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University of Southampton

Faculty of Environmental and Life Science

School of Geography

Inequality and Parent Mental Health: A mixed methods study exploring multiple perspectives on the issues impacting, and options to support, parent mental health and wellbeing in the UK

by

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Abstract

Faculty of Environmental and Life Science

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Doctor of Philosophy

Inequality and Parent Mental Health: A mixed methods study exploring multiple perspectives on the issues impacting, and options to support, parent mental health and wellbeing in the UK.

by

Rachel Elizabeth Houweling

Parents face multiple pressures on mental health and wellbeing but such pressures are not well accounted for and there has been inadequate attention given to barriers parents face to access support. This study explored multi-dimensional pressures impacting parent mental health and wellbeing and examined how such pressures are experienced unequally. It considered inequalities in access to relationships and spaces of support, by adopting the African proverb ‘it takes a village to raise a child’ as a central thread. The mixed methods (qualitative dominant) enquiry combined multiple methods with different stakeholders. The methods were social media analysis (N=829 social media posts written by parents, extracted June 2020), online survey of parents (N=274 responses, disseminated February – May, 2021), asset-map development (parent support offerings in a case study county, data extracted January – June, 2022), and qualitative interviews with people who worked or volunteered with parents (N=13, May – August 2022). Data from all methods were integrated into a thematic analysis to inform three findings chapters focused on environments of home, community, and service landscape. Variations in need for support were identified alongside unequal access to resources of relationships, space, time, and money. It was found that many parents face inequalities but particular concerns were identified for single parents, parents with a mental health condition, on low-incomes, and/ or raising children with additional needs. The COVID-19 pandemic exacerbated many issues but difficulties at this time were widely connected to (and illustrative of) ongoing inequalities. It was found that support services have been eroded, leaving families with fewer options, and creating challenges for those who work or volunteer in the sector.   In conclusion, it is argued that structural factors influencing parent mental health and wellbeing and the role of the ‘village’ in supporting parents needs greater attention, alongside improved and earlier access to support, in order to address mental health and wellbeing at a family level.

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Research Thesis: Declaration of Authorship

Print name: Rachel Houweling

Title of thesis: Inequality and Parent Mental Health: A mixed methods study exploring multiple perspectives on the issues impacting, and options to support, parent mental health and wellbeing in the UK

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. Parts of this work have been published as (Houweling et al., 2022).
8. Signature: Rachel Houweling Date: 01.07.2023

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Rob, Joshua and Aaron, my biggest inspiration, and providers of endless emotional (and IT 😊) support, I really couldn't have done it without you. I wouldn't have done it without you. Love you x

Definitions and Abbreviations

Additional needs: the term is usually in the context of referring to parents of children with additional needs. ‘Additional needs’ is applied broadly, to include children with physical disabilities or chronic/ serious health conditions, learning disability, mental health condition, neurodivergence, or any other circumstance where the child requires care above and beyond what may be expected in ‘typical’ parenting duties. The focus in this study, is on the experience for the parent of providing that additional level of care and so for that purpose, further categorisation of child need was not deemed purposeful.

CAMHS: Child and Adolescent Mental Health Service provided by the public sector for children up to the age of 18yrs (Hampshire Child and Adolescent Mental Health Service, 2023).

Child and Children: The terms ‘child’ and ‘children’ are used to describe the ages of 0-19yrs, in keeping with Hampshire County Council strategic documents (such as, Hampshire County Council, 2016).

IAPT: Improved Access to Psychological Therapy, explained more fully in section 2.4.2.1.

Offering: ‘Offering’ is used as a broad term to refer to a charity or public sector organised support to a parent. It is a term used by Hampshire County Council (also explained in section 2.4).

Support Provider: the term ‘support provider’ is used to refer to people who are paid or formally volunteer, in parent support roles. It was preferred to ‘service provider’ to better include volunteers.

Chapter 1 Introduction

1.1 Introduction

Mental health conditions account for approximately 7% of ill health in the UK and cost the economy £117.9billion annually, which was approximately 5% of UK GDP in 2019 (McDaid and Park, 2022). Half of adult mental health disorders begin in childhood, before the age of 14yrs (Mental Health Taskforce, 2016) and this has generated growing interest in risk factors for poor mental health outcomes that begin in childhood and persist into adulthood (Callaghan et al., 2017). Varying risk factors will be introduced but one area of attention has been risk of poor mental health outcomes in children who have a parent with mental illness (Reupert and Maybery, 2016). However, concern about the impact of poor parent mental health on children has not necessarily resulted in adequate levels of mental health care for children (Bell and Pollard, 2022), and nor has it attracted sufficient support for the mental health and wellbeing of parents (Greg, 2010), which is the focus of this thesis.

There are considerable pressures upon the mental health wellbeing of parents. Social messaging about expectations of parenthood have increased (Holloway and Pimlott-Wilson, 2014), whilst for many parents, social support has declined (Nowland et al., 2021). Financial pressures impacting parent mental health have intensified from austerity (Hall, 2019), the COVID-19 pandemic (Blundell et al., 2020) and rising inflation (Chakravorty, 2022). Furthermore, concern from the State about parenting *skills* has intensified, whilst professional support services for parents such as Sure Start Children' Centres (Jupp, 2022a) and Health Visitor sessions (Institute of Health Visitors, 2023) have reduced, and unlike some comparable countries (see for example, copmi.net.au in Australia), the UK does not have a national response to improving mental health care for parents. There is concern that these factors present a perfect storm of increasing pressures on parents and insufficient access to support.

The African proverb 'it takes a village to raise a child' is used as a central thread throughout this thesis, bringing a reminder that families need networks of (social and professional) support through the journey of raising children, whilst exploring inequalities in access to these networks. The rationale for the use of this proverb is returned to and expanded later.

Interest for this research, like the study itself, came from multiple sources. It began with Hampshire County Council (HCC) proposing to a supervisor that a PhD candidate explore mental health and inequality in the county and was later funded by the South Coast Doctoral Training Partnership (SCDTP). On discussion with HCC, this interest was refined to focus on the needs of parents experiencing poor mental health. This interest from the council connected with my professional background in occupational therapy, having previously worked with parents experiencing mental illness and their children, as well as in other mental health care settings and carer support. The focus on parent mental health and inequality also connected with my academic studies in public health, exploring social determinants of health and the impact on mental (as well as physical) health. Furthermore, a scoping review of literature and support services available for parent mental illness in the UK conducted for my master's degree dissertation, confirmed that whilst there was much written about concerns for the impact of parental mental illness on children, there was limited and inconsistent access to support services dedicated to parent mental health and limited UK-focused academic literature exploring parent mental health, particularly for the stages of child-rearing beyond the perinatal period. The development of the specific methods used to conduct this study are described in Chapter 3, but the genesis of this research evolved from these influences.

In this first chapter, the rationale and framework for the project are introduced. There will be an introduction to literature regarding mental health, inequality, and parenthood, followed by a brief statement about the impact of the COVID-19 pandemic. Finally, the research aim and questions will be presented, along with a guide to the thesis structure.

1.2 Mental Health

1.2.1 Defining Mental Health and Wellbeing

Many terms to describe mental health and mental illness are used within and between government, clinical, and academic publications, and such terms are often poorly defined. It makes it difficult to present and compare findings when boundaries are inconsistent, contested and change over time (Telles-Correia et al., 2018). In this thesis terms such as 'poor mental health' or 'mental health issue' describe a general state of persistent thoughts and feelings which cause distress to a person and/ or, impede their relationships with others (WHO, 2022) whilst recognising, that this does not always suggest a diagnosed mental illness. However, when referring to literature or participants that specifically reference another term, the language of the original material is used to maintain the integrity of that source, particularly when referring to medically diagnosed conditions. This approach is suited to the purpose of this thesis, which is to explore inequalities in issues impacting upon parent mental *health* which, in keeping with the public health framework introduced later, is relevant for everyone, and as such includes but does not solely focus on, those experiencing mental illness or disorder.

