younger children due to being exposed longer to conflict, substance use, or mood changes. One mother felt she was able to shield her younger child from her substance use by limiting her awareness and direct exposure, which she felt meant her substance use had not impacted upon her daughter emotionally:

Because she was – I was very lucky she was so young and I'm really really grateful that I got into recovery when she was so young. – P12 (*Mother*, *MH*, *SU*)

However, this mother did reflect that she "*struggled bonding with her* [*daughter*], [*she*] *didn't have that instant connection. And* [*she*] *found it tough, like becoming a mam…so it's probably took until now to sort of build that relationship*". There was less recognition by many parents of the indirect effects of parental risk factors. For example, parents often overlooked the impact on the child due to a lack of parental emotional availability or poor parent-child attachment.

Parents reported having low social support, such as from their own parents, siblings and friends. Where this had previously been present, many of the parents reported that their relationships with friends and family had broken down. Additionally, they often described experiencing a loss in connection to their local community resulting from the social stigma they experienced relating to mental health, substance use, and DVA. Parents discussed how their children experienced impacts to their social wellbeing due to their substance use problems or DVA, with feelings of isolation and stigma relating to other families not wanting their children to interact with families where there were known issues. Parents observed that for some children exposed to parental risks, they had difficulty forming relationships with other children, resulting in poor social networks and connections. For families who had to relocate due to experiences of DVA, parents described interpersonal instability as a result from relocations, and the contribution this had to their child (ren) being lonely and removed from their friends.

Yeah, because we left everything behind. We don't have anything here. So going from different place and making friends and then starting again. So that was not for me, for my kids, a little bit hard – P10 (*Mother*, *DVA victim/survivor*)

3.3. Families navigating risk

3.3.1. Strategies to navigate risk

Parents employed a range of strategies in an attempt to minimise their children's exposure to harmful situations and parental risk factors within the home. Strategies described by parents were threefold: 1) mechanisms to reduce exposure to risk within the household, 2) reduce exposure by leaving the household (including family separation), and 3) approaches in managing risk during contact with the 'risky' parent.

When the risk was present within the household, parents would seek to separate children from the risk by sending their children to bed, locking doors or taking them to stay with extended family members or friends. Although some approaches removed children from directly witnessing substance use or parental conflict, these strategies also left children with uncertainty and fear.

There was a lot of like plates getting smashed, we had a really bad like DV episode, which went on for about 2 and a half, three hours, like extreme DV, but because I thought like I kept him away from the kids because they were upstairs, out of the way, I thought that was good, but then what I found out over the years was that was worse for them because they were hearing it and imagining what was happening, and it was way worse than what was happening - P1 (*Mother*, *SU*, *DVA victim/survivor*, *partner SU*)

In addition, parents who were regarded as the 'safer parent', as in, were not violent or currently using substances, and were co-parenting with an ex-partner where risks were present, often reported trying to navigate and manage their children's relationship with the (other) parent. These 'safer parents' tried to mitigate risk while also respecting their child's wishes, and love for the other parent. This included agreeing rules on when, and in what circumstance, it was 'safe' for the child to engage with this parent or educating their child on potential exposure to specific risks. Parents also spoke of their children's own vigilance in the family home wherein they would adapt to their home environment through their behaviour and emotional responses. For example, parents told us that their children would often recognise fluctuations in their parents' behaviours, such as shifts in mood, and would be watchful for changes in their environment. During such occasions, children would respond by removing themselves and their siblings and implementing learnt strategies to navigate their experiences and mitigate risk.

The kids are very aware when their dad's not alright, just by the way he speaks, the way he reacts. They have had to learn to understand what the difference is when he's using and when he's not because he can come out with some vulgar stuff when he's using - P1 (*Mother*, *SU*, *DVA victim/survivor*, *partner SU*)

3.3.2. Children as motivation

Parents reported that children were a key motivating factor for them to address their experience of mental health, substance use, and/or DVA. They typically said they wanted better life experiences for their children, and often contrasted this to their own childhoods. For some parents, this motivation was demonstrated through consistently remaining on medication for mental health problems or substance use.