Within social sciences and health literature, there are differing definitions of 'wellbeing' and indeed, perhaps the only element to be agreed upon, is that it is a contested term (Andrews et al., 2014; Cooke et al., 2016; Fleuret and Atkinson, 2007; Fuller, 2016; Huppert and So, 2013; Marsh et al., 2020; Seligman, 2018). Without a universally accepted definition of wellbeing in social sciences, it was necessary to explore interpretations and critically consider what would guide my interpretation in this research. Furthermore, with so much debate about wellbeing, I needed to ensure that I explored definitions suited to my research goals and as such, focused on geographic literature centred on connection to place, as explained below:

> Wellbeing, however defined, can have no form, expression or enhancement without consideration of place. The processes of well-being or becoming, whether of enjoying a balance of positive over negative affects, of fulfilling potential and expressing autonomy or of

> mobilizing a range of material, social and psychological resources, are essentially and necessarily emergent in place (Fuller, 2016, p. 3).

Indeed, geographic understandings of wellbeing move beyond experiences of wellbeing at an individual level (Fuller, 2016), to consider the spaces of wellbeing (Fleuret and Atkinson, 2007). Geographers also situate understandings of wellbeing within socio-political environments, particularly regarding the ways in which wellbeing has become the focus of policy objectives (Atkinson and Joyce, 2011). However, my attempts to locate a succinct definition of wellbeing were left wanting. 'Wellbeing' is therefore recognised as a fluid term, subjectively interpreted. My interpretation of wellbeing is guided by a sense of place, grounded in relational concepts of both intimate and societal/ political relationships, as well as experienced at an individual level with parents' themselves determining how they construct wellbeing.

1.2.2 Prevalence and Distribution of Mental Health Conditions

In the UK, 1 in 4 of the adult population are affected by a mental health condition each year (Mental Health Taskforce, 2016). Recent estimates for children and young people are that 18% of those aged 7 to 16 years have a probable mental disorder, with a further 10.8% having a possible mental disorder (and 71.2% unlikely to have a mental disorder, Newlove-Delgado et al., 2022). This study is focused on the UK context but can be compared with similar nations, who also have high burden of disease from diagnosed poor mental health. For example, in the United States it is estimated that 1 in 5 adults and children experienced mental illness or disorder in a given year (National Center for Chronic Disease Prevention and Health Promotion, 2021) and in Australia, 44% of the population are estimated to experience a mental disorder at some stage in their life (Australian Institute of Health and Welfare, 2022). The literature used in this thesis predominately heralds from the UK and similar nations with a common interest in improving mental health and wellbeing at a population level.

Anyone can experience mental health issues, but they are not distributed equally in the population. There are ‘differences in mental health that are based on place’ (Hudson, 2012, p. 108), with higher rates of mental health issues in areas of socioeconomic deprivation across urban and rural areas (Anakwenze and Zuberi, 2013; Carson et al., 2016; Riva and Smith, 2012). Rates of mental disorder increase at population level during economic downturns amongst both adults (Barr et al., 2015) and children (Golberstein et al., 2019). Poverty has been associated with rising prevalence of depression and suicide (Stuckler et al., 2017) and there are higher rates of suicide in areas with higher rates of worklessness (Dorling and Gunnell, 2003). Nearly half of people receiving Employment and Support Allowance (welfare payment for those aged below retirement age with a health condition or disability impacting their capacity for employment) had attempted suicide at some point (McManus et al., 2016). Being in debt and worry about personal finances has been widely associated with poor mental health outcomes (Richardson et al., 2013). Rates of mental disorders have been climbing since the financial crisis of 2008 (Barr et al., 2015) which has been linked with policies of austerity that have disproportionately affected people with mental illness, ethnic minorities, people with lower levels of education, precarious employment, the unemployed, people using welfare system, and women/ girls (Barr et al., 2015; Elliot, 2016; McManus et al., 2016). Following on from austerity, there have been the more recent crises of the COVID-19 pandemic (Blundell et al., 2020) and rising inflation (Chakravorty, 2022), creating further financial strain and pressures on mental health.

1.2.3 Mental Health Services and Treatment

There have been recent innovations in mental health care in the UK, such as the Improved Access to Psychological Therapies (IAPT) programme (Delgadillo et al., 2016; NHS Digital and Thandi, 2022). However, mental health care has been underfunded compared to physical health, receiving only 13% of NHS expenditure (The Centre for Economic Performance’s Mental Health Policy Group, 2012) despite longstanding and ongoing concern to promote ‘parity of esteem’ between mental health and physical health conditions (Hilton, 2016). Most adults and children experiencing problems with their mental health do not receive care from mental health services (McManus et al., 2016), which is expanded upon in Chapter 2.

1.2.4 Public Mental Health

Rising demand on mental health services has led to calls for prevention, promotion, and early intervention efforts at a community level to reduce the need for mental health services (Compton and Shim, 2020). This is not only a moral imperative but also a financial and practical priority given the costs associated with mental illness (McDaid and Park, 2022). In a typical public health model, primary mental health promotion refers to reducing risk factors and encouraging factors protective of mental health and wellbeing universally, whilst secondary mental health promotion involves early intervention for those starting to experience mental health issues. Tertiary interventions refer to appropriate care for those with diagnosed mental illness. However, the model has been critiqued as focused on *when* interventions are offered, without contextualising the nuances of who can access these different layers of support (Compton and Shim, 2020). Therefore, public mental health approaches need consideration of the social determinants of health framework, that recognise and respond to inequalities in the conditions that lead to poor mental health, as well as strategies applied (at any level) to accessing prevention and promotion initiatives (Shim and Compton, 2020).

If treatment rates for people with mental illness in the UK are poor though, then public mental health interventions are even more dire. In 2013 in England, public health responsibilities were largely moved from the National Health Service (NHS) to Local Authority control, following the 2012 Health and Social Care Act (Marks et al., 2015). However, Local Authorities, have seen ‘hugely significant’ budget cuts (Marmot et al., 2020, p. 9) and budget cuts have been greatest in the most deprived areas (Marmot et al., 2020), so even though public health budgets have been described as ‘ring-fenced’ (Marks et al., 2015), they derive from a diminished source. Local Authorities in England, such as Hampshire, report that ‘smaller budgets are available to deal with an increasing pressure of ill-health’ (Hampshire County Council, 2016, p. 5). Competing demands on expenditure resulted in only 1.6% of the public health budget for 2018/ 2019, spent on public mental health (Ministry of Housing, 2018). In addition to public health services, Local Authority funding includes education, adult and child social care, housing, and cultural spaces, amongst other responsibilities (ibid), which can also be viewed as relevant to public mental health from a social determinants of health perspective (Shim and Compton, 2020). In one area of particular relevance, the early intervention budget to Local Authorities was reportedly reduced by 64% between 2010/11 and 2017/18 following austerity cuts from central government (G. Smith et al., 2018). In response to growing pressures and reducing services, reliance on charitable organisations in many sectors (again, including but not limited to mental health) has increased as they attempt to 'fill in the gaps' (Jupp, 2022b, p. 24) left by a retreating state, creating new challenges and potential for inequality in service distribution and access.

1.2.4.1 Public Mental Health and Space

An area of public mental health concern with particular interest and relevance to geographers, relates to the impact of the environment (Compton and Shim, 2020). A more detailed exploration will follow in the literature review, but introduced here, with recognition that environments can be damaging towards mental health or mental health enhancing (Liu et al., 2020; Parr et al., 2004; Twigg and Duncan, 2018), whether at home (Thompson et al., 2017), through contact with nature (Pouso et al., 2021), general community engagement (Cattell et al., 2008) and in more specific sites in which peer support and friendship can be nurtured (Feeney, 2019; Parr, 2000). These examples begin to emphasise how many factors that influence mental health in helpful and/ or harmful ways, form outside of medicalised models of care (Shim and Compton, 2020) and so whilst this thesis will devote considerable attention to engagement with services, it will also take a broader view of environments influencing mental health and wellbeing.

1.2.4.2 Public Mental Health and Families

The promotion of child and adolescent mental health has received political and social commentary, even if not necessarily corresponding levels of support, because experiences in childhood (see list of definitions) can hold long-term influence over mental health and wellbeing in adulthood (Callaghan et al., 2017). Children are identified as being at greater risk of developing mental health issues if they grow up socioeconomically disadvantaged (Reiss, 2013), are exposed to adverse life events (Edwards et al., 2003), when their parents have no or low-level qualifications, and when their parents are not in work (Morrison Gutman et al., 2015). Particular concern has been raised about the risk of poor outcomes for children who have a parent with mental illness (Reupert and Maybery, 2016). Mental illness amongst parents is common, although the lack of routine data collection of parenting status makes prevalence difficult to estimate (Maybery et al., 2015b). However, one service reported that 25-28% of adult mental health service-users were parents (Howe et al., 2012). Many adults though, do not or perhaps cannot, access mental health services when needed (McManus et al., 2016) and so it is unreliable to estimate prevalence from service-user data. In England, it has been estimated that as many as 1 in 3 children live with at least one parent experiencing 'symptoms of emotional distress', rising to half of children living in households with two parents not in work (Celebi et al., 2019). Parents are more likely to have mental health issues if they experience adverse social determinants of health such as poverty, discrimination, and inadequate housing (Shim and Compton, 2020) but such structural challenges are often given less attention than commentary on individualised parent behaviour (Callaghan et al., 2017). Furthermore, relatively little attention considers everyday factors that promote parent mental health and wellbeing or that facilitates access to mental health care and other support services (Falkov, 2015).

The purpose of this research is to explore factors impacting parent mental health, how and where such factors are experienced unequally, and how parent mental health and wellbeing might be better supported. There is a dual purpose for doing so. Promoting parent mental health can benefit children which is a positive reason to consider parent mental health (Reupert and Maybery, 2016). However, I also adopt the position that enhancing parent mental health and wellbeing is a worthy goal *in its* *own right* and that approaching the 'problem' of parent mental health issues only from the perspective of their capabilities as a caregiver is not, as Eleanor Jupp summarises, 'a productive starting point' (Jupp, 2022a, p. 68). This standpoint in no way diminishes the needs of children or a parents' responsibilities of care towards them (Reupert et al., 2022) but as one parent described, a parent needs to put their own oxygen mask first, before helping children (van der Ende et al., 2016). This research is therefore centred on a parents' access to the metaphorical oxygen mask when required, but also on creating conditions that reduce the likelihood of such need. Before progressing this point further however, it is important to pause and consider what is meant by terms such as 'parent' and 'family', as these have a bearing on how parents' experience their mental health, and how issues impacting this population are situated in wider socio-geographic contexts.

1.3 Defining Parenthood, Family, and the Village

The term 'family' is often understood in problematic, normative ways. What society constitutes as 'family' is politicised and can be exclusionary (Bunting et al., 2017; Dermott and Pomati, 2016; Harker and Martin, 2012; Prendergast and MacPhee, 2018). In this thesis, 'family' is viewed fluidly as a self-defined concept but given the interest on child raising, is used primarily to describe relationships between adults and children who regard each other as family. A family therefore, may or may not live together and may or may not share biological or intimate partner ties (Reupert et al., 2022). Similarly, 'caring' as a general ethos (Middleton and Samanani, 2021) and parenthood more specifically (in the example of Berger et al., 2022, motherhood in particular) involves many activities but is not limited only to tasks, it also encompasses the affective experiences of caregiving. Often this is associated with a biological relationship but not necessarily and others may 'parent' where they both care for and about children they are raising (Luzia, 2010). That broader interpretation of parenthood is applied.

The term 'parent' is chosen as a 'relatively non-gender specific' term (Luzia, 2010, p.363) because there is interest in exploring male and female perspectives. However, parenthood is gendered (Aitken, 2000; Ekinsmyth et al., 2004). Much of the literature explores experiences of mothers *or* fathers and so this will be addressed where appropriate. The longstanding inequalities impacting women in relation to household caring relationships will be highlighted through this thesis (see for example, Franklin, 2019; O'Reilly and Green, 2021). However, that does not preclude concern for the experiences of fathers (Tarrant, 2021) and indeed, the intention of this research was not to treat a father's engagement with their children as extraordinary. Therefore, the term 'parent' is used primarily and viewpoints of women and men are considered, within a framework that acknowledges gendered differences of motherhood and fatherhood.

At times, reference will be made to the 'occupation' of parenthood. Occupational therapists define 'occupation' as being 'all the things we need, want or have to do' (Wilcock, 2006, p. xiv). Critically, occupation refers to the subjective experience of doing these things and the meaning attached to the actions (Kielhofner, 2006) and as such, is a useful construct under which to approach the practical and affective experiences of raising children. Parenthood is a complex but highly valued occupation to which many adults are deeply attached (Llewellyn, 2010). Framing parenthood as an occupation has added relevance when considered in terms of how the term is usually applied outside of occupational therapy, when referring to paid labour. There are longstanding critiques of the ways in which household labour, often performed by women, are under-valued in society (Franklin, 2019). In this research therefore, the occupation of parenthood is valued for what it means to the parent, to show respect for the considerable level of effort it entails, and a subtle reminder of the socio-political background.

The environments of parenthood are considered as physical and metaphorical concepts. Drawing from geographies of care literature broadly (not only in relation to parenthood) conceptual terms include the 'landscape of care provision' (Power and Hall, 2018) and 'Caringscapes' (Bowlby, 2012). Both concepts enrich social and spatial understandings of caring relationships. However, the African proverb 'it takes a village to raise a child' will be used because as a metaphor, it encapsulates three key points. Firstly, the image of a ‘village’ speaks to the physical environments in which parenthood takes place. Features in these environments, how they are used, experienced, and influence parent mental health and wellbeing, are appropriate areas of interest. Secondly, the metaphor highlights the value of relationships between ‘villagers’ and the supportive networks or lack of them. Such relationships can be with family, friends, neighbours (Bowlby, 2011) and with service providers (Jupp, 2013). However, given concern about fractured communities, parent isolation (Bessaha et al., 2020) and cuts to services (G. Smith et al., 2018) it is important to explore access to supportive relationships in the current context. Perhaps most crucially, the metaphor testifies that raising children is not an individual pursuit, yet modern UK society widely reduces child-rearing to the responsibilities of parents and paid childcare (to enable the parent to work). Support for parents is problematised as ‘interventions’ to redress deficit parenting (Jupp, 2022a) without duly considering the responsibility of the ‘village’ to create a supportive environment (Reupert et al., 2022). A challenge to such individualistic framing and concern about the abdication of collective responsibility to support families is at the heart of this thesis.

‘It takes a village to raise a child’ was the theme of an international conference about supporting families where a family member had a mental or physical illness, or substance misuse issue. A perspective article inspired by the conference proposed a ‘village approach’ to supporting families involving the child, their parents, other caregivers and siblings, social contacts, and professional contacts (Reupert et al., 2022). Authors reaffirm that metaphorical (professional and social) ‘villagers’ are involved not only through direct care of the child, but through support given to parents. Furthermore, a village concept is relevant to developing understanding about issues and inequalities impacting parents, as explained below:

> The village concept implies a need to identify the magnitude of exclusion (that is, who is being excluded and from what), specify why they are excluded and, on that basis, promote access to essential services for individuals and their families and challenge societal attitudes and media misrepresentations (Reupert et al., 2022, p3).

In my research, I follow a similar framework but with more of a focus on the environments of the village; at home, in the community, and engaging with the service landscape. Experiences in and of these spaces, and if they promote mental health and wellbeing or create a detriment, are connected to the needs and characteristics of family members and their access to resources of relationships, space, time, and money. The importance of access to these four key resources were identified at multiple points through the data and shall be referred to frequently.

1.4 Methods and COVID-19 Impact Statement

The original plan for this research had been a co-production project with parents being treated by mental health services. However, as contacts were being made to establish a partnership with a suitable service, the COVID-19 pandemic emerged (March 2020), putting huge pressure on mental health services and significantly limiting opportunities to conduct research in-person. A pragmatic decision (section 3.2) was made to adopt different, more remote methods. This meant that the research focus shifted to explore breadth of experience, leading to a decision to use multiple-methods and ultimately, integrate the analysis for a comprehensive broad perspective of parent mental health and inequality.