> *And that's one of the main reasons why I don't want to go back there now. That's why I'm like, not messing about with my medication and, just really sticking to it, because I wanna be there for my family, especially my kids and things like that. But, you know, who am I to moan and complain? All I care about is them. And, I just want to be the best father that I can. – P16* (*Father, MH, partner MH*)

For some parents of multiple children, the awareness of the impact upon their older children led to deliberate efforts to parent their younger children differently. This included parenting more positively and being more responsive, for example by being more open and communicative about emotions with their children and addressing their parental risk factor in order to parent in this desired way.

> *I think, so with my son, I spent a lot of his life depressed and anxious. And then I was just miserable and I didn't want to live like that. And then I think the girls came along, and I don't know if it's something, I don't know if it's because they're girls, or it was almost like a second chance to make things different. I thought, you know, I don't want them to grow up with that. I don't want them to not go to classes because I'm too anxious, and to not go out and do things because I feel too depressed – P6* (*Mother, MH, DVA victim/survivor, ex-partner SU*)

3.4. Theme 4: Family support

3.4.1. Ineffective support

Parents and young people emphasised the inadequacy of current support from health and care services for the individual and the whole family. In particular, the siloed structure of services focussing on one risk factor were largely ineffective at responding to the cumulative stresses the families often experienced. This fragmented approach reportedly led to individuals being lost in a system which often withdraws support abruptly and before the family's needs were met. One father shared his experience of "*fall*[*ing*] *in the cracks*" due to having multiple needs that no singular service could address.

> *I remember that no drug treatment would touch you, mental health's too bad. So, you're meant to get help with your mental health and they wouldn't help you. Mental health wouldn't help because you're drinking and using drugs so you fall in the cracks. – P17* (*Father, MH, SU, DVA perpetrator, ex-partner SU*)

These experiences of barriers were also commonplace for young people exposed to parental risk factors, including the inability of services to support young people with complex needs. One young person's account of her experience with Child and Adolescent Mental Health Services (CAHMS) highlights the difficulty in providing and benefiting from therapies when there are ongoing social problems:

> *I think CAMHS did help at first, but they said that a lot of what was going on with my home life was too complex for them to deal with, because of my brother* [*substance use*] *and my mam being, like, she's an older mam and she's poorly. So they couldn't deal with that, I was passed on to another service, which had a huge waiting time, and I think I turned 18 before they were even able to do that so CAMHS obviously brought me here. And then you pretty much just, you get just chucked away when you turn 18, they don't refer you to adult services, unless you need ongoing, like, treatment for certain disorders. But because they hadn't been able to diagnose with anything because it was too complex, I was sort of just left with nothing. – CYP6* (*Young person, female, 20 years, parental MH; co-occurring sibling MH & SU*)

Parents stressed the need for more support for their children, including mental health support, education regarding risk factors and health, and awareness of exemplars of family life outside of those impacted by such adversity. The following mother remarked that this awareness alongside professional support could assist in disrupting the intergenerational cycle of risk.

> *I think our children have been brought up in that environment, I definitely think there should be a huge amount of support for them because obviously it's just cycle, isn't it? It's like you're both in that life and then you have them repeat that life and then their kids, then repeat that life. And I think it's just for kids to understand that there is a different way of life, and definitely for them to have some therapy or outlet of explaining how they feel about it. Because if they don't, they are just going to continue the cycle. – P12* (*Mother, MH, SU*)

3.4.2. Characteristics of good support

When discussing the support they felt was essential for their family, parents highlighted the contribution of parenting classes in developing their parenting skills, confidence, and strategies to manage their children's difficult behaviours, as well as the importance of financial support during times of transition and crisis. Several mothers spoke highly of the parenting classes they had accessed through charities and community organisations. The benefits of these classes included increased knowledge of child development and mental health, learning strategies to parent positively and support their children, and reassurance of their capabilities.

> *And I also was put in touch with Home-Start who ran some courses that helped, not even necessarily related to mental health, but around parenting, I think because I was always made to doubt myself and my parenting, and then going on these courses and thinking, Actually,*

no, I'm not doing it wrong, and that what I'm trying to do is normal, and I'm not damaging my children. – P6 (*Mother, MH, DVA victim/survivor, ex-partner SU*)

Regardless of the combination of risk factors, parents and young people highlighted the importance of having social connections, especially with others with similar experiences. This was reported by parents and young people to reduce feelings of isolation and provide validation of their experiences. In addition, social connections provided them with awareness, links, and advice to accessing formal support services.