1.5 Research Aim and Questions

1.5.1 Aim

Explore influences on parent mental health and wellbeing, to improve awareness of inequalities and develop evidence-informed recommendations to support parent mental health and wellbeing.

1.5.2 Research Questions

Q1: If ‘it takes a village to raise a child’, how is the modern day ‘village’ constructed for and by UK parents?

Q2: What resources are required to access the support of the village, and what inequalities exist in parent access to these resources?

Q3: What are the impacts on parent mental health and wellbeing from unequal access to support?

Q4: How can findings from research questions 1-3, inform efforts to improve equitable access to support for parents, in order to better promote mental health and wellbeing?

1.6 Thesis Plan

This introduction has outlined the area of study and research questions. In Chapter 2, the literature review will develop points of interest pertaining to parenthood and then mental health, particularly in relation to social determinants of health. The Methods Chapter (Chapter 3) will follow, with an explanation of the methods; social media analysis, anonymous online parent survey, asset map and support provider interviews. Chapter 3 will also detail the rationale and process for the integrated analysis, which drew together insights from all data sets. Because an integrated analysis was used, findings chapters are, presented thematically rather than by method, with Chapter 4 focused on 'Home and Household', Chapter 5 exploring 'Community' and Chapter 6 focused on the 'Service Landscape'. Chapter 7 presents a discussion of research questions 1-3 in a unified critique of what has been learnt about inequalities of parent mental health and wellbeing. In Chapter 8, research question 4 is addressed, as what has been learnt from the research is applied to points for consideration for policy and practice and presented in a format intended to appeal to academic and non-academic audiences, given the interest from Hampshire County Council in strategies to address inequality and mental health issues in the county. The format chosen to communicate this message is the 'quick wins, best buys, and game changers' framework, adopted in the 'Research Roadmap for the COVID-19 Recovery' (United Nations, 2020).

Chapter 2 Literature Review

2.1 Introduction

Constructs of family are created by historical and geographical influences (Duncan and Smith, 2002), but whilst ‘family’ comes in many forms, the focus here, as already noted, is on families raising children. Luzia (2010, p.360) states that ‘people ‘do family’ and they do it *somewhere*’. Furthermore, ‘doing’ family is situated in a ‘dynamic social system’ that involves the parent, their kin, community, and socioeconomic resources (Hartas, 2015, p. 609). This review will explore what parents ‘do’, in what environments, and how that is influenced by social relationships, social determinants of health, and policy decisions. It considers a series of interconnected environments, from home, community, and service landscape with connections to policy, politics, and funding, all of which are critical domains in the metaphorical village (see also, Dahlgren and Whitehead, 2021). Throughout, there is interest in how ‘the big stuff’ of socio-political environments, influence ‘the little things’ in the everyday lives of parents and their children (Stenning, 2020, p.204) and how social determinants of health are experienced unequally, impacting parent mental health and wellbeing in different ways.

Social changes evolve in response to ‘longer term secular changes in society’ (Bowlby, 2012, p. 2106), but also, in response to ‘sudden shocks, such as wars or epidemics’ (ibid). The COVID-19 pandemic presented a worldwide shock (O’Reilly and Green, 2021) and new ways of ‘doing’ and ‘being’ family, predominately in home spaces (Aznar et al., 2021). Like many countries, the UK government directed periods of home-working and school closures resulted in home-schooling for most children (Institute for Government Analysis, 2021, see Appendix H). It was recognised internationally as a stressful time for parents (Hiraoka and Tomoda, 2020). However, factors that influenced experiences of home in lockdown were connected with wider determinants (Blundell et al., 2020). This review therefore, incorporates COVID-19 experiences but draws predominately on longer term issues.

2.2 Parenthood at Home and Household Relationships

The idealised vision of home is of a space associated with safety and comfort. The metaphor 'feeling at home' (Blunt and Dowling, 2006, p. 2) represents a sense of belonging within one's living space However, as the quote below exemplifies, experiences of home are complex:

> The word 'home' arouses strong attachments, multiple associations and everyday experiences. The idea of home can evoke family and intimate relationships; it can be a place of creativity, terror, loneliness, love, pleasure, warmth, overcrowding, inequality, desperation and plenty (Jupp et al., 2019, p. 5).

Literature pertaining to mixed experiences of parenthood at home will be explored in relation to how they impact parent mental health and wellbeing. Where relevant, the chapter also touches on the needs of children given the enmeshed nature of household relationships (Falkov, 2015).

Family relationships begin at home, providing the setting in which much of the joy, as well as the struggles, of family-life take place (Jupp et al., 2019). Different parts of the home facilitate different shared activities, such as playing, sleeping, eating or personal care, which may be enjoyable or challenging (Turner et al., 2012). Parts of the home therefore, adopt affective associations, for example becoming associated with enjoyment and loving care exchanges (Kehily and Thomson, 2011) or with arguments that occur in 'flashpoints' such as the kitchen (Gabb and Singh, 2015). Whilst family disagreements are common, problems in the parent-child relationship can be upsetting and of particular concern for children given their more vulnerable position (O'Shaughnessy, 2015). Furthermore, disputes between partners can be distressing for children to witness, cause stress for those partners and sometimes result in relationship breakdown (Harold et al., 2016). New formations of family may be created, sometimes crossing between homes, for example as children divide their time between both parents (Walker, 2022). Such experiences are common. However, in some situations there is greater concern, such as if children are at risk of serious harm from their parent (O'Shaughnessy et al., 2015), parents experience child-to-parent violence (Holt, 2011), and/ or, there is domestic violence between partners

(Austin et al., 2019). It can be seen that relationships at home influence the affective experience of that space, which can bring benefits towards mental health and wellbeing, but also everyday strains or serious risks.

The home is transformed with 'the amount of stuff' acquired and purchased for children (Boyer and Spinney, 2016, p. 1119). Societal ideals of parenthood are conveyed though romanticised images of what a home should look like (Doucet, 2011) and what 'good' parents should buy and have (Kehily and Thomson, 2011). Such perfect images poorly reflect the reality for many (Luzia, 2010). Whilst the disorder may just be an annoyance, it can lead parents to avoid having others come into the home and create a barrier for support. Furthermore, it may not just be embarrassment about the mess or how the home is equipped that creates dissatisfaction, but a lack of essentials, including food (Thompson et al., 2018) and even an unsafe environment, for example through dampness (Serjeant et al., 2021). Indeed, the home itself may not be suitable, explored next.

The arrival and growth of children prompts some parents to move and seek an environment more suited to children (Gambaro et al., 2017). However, many families lack finances to move and for tenants in social housing, there are often long waits and little choice for requests for housing to accommodate the needs of a growing family (Thompson et al., 2017). Parents often attempt to reimagine spaces and adapt where necessary (Luzia, 2010). Parents and/ or children, with a health condition or disability may experience particular challenges within poorly suited home environments (Bowlby, 2019; Thompson et al., 2017; Turner et al., 2012; Wint et al., 2016). Many families living in social housing experience over-crowding (Thompson et al., 2017) but space is also restricted through the housing benefit cap (commonly known as 'bedroom tax') which penalises tenants deemed to have a 'spare' bedroom (Bowlby, 2019). Some parents face the trauma of homelessness (Rybski and Israel, 2017). Lack of appropriate housing can restrict child custody/ visitation (Wilkinson and Ortega-AlcÁzar, 2017) and there are high rates of mental illness amongst mothers experiencing housing insecurity or homelessness (Bassuk and Beardslee, 2014; Corman et al., 2016). In these examples it can be seen that access to an appropriate home environment is compromised for many parents, with resultant stress and pressure on mental health and wellbeing.