Parents and young people valued practitioners that they perceived to be knowledgeable, understanding, and non-judgmental about their circumstances. The knowledge that parents thought service providers should possess included awareness of risk factors and trauma, including sensitivity towards previous experiences parents and children may have endured. Understanding and non-judgemental support could be reflected by more strengths-based approaches and focussing on the positive aspects that the parents and young people possess instead of simply their risk factors and circumstances. Enduring contact with practitioners not bounded by restricted timeframes, enabled the gradual building of trusting relationships.

These positive attributes and social assets were considered especially important given the reported stigma experienced by families with parental mental health problems, substance use, and abusive relationships, as well as the threat parents experienced when child protection concerns may be present. The necessity of ongoing support was expressed among parents as an avenue for developing trust and building relationships, and to provide them with a sounding board when needed. Given the continuing and evolving nature of the risk factors experienced by parents and young people, ongoing support was described as having consistent access throughout different transitional stages and that decisions of termination of support should incorporate the individual and family's view of readiness.

Regarding health and social care services, parents and young people typically spoke of a key individual that contributed to their support experience being positive and fruitful. The examples provided by parents often depicted a worker with profound understanding of their experience and going above and beyond their role to provide support. This understanding was either due to a wealth of experience or knowledge base of the risk factors and broad factors, while going above and beyond their role included performing tasks outside of their job description (e.g., support with the legal system) and being accessible and contactable any time.

It was just the lady that was my support caseworker was just like an angel to me. She felt my pain and ready to push me, ready to fight for me. It was sometimes, if I call her and I'm crying, she just lifts my spirits and even when she told me that she has supported me now and it's time for her to move on, I felt like, 'No you don't have to go' and they told me if anything happens and maybe I feel I'm not, maybe I feel he knows where I live now. And is coming around, [inaudible] me, stalking me, I should let them know and they'll get back to the case. It was, they were so good for to me. – P7 (*Mother, MH, DVA victim/survivor*)

4. Discussion

Our study highlighted the complex and interconnected nature of parental risk factors with structural and interpersonal factors, such as poverty (Adjei et al., 2022; Skinner et al., 2022), and the cumulative impact this has on family units. Parents described their experiences of struggling to parent in very difficult circumstances. They often made efforts to achieve positive changes but were frustrated by the siloed nature of services for mental health problems, substance use, and DVA. The findings of this study have implications for health and social care services.

This study illustrates the interconnectedness of family adversity where parental risk factors interplay with other stressors within the family and broader social determinants, including poverty (Adjei et al., 2022; Skinner et al., 2022). Complimentary to previous research (Boppre & Boyer, 2021; Stanley et al., 2012; Yamamoto & Keogh, 2018), parents and young people in the present study described a broad range of consequences as a result of parental risk factors, including physical, emotional, social, and behavioural impacts. Parents in the present study discussed how their risk factor(s) impacted their ability to bond with their children, and confidence to parent positively (Chiesa et al., 2018; Domoney & Trevillion, 2021; Herbell & Bloom, 2020). Other research has articulated the need for interventions to target parenting self-efficacy and skills training, especially in the context of these trio of risks (Bröning et al., 2012; Domoney & Trevillion, 2021; Sousa et al., 2022).

Our study highlights the need for services that are able to respond to clusters of interacting and cumulative or syndemic risks. The integration and coordination of services for mental health problems, substance use, and DVA is a recommendation made by researchers and practitioners elsewhere (Allen et al., 2022; Isobe et al., 2020; Mason & O'Rinn, 2014). Successful integration of services may involve increased communication and data sharing across services, the provision of multidisciplinary teams, or upskilling service providers with the knowledge and skills to support complex issues, such as trauma-informed approaches (Das et al., 2016; Lemmens et al., 2015; Sperlich et al., 2017).

While more effective integration and collaborative work across services and sectors is critical for supporting these families, greater practical and emotional support in navigating current systems could mitigate the barriers and stress described by parents and young people in this study. Social prescribing may be one approach that can be implemented to support families in navigating and accessing current complex systems. This approach involves a support worker linking clients to community and voluntary services and resources providing support for non-medical needs to improve health and wellbeing, such as by connecting individuals to financial support or social groups (Kiely et al., 2022). There are several social prescribing models implemented in the UK, within the primary care sector, to assist people with social needs to access a broader range of services and to provide personalised care (Pescheny et al., 2020). There is emerging evidence that social prescribing can improve health-related behaviours and social interactions and reduce demand on primary and secondary care services (Bickerdike et al., 2017; Kiely et al., 2022; Pescheny et al., 2020). However, current evidence is

mixed, and there is a need to evaluate social prescribing programmes that are currently implemented across the UK to determine when and for whom social prescribing is most effective (Bickerdike et al., 2017; Kiely et al., 2022; Pescheny et al., 2020).