Consideration is given next, to the use of time at home. The home is site of much work and parents, often mothers, spend a large portion of time on household tasks (Franklin, 2019). Tasks can include childcare (Luzia, 2010), managing family schedules (Dowling, 2000), domestic chores (Blunt and Dowling, 2006), and broader caring responsibilities (Evans et al., 2017). It is not only time spent in these tasks that impacts parent mental health and wellbeing but also time spent managing the mental load or 'worry work' of everyday life, which can be especially consuming for parents of children with additional needs (Watt, 2017) and parents living in financial precarity (Hall, 2019). Furthermore, such tasks are argued to be gendered, with mothers spending more time and experiencing more stress, than fathers (McKie et al., 2002). Home, therefore, is not necessarily a place of rest (Blunt and Dowling, 2006) and parents can find it difficult to find places to be quiet and alone (Turner et al., 2012) even at night, when caregiving tasks are sometimes needed at unwelcome times (Bowlby, 2012). Not surprisingly perhaps, mothers have described their own needs as 'last on the list' (Evans et al., 2017, p. 375). These 'everyday' pressures can influence mental health and wellbeing in under-appreciated ways (Middleton and Samanani, 2021).

For many parents, demands at home are 'juggled' around time at work. In countries such as the UK, more mothers are employed than in previous generations (McKie et al., 2002). The complexities of combining paid work and child-rearing are still managed predominately by women (McKie et al., 2002) but are often poorly supported by policy and services which creates additional pressure on working-mothers (Berger et al., 2022). However, fathers can experience significant pressure and poor support to combine work and care as well (Bourantani, 2018). Whilst some parents find satisfactory solutions, others adapt by working fewer hours, avoiding career-development opportunities, or conversely working more hours to provide financial security (McKie et al., 2002). Attempting to juggle work and family demands can add significant stress (Evans et al., 2017).

2.2.1 Added Challenges to Parenthood at Home and Household Relationships

Parents with mental illness integrate everyday joys and challenges of parenthood alongside their mental health condition (Solantaus et al., 2015). Parents often try to minimise impacts of their mental health condition on their children but it can make everyday activities and relationships harder (Reupert and Maybery, 2016). For example, a parent with depression may struggle with energy to engage with children or the affective expression to convey joy in their child's achievements (Gladstone et al., 2015a). These experiences are considered below, starting with the perinatal period and then thinking about issues that continue as children get older.

Childbirth is an emotional as well as physical experience, connected to cultural attitudes. For many women, childbirth is not what they hoped for and can be traumatic, even leading to PTSD or other psychological symptoms (de Graaff et al., 2018). The postpartum period can bring joy but also physical and mental health challenges, such as coping with a crying baby, fatigue (Kurth et al., 2011) and feelings of guilt when experiencing breastfeeding problems (Penniston et al., 2021). There are high rates of postpartum depression in mothers (Shorey et al., 2018) and the risk is seven times higher for teenage mothers (Swift et al., 2020). Men too, experience higher rates of mental health problems after the birth of a child (Wong et al., 2016). Furthermore, women with bi-polar affective disorder are at higher risk of post-partum psychosis (Lewis et al., 2018) adding to an appreciation that the postnatal period is a time of heightened risk for poor parent mental health.

As children grow, challenges change but do not disappear, although receive less academic and clinical attention (Bee et al., 2014). Manging child and adolescent behaviour, educational needs, and sometimes additional needs, can be harder whilst experiencing mental illness (Solantaus et al., 2015). Indeed, many parents with a mental illness have children with additional needs, including mental health conditions (Campbell et al., 2021). These pressures can make it hard for parents to have time and space for their own self-care (Turner et al., 2012). In addition, parents with a mental illness are more likely to experience socioeconomic disadvantage (Shim and Compton,

2020) and other complex circumstances, including addiction, abusive relationships, and inadequate housing (MacAlister, 2022). Indeed, financial strain is itself, a risk factor for mental illness, as noted previously. It is now considered in more depth, with a focus on parents and families.

Financial strain is a well-established risk factor for mental illness, exacerbated in the UK by austerity (Stuckler et al., 2017), the pandemic (Blundell et al., 2020) and rising inflation (Chakravorty, 2022). Families with children are more likely to live in low-income households than those without children (Sorensen, 2020), and nearly 20% of children live in a household that has experienced reduction in household income (Newlove-Delgado et al., 2022). Socioeconomically disadvantaged children (defined by factors such as household income, parent education and parent occupation) have higher rates of mental disorder than wealthier peers (Reiss, 2013) and children with a probable mental disorder are more likely to live in households that could not afford to adequately heat their home or buy sufficient food (including use of food banks, Newlove-Delgado et al., 2022). Children are ten times more likely to be on a child protection plan or have been removed from their parents' care if they live in the 10% most deprived areas, than the 10% least deprived areas (Bywaters and Featherstone, 2020) and children exposed to chronic family stressors created by poverty are at heightened risk of developing mental health disorders that may persist into their own adulthood and indeed, impact their own parenting (Marmot et al., 2020). Children though, live in poverty because their parents do. If intergenerational concerns of poverty and mental illness are to be addressed, it begins with considering the socioeconomic opportunities and pressures on parents.

Mental illness impacts the capacity of an adult to seek, gain, and maintain employment (Chakravorty, 2022) but also, to manage conditions required by welfare payments (Loopstra and Lalor, 2017). Inadequacies of welfare payments not meeting income requirements add further pressure on mental health and wellbeing (Marmot, 2020). For parents who have the needs of children to consider, this can create further stress and parents may forego their needs to provide for children (Dermott and Pomati, 2016). Rates of mental illness are high amongst lone parents facing socioeconomic disadvantage (Barnes et al., 2011, Cooper, 2008) and 'clusters' of postnatal depression have been noted in areas of social disadvantage (Eastwood, et al., 2014). Considerable concern has been expressed about the impacts of austerity on parents, particularly mothers (Hall, 2019). To explore the link between severe financial strain and parent mental health more closely, food security provides a pertinent example.

Food prices have risen disproportionately to salaries since 2010 (Chakravorty, 2022) and food bank use has risen exponentially in that time (Sosenko et al., 2019). Over six million children and their working-age parents are estimated to be at risk of food insecurity in England (D. Smith et al., 2018), with parents (often mothers) sometimes neglecting their own dietary needs to prioritise children (Thompson et al., 2018). Lone parents and their children are the biggest users of UK food banks (Loopstra and Lalor, 2017). Poor physical and mental health are common amongst those facing food insecurity (Smith et al., 2022) and the prevalence of mental illness increases as the level of food insecurity rises (Tarasuk et al, 2018). It has been estimated that 1 in 5 adults hospitalised for a mental health condition were severely food insecure (Tarasuk et al, 2018) and food insecurity has been linked to heightened risk of suicide (Maynard et al, 2019). Mental health issues are particularly high amongst women (Martin et al, 2016) and pregnant women (Power et al., 2017) in food insecure households. Mental illness may contribute towards a person becoming food insecure (i.e., through unemployment or benefits sanctions) but the stress of food poverty also threatens mental health, especially when other sources of support are lacking (Martin et al, 2016).

This review has focused so far on mental health and severe financial stress but inequality is experienced *across* the income gradient and it is not only those in the extreme positions to be impacted negatively (Marmot et al., 2020). Referred to as ‘the squeezed middle’ (Stenning, 2020), numerous working parents face financial pressure impacting mental health and wellbeing (Hall, 2019). Pay is often low for many keyworkers, and women and people from ethnic minorities are over-represented in keyworker positions (Blundell et al., 2020). Against this backdrop, a new cost of living crisis is impacting UK families, leading to real-term losses to household income for many and creating further pressure, particularly on low-income parents and those with pre-existing mental health issues (Chakravorty, 2022). There are widespread pressures on family finances and concern about the impacts of financial insecurity on parent mental health and wellbeing in the UK relates to the breadth, as well as depth, of that issue.

2.3 Community

The term community can be used to refer to people with shared physical location and people with shared interests (MacQueen et al., 2001). In this review, both interpretations are applied, firstly exploring locations of community and then, moving to socially constructed communities in the modern 'village'. Latterly, the review will broaden to explore societal messaging around parenthood. In every situation, there is interest in experiences of inequality in access to support.