Beyond the challenges of accessing services, the parents and young people interviewed associated the involvement of support services with feelings of mistrust, fear, and threat, in part due to previous experiences and reactive responses from professionals when seeking support and the broad stigma associated with these risk factors (Davies et al., 2022; McGovern et al., 2022; Muir et al., 2022; Stanley et al., 2012). It is likely that a move away from adversarial and/or surveillance-based approaches to a model of family support will be required (Collyer et al., 2021; Rodger et al., 2020) to support active efforts of working *with* the family.

Our study further reiterated qualities that parents and young people in these circumstances consider critical to develop trusting partnerships with support services. Many of these attributes reflect and build upon previous research (Forrester et al., 2016; Lester et al., 2020) and trauma-informed practice (Substance Abuse and Mental Health Services Administration, 2014). For example, the need for ongoing support to establish trust and a sense of safety, and for support to be available on a continuing basis and not just during peak times of stress, especially considering the ongoing impact of these risk factors after they have been addressed (Muir et al., 2022; Stanley et al., 2012).

Parents and young people in our study accentuated a lack of regard for the whole family context, with support typically focussing on one family member and limited support given to those broadly impacted by the risk(s). There is a need to tailor family-based support to all family members, for example, by redesigning family focused interventions to recognise and work with the whole family (Allen et al., 2022), while considering the context and appropriateness of these approaches (e.g., in the context of DVA). Needs of individual family members differed and therefore support that respond to individual needs is also essential in improving outcomes for families facing adversity. Fathers are often excluded from whole-family or parent-child interventions and services (Barrett et al., 2023), with the focus typically being on mothers as solely responsible for their children's wellbeing. The fathers in our study described the challenges they experienced with the transient nature of their relationship with their children because of their risk factor(s), and several fathers recognised the benefit of individual support for themselves, and separately for their children.

While there is some evidence for what works for parents regarding mental health problems, substance use, and DVA, less is known about targeted support for children, especially for those affected by substance use, DVA, and a combination of these factors (Barrett et al., 2023). In the present study, parents were most concerned about the associated impact and lack of support their children received and wanted greater mental health care provision. A recent systematic review on children and young people's lived experience of parental substance use articulated children's experience of support being solely for their substance using parent, and children's desire for whole family support (Muir et al., 2022). Family support does not necessarily mean joint sessions with parents and children, but instead it is important for children and young people to have separate support and spaces, to enable them to speak openly about their experiences without the challenge of their parent(s) being present (Muir et al., 2022).

4.1. Limitations

The present study provides insight into the lives of individuals within families experiencing multiple parental risk factors, and the current lack of capacity and appropriateness in services to provide support for these complex needs. However, the findings need to be considered in the context of some limitations. Firstly, due to ethical reasons, most parents and young people were recruited from support services and therefore we did not hear from families who have not received support. In addition, we were unaware of the number of parents and young people who were approached by gatekeepers but chose not to take part. While we ensured these interviews were accessible and appropriate for children (e.g., having a family member or support person present), a second limitation was the low number of children and young people recruited, and only managing to recruit young people in mid-late adolescence and not earlier ages.

Given the fears articulated by parents around social services and the risk of re-traumatisation of children through discussing these topics, future qualitative research should continue to involve families in co-design and production to ensure shared power between researchers and participants, and appropriate and safe methods of engagement with children in these spaces (Fargas-Malet et al., 2010). The research findings concerning service provision and structures are especially pertinent to the context of England. Therefore, findings from this paper on specific support needs may not be generalisable to other contexts.

5. Conclusion

The current study has important implications for practice in supporting families facing multiple adversities. Our findings demonstrate a need for systems and services to be able to respond appropriately to syndemic risk, which may be achieved by more investment in deconstructing siloed sectors and implementing more integrated support. Both whole family and individual needs should be recognised alongside assistance to navigate and support access to complex systems.

Data availability

The data that has been used is confidential.

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