2.3.1 Accessing Community Spaces

2.3.1.1 Accessing Physical Spaces in the Community

At times, the safety of home represents a juxtaposition of unsafe or inaccessible outside spaces, influenced by perceptions of neighbourhood safety (Robinette et al., 2021), or physical inaccessibility for people with mobility challenges (Corran et al., 2018). A common challenge for parents though, is journey-making with young children (Boyer and Spinney, 2016). Luzia (2010, p.366) describes parents 'bunkering down' at home because of the complexities of getting out with children whilst Boyer and Spinney (2016, p.123) share a mother describing leaving home as 'a military operation'. Parents with young children, may use a pram (Boyer and Spinney, 2016) but prams can be difficult on public transport and attract disapproval, discouraging community access (Clement and Waitt, 2018). There is an increasing move towards car ownership, particularly amongst mothers as they manage 'complex spatial and temporal schedules' of family members (Dowling, 2000, p. 346) but not all families have a car. Some choose not to (Luzia, 2010) but for some families, it is a financial restriction which denies access to a car. Being without a car can complicate journey-making (Clement and Waitt, 2018), making it more difficult to complete activities such as food shopping (Hall, 2019). Lack of transport, linked to financial constraint, can worsen the risk of social isolation (Attree, 2005). In all of these ways, leaving home can be problematic for parents.

Parents of babies and young children describe being more visible in public. This can be positive, as strangers smile and talk to the child (Boyer and Spinney, 2016). However, it can generate fear of judgment, such as with an unsettled child, creating additional anxiety about going out (Middleton and Samanani, 2020). Some parents feel ignored as people talk to the child and ignore the parent, giving a sense of being unseen (Longhurst, 2012). Men describe situations in which their fathering is afforded 'disproportionate appreciation' (Bourantani, 2018, p. 144) with congratulations bestowed on them for performing basic childcare activities (rarely bestowed on women) and publicly de-valued with comments such as 'you're just babysitting' (Bourantani, 2018, p. 141). The lack of public recognition of fathering is physically represented by a lack of baby-change facilities in male toilets, which has been subject to a social media campaign '#SquatForChange', sharing stories such as this:

> Was in Saundersfoot with my son who'd crapped his pants. Asked if they had baby changing in the restaurant we were in. Was told 'only in the ladies'. Had to change my kid on a bench in a park (Twitter, Tony@Big8409, 2018).

Paradoxically this neglect leads to situations where the parent becomes *hyper-visible*, perhaps attracting the disapproval of others, such as from onlookers as the father changed his child's clothing on the public-bench.

Another example, where poor accommodation of parent needs in public spaces, leads to hypervisibility, is breastfeeding. There are limited dedicated spaces for breastfeeding but widespread disapproval (Morris et al., 2016). In the example below, a new mother allegedly was asked to stop breastfeeding in her car because it was 'inappropriate'. Anyone could find this distressing but this mother was suffering from postnatal depression. She reported:

> It’s really triggered me. The car park was really quiet with hardly any cars, and I even took Rosie out of the store to breastfeed. I just burst out crying…. I was in such a mess I just wanted to go back home. I have not left the house since. I felt okay to go shopping on Friday but then this has just solidified my response that I shouldn’t go out the house (Beth Coles, cited in article by Jones, 2022).

The UK has low levels of breastfeeding, particularly in areas of higher socioeconomic disadvantage (Oakley et al., 2013). It is hard to imagine breastfeeding rates improving whilst mothers receive such negative community reaction and those who do breastfeed, may find the experience isolating if they are fearful to do so away from home.

Due to barriers described above, parents make changes to their ‘micro-social geographies’ (Ekinsmyth et al., 2004, p. 100). Previously frequented spaces become harder to access, less relevant and/ or stimulate new anxieties (Luzia, 2010) whilst different places, accommodating of travel with children and sympathetic to parent and child needs, open-up (Ekinsmyth et al., 2004). In order to leave home and engage in community spaces with children, particularly young children, it is therefore critical that communities offer ‘child-friendly’ locations for parents to access.

2.3.1.2 Parenting Communities Online

Online environments are a space of growing importance for parents (Drentea and Moren-Cross, 2005). During the pandemic, online socialisation became more prominent and offered unimpeded peer support (O’Reilly and Green, 2021) but the importance of virtual spaces has been growing for many years (Lupton et al., 2016). The internet can allow ‘hidden’ demographics, that may be unable or uncomfortable to access in-person parent activities, to access social connection, such as men (Eriksson and Salzmann-Erikson, 2013; Pedersen, 2015), working parents (Madge and O’Connor, 2006), and young mothers (Ruthven et al., 2018). The internet can offer an extension of ‘real life’ relationships, enabling people to keep in touch with family, friends, and acquaintances in a convenient manner (Lupton et al., 2016).

However, the internet also allows access to anonymous online forums where parents engage without the constraints attached to their in-person associations and where they are not bound by a geographic location. Anonymous online forums allow parents to exchange emotional support, information, and advice with people with whom they share common experiences or interests (Jaworska, 2018). Participants collectively build the accepted knowledge of that space through written conversations (Drentea and Moren-Cross, 2005; Pedersen and Smithson, 2013). Whilst often such exchanges reaffirm professional advice and public consensus, they can also 'disrupt the 'scientific narratives of experts' (Madge and O'Connor, 2006, p. 208) and seek to dispel the 'myth of motherhood' with alternative stories of mothering (Brady and Guerin, 2010). There can be a strong sense of community attached to these forums (Drentea and Moren-Cross, 2005). One woman said 'it's hard to see how an outsider can understand the real feeling of what it's like to be part of this (Mumsnet) community' (Mackenzie, 2017, p. 309) and another shared how it was her online community rather than 'real life' friends, who provided the strongest support following a bereavement (Brady and Guerin, 2010). Indeed, whilst many parents use such forums, research found online social support to be particularly important amongst lone parents, those experiencing lower educational or socioeconomic advantage (Sarkadi and Bremberg, 2005) and those facing difficulties that are socially stigmatised, such as or child-parent violence (Holt, 2011), postnatal depression (Jaworska, 2018) and other mental health issues (Goodings and Tucker, 2019).

There are limits to online support though. Virtual connections can provide a 'listening ear', but not usually a 'helping hand' with the practical needs of childcare. Parents also have unequal and sometimes limited access to the internet (Gann, 2020) and some groups may find parenting sites lack inclusiveness. Pedersen (2015) explores differences in online support for men and women, and LGBTQ parents may face lack of inclusivity into some parenting cybercommunities (see for example, Lothian-McLean, 2019). Online communities offer an opportunity for many parents but not all parents can access sites equally. Furthermore, much of the interest has been focused on the perinatal periods (Brady and Guerin, 2010; Drentea and Moren-Cross, 2005; Jaworska, 2018; Madge and O'Connor, 2006) with less research exploring the role of parenthood online for parents of older children (although Holt, 2011 offers an exception). There has also been limited exploration of online peer support between those experiencing mental illness, (Goodings and Tucker, 2019), although see Boyle (Boyle, 2019) , for an interesting exploration of the use of online peer support forums amongst people with social anxiety and Jaworska, (2018) regarding postnatal depression.

2.3.2 Social Constructs of Community

2.3.2.1 The Pros and Cons of Social 'Support'

Parents describe the importance of friendships with other parents who have children of a similar age (Jupp, 2013) and mothers well supported by relatives, report higher life satisfaction (Mikucka and Rizzi, 2016). Indeed, feelings of social connectedness with others is a protective factor for mental and physical health (Qualter et al., 2023). As explained in the previous chapter, this research is centred around a position that a community of support surrounding parents to provide practical and emotional assistance is critical as a 'ballast' in difficult situations (MacAlister, 2022, p. 18) but also, as a normative ideal including in situations where there is not a problem. There must be caution though, that whilst recognising the value of social relationships, the potential for harm needs consideration too. Peer support can be a 'mixed blessing, offering both advice and reassurance but also … judgement and anxiety' (Middleton and Samanani, 2021b, p. 35). Relationships can be experienced as 'negative support', in which the involvement of others is intrusive and critical (Ghate and Hazel, 2002). It is often the people living in the most challenging circumstances that can be most wary of 'support' (Attree, 2005).

2.3.2.2 Loneliness and Isolation

The terms social isolation and loneliness can be interrelated but are not interchangeable. Social isolation is an objective lack of social contact whilst loneliness is the subjective experience of feeling alone (Leigh-Hunt et al., 2017). For example, young people aged 16-24yrs are more likely to feel lonely, despite typically being exposed to a high number of social contacts (Pyle and Evans, 2018). Conversely, during the pandemic people were socially isolated (Williams et al., 2021) but not everyone felt lonely. Indeed, whilst there was an increase in loneliness, a meta-analysis found the effect size to be small (Ernst et al., 2022) and risk factors to be similar to those identified before the pandemic (Groarke et al., 2020). Loneliness has been associated with poor cardiovascular health and all-cause mortality (Leigh-Hunt et al., 2017). Loneliness and social isolation are also recognised risk factors and consequences of mental illness (Qualter et al., 2023) and are higher in deprived communities (Algren et al., 2020). There is intersectionality between these factors, with for example, higher rates of mental illness amongst socially isolated women who are food insecure (Martin et al., 2016).

Loneliness and social isolation are often considered for older people and whilst it is an issue for this population, it is common across adulthood (Bessaha et al., 2020). However, loneliness in adults has received less attention. In a meta-analysis of 75 longitudinal studies, only 5 related to adults aged 25-60yrs (Mund et al., 2020). Concern about this 'dearth of studies focused upon midlife' and the structural factors that influence it have prompted calls for further research about loneliness in mid-life (Qualter et al., 2023 paragraph 22). Parents are one of the populations identified as being at risk of loneliness (Bessaha et al., 2020). Isolated parents can feel less confident (Davidson, 2001), and are at risk of being more severely impacted by other stressors (Bunting et al., 2017). Parents with mental health conditions often experience isolation and loneliness (Bassett et al., 2001; Coates et al., 2017). Many families where a parent has mental illness fear social stigma and do not feel connected to a community, avoiding social or professional contacts where parenting may be scrutinised (Reupert et al., 2022). In turn, isolation of the family and loneliness of the parent create additional strains on mental health, with lack of practical and emotional support (Falkov, 2015).

2.3.2.3 Societal Messaging about Parenthood: 'Great Expectations'

The lens is cast more widely now, to consider societal messaging about parenthood and expectations on parents. Aspects have been alluded to, with references to what makes a 'good' or 'bad' parent. To briefly synthesise, there is concern about societal ideals for parent*ing* that are unobtainable, with mothers in particular set impossible expectations (Berger et al., 2022) creating ‘no-win’ situations (Damaske, 2013). For example, women describe social messaging that they should work, but not ‘too much’ (Berger et al., 2022). Working mothers receive criticism for placing children in childcare (Pedersen, 2016) but non-working mothers are socially derided and politically targeted (Whitworth and Griggs, 2013). The childcare environment is characterised as non-nurturing (Boyer et al., 2013) but children who do not attend pre-school are said to be disadvantaged in school readiness (Meloy et al., 2019). Policy initiatives promote working parents (Whitworth and Griggs, 2013) but services are largely offered in ‘business hours’. Men face the paradox, too, required to simultaneously be involved fathers (Tarrant, 2021) but also the ‘breadwinner’ (Harker and Martin, 2012). Men have historically had barriers to taking child-care career-breaks (Birkett and Forbes, 2019) and may feel excluded by female-dominated child-focused spaces (Bourantani, 2018; Pedersen, 2015). Such contradictory expectations, and the message that every choice is wrong (Damaske, 2013) can be exhausting and damaging for parents. Attempts to meet these ‘competing and contradictory ideologies’ (Pedersen, 2016, p. 32) often result in an emotionally damaging sense of guilt, particularly for mothers (Berger et al., 2022; Ekinsmyth et al., 2004; Longhurst et al., 2012).

A question arises about where such messaging comes from. This is a complex matter that can only be touched upon here but one element of interest, are parent*ing* resources. Parents (especially mothers) scour ‘books, magazines and websites’ (Pedersen, 2016, p. 35) for advice about child development and how to be a ‘good’ parent. These resources may be provided with the intention of supporting parenting but can carry side-effects of inducing guilt, self-doubt, and confusion, as shared below:

> I was advised by some mothers, neighbours and health care professionals to use Gina Ford’s (1999) Contented Little Baby Book, and by others to burn the book ceremonially at the bottom of the garden. The age-related routines this book recommends for babies (and their mothers) were a godsend to some of my friends, but a complete anathema to me… I was shocked by the ability of the text to

> make me feel guilty about mothering in a different way (Holloway, in Ekinsmyth et al., 2004, p. 99).

The capacity to share parenting advice and perhaps even more influentially, *compare* parenting practices has increased dramatically with the internet and social media. Communities of online support were introduced above but more broadly, social media can bombard parents with unrealistic images that create feelings of doubt and inadequacy, particularly amongst parents already vulnerable (Pedersen, 2016). It can be seen that community engagement and social relationships have a complex influence over parent mental health and wellbeing, with potential for support and distress.

2.4 The Service Landscape

The term 'service landscape' encapsulates spatial and socio-political framing of formalised care services provided by the welfare state (Daniels et al., 2011), the voluntary sector (for example, Bolton, 2015 explores the faith-based service landscape), or even the 'post-service landscape' created by retreating place-based state services (Power and Bartlett, 2018). In this study 'service landscape' is applied broadly to the range of health, social, and community-led services that parents engage with across two relevant streams of provision. One considers services primarily supporting parents and children in parenthood and child-development. For example, stay-and-play groups, Children's Centres, and health visitors. The other stream considers services to promote mental health and treat mental illness, such as primary mental health care from the GP, the Improved Access to Psychological Therapy (IAPT) programme, and secondary mental health services. These services overlap, but will be presented separately, beginning with supports for parents and children. The term 'offering' is used to describe the range of interventions, as it was the terminology used by Hampshire County Council.

2.4.1 Parent Services

2.4.1.1 Sure Start and Beyond

Since the turn of the last century, the State's involvement in spaces of parent support has undergone significant changes. Sure Start was the flagship program of the New Labour Government (1997-2010), offering universal access to services in 'pram-pushing distance' for parents with children aged 0-5yrs (G. Smith et al., 2018). Research highlighted Sure Start as a valued place of support (Jupp, 2013) and early childhood services including Sure Start were described as 'vital' (Marmot, 2010, p. 22). However, there were criticisms that those most in need were not necessarily accessing Sure Start (Coe et al., 2008), although others argued that evaluations (focused on child outcomes) did not fully capture the benefits, particularly for parents (Boot and Macdonald, 2006). A new government in 2010 and policies of austerity brought significant changes, with a move from universal access towards targeted services, alongside cuts to Local Authorities funding (Jupp, 2022a). Subsequently, approximately 1000 Children's Centres closed, with those remaining offering reduced and targeted services (G. Smith et al., 2018). This attracted public anger and growing concern that the lack of accessible universal access spaces, has resulted in higher risks of difficulties for parents and children (Jupp, 2022a).

As the State retreated from providing universal spaces of parent support, volunteers, faith groups and charities have offered what they can in community centres, church halls, and parks. Typical examples include 'baby groups', 'toddler groups', walk-and-talk groups and parent coffee mornings. The popular term 'stay-and-play' will be used to encapsulate such offerings, as it emphasises the co-presence of parent and child. Research has described benefits for parents and their (usually pre-school aged) children at stay-and-play groups, including for parent mental health and wellbeing (McLean et al., 2020; Townley, 2022; Williams et al., 2020). However, there are challenges too. Groups can be exclusionary, with social 'cliques' and they can be difficult to engage in for men (Bourantani, 2018), where there are different cultural norms around parenthood (Eastwood et al., 2014,) and for parents with a mental illness, where unwelcome comparison can add to feelings of difference and distress (Mauthner, 1995). Many of these criticisms were also levelled at Sure Start (see Jupp, 2013 for discussion) and should not be considered as particular to the voluntary sector. It does though, highlight complexities in offering universal spaces of support and that these challenges are increasingly met by volunteers as the State reduces support (Jupp, 2022a). Recently 'new' universal access Family Hubs have been announced (HM Government, 2023). There is little written about them to date but they will be considered in what detail is possible, in the Discussion (section 7.3.3) alongside findings from this research.

2.4.1.2 From Universal Support to Targeted Services

The role of the State in offering targeted support to parents has attracted debate, particularly as the narrative has moved from 'support' to 'interventions' (Callaghan et al., 2017) in response to 'failed care' from parents, which the State must then 'fix' (Emejulu and Bassel, 2018). Returning to the example of Sure Start, many centres were re-purposed as the base for referral-only services for families experiencing problems. Improved access for families in complex circumstances is welcomed but concerns have been raised about neglecting support needs at a universal level (Marmot et al., 2020), eroding trust in peer support in favour of professional advice (Townley, 2022), creating an unwanted paradox that a situation needs to escalate before support is available, and creating stigma (Jupp, 2022a). These changes moved the conversation away from parent support as a normalised part of child-rearing, towards a language in which help is reserved for those whose parenting is deficient (Bunting et al., 2017; Callaghan et al., 2017). This removes a site of professional and social support for many new parents and risks increasing service refusal from those it is intended to support (Holloway and Pimlott-Wilson, 2014). Specialist services can be viewed as stigmatised and parents therefore, may feel embarrassed or scared to access (Feeney, 2019). Indeed, a recent government report also recognised this widespread concern (HM Government, 2023).

There have been programmes designed for families 'most in need' such as the Family Intervention Project from the Labour government (Greg, 2010) and Troubled

Families initiative from the Coalition government (Bunting et al., 2017), re-branded in 2021 as ‘Supporting Families’ (Molloy and Waddell, 2021). Such programmes have been critiqued for an individualistic focus on ‘problem’ behaviours with neglect of structural factors that create and sustain disadvantages (Bunting et al., 2017). Furthermore, despite the focus on parent mental illness as a reason for referrals, some programmes have been accused of failing to attend to parent mental health needs (returned to later in the chapter) (Greg, 2010).

Another type of parent specific intervention are parenting ‘courses’. These begin with antenatal courses such as offered by the National Childbirth Trust (NCT), although such courses are fee-paying (www.nct.org.uk). For later stages of child development, there are a myriad of parenting interventions aimed at teaching parenting ‘skills’. Some of the most well-known include Triple-P (Coates et al., 2017) and The Incredible Years (Leijten et al., 2018) but there are many more (Asmuseen et al., 2016; Buchanan-Pascall et al., 2018). Such programmes can be viewed positively by parents (Holloway and Pimlott-Wilson, 2014) and have many positive evaluations (Asmuseen et al., 2016; McDaid and Park, 2022). Calls have been made for parenting programs to be ‘implemented at scale’ (Asmussen et al., 2017, p. 10) with universal access ‘across the social gradient’ (Marmot, et al., 2010, p.22). Parenting programmes have been described as a cost-effective, as well as clinically effective, intervention (McDaid and Park, 2022). Concerns have been raised too though, particularly about the quality of some research into parenting interventions (Asmuseen et al., 2016; Bee et al., 2014) and it must be recognised that the primary purposes of such programs relate to child outcomes, although some claim to have positive impacts upon parent mental health and wellbeing as well. However, systematic reviews give a confused picture, with some concluding parenting programmes do not have a significant effect on parental stress and mental wellbeing (Leijten et al., 2018), others claiming small improvements (Weber et al., 2019) and others concluding parenting programmes do improve parent mental health and wellbeing, at least in the short-term (Trivedi, 2017). However, many parenting programmes have low recruitment and retention rates and uptake is lower amongst populations deemed most vulnerable (Pote et al., 2019). This may be associated with less information about available service, barriers from financial costs, transport, child-care provision, and time, but also from the acceptability of services for people wary of professional involvement (ibid). There is also concern that the focus on individual behaviours and neglect of social determinants of health, make it difficult for parents to adopt recommended changes, leading to the criticism that services offer 'education courses [to parents] when what is really needed is practical support' (Bunting et al., 2017, p.37).

2.4.2 Treating Mental Illness and Promoting Mental Health

2.4.2.1 Mental Health Services

Attention turns to mental health care, firstly exploring services intended to treat mental illness. Treatment for mental illness has changed considerably over the past century. There was a time when people were physically excluded from society, with removal to 'asylums' situated in intentionally isolated areas (Milligan, 2000). Such places became infamous and avoided unless necessary (Parr et al., 2004). Indeed, their enduring legacy continues to impact perceptions of mental health today (Moon et al., 2015). However, during the 1970s a shift from institutional care began and by the 1990s, the majority of long-stay psychiatric hospitals had closed or were repurposed (see Parr et al., 2004 as an example). A minority of people with mental illness do still have periods of (usually short-term) hospital care, although this form of treatment is higher for certain demographics, such as Black men (Weich et al., 2014). However, '90% of people with mental health problems are cared for entirely within primary care' and 30% of GP visits include 'a mental health component' (England, 2017, p. 4), demonstrating this shift from institutional settings to community-based care.

Most people who need mental health care do not receive it (McManus et al., 2016). For example, Black or Black British women were 29.3% more likely than White British women to experience a common mental disorder but Black adults had the lowest rate of mental health treatment at 6.9% (McManus et al., 2016). Low rates of access to mental health care by people from ethnic minorities has been observed in other studies too (Power et al., 2017), as well as by men (McManus et al., 2016) and socially isolated lone mothers (Attrree, 2005). There are many reasons for this variation but two to be explored here, are distance and financial circumstances, before considering structural pressures on mental health services.

The distance effect proposes that the further a person lives from a treatment facility, the less likely they are to access it (Carson et al., 2016). This can impact rural areas as services tend to be concentrated in urban hubs (Parr et al., 2004). Unequal service development and funding allocations can create a ‘postcode lottery’ of services. For example, funding for CAMHS (child and adolescent mental health service) is not strictly correlated with need and low CAMHS spending in areas of high physical disease suggests CAMHS compete with other priorities for limited resources (Rocks et al., 2019). Voluntary services are subject to even more variation in the distribution of support developed as they are, according to the availability of volunteers and space rather than a strategic response to need (McDonnell et al., 2020). Parents therefore, may not have access to the services that they need for themselves and/ or their children, in the location where they live.

Socioeconomic status influences access to mental health services (Delgadillo et al., 2016). The inverse care law (Tudor Hart, 2000) recognises that those most in need of support are less likely to be able to access to it, with those who are better educated and more financially secure, having greater engagement with NHS services than those facing disadvantage (Elliot, 2016, Barr, et al., 2015). People living in deprived areas are more likely to seek but less likely to engage in mental health treatment (McManus et al, 2016). For example, families living in deprived districts of Glasgow were more likely to miss scheduled appointment (Harris and Wilson, 2018). Another example is with the Improved Access to Psychological Therapy (IAPT) scheme, which is a major primary mental health care initiative in the UK (Delgadillo et al., 2016), offering predominately cognitive behavioural therapy (CBT) primarily for people with depression and/ or, anxiety disorders (NHS Digital and Thandi, 2022). Numbers of referrals to IAPT during the year 2021 – 2022 increased in direct correlation with rising rates of deprivation, with the fewest referrals from the wealthiest 10% of areas (124,907) rising to the most referrals in the most deprived 10% of areas (236,885). However, an inverse corelation is seen for completing treatment. Whereas 45% of people referred from the least deprived quintile finished a course of treatment (the highest for any demographic), only 28% of people referred from the most deprived areas finished treatment (the lowest of all demographics, NHS Digital and Thandi, 2022).

Part of the reason for unequal access to and completion of treatment is because people seek care from unequal starting points. Managing health takes physical, emotional, social, and material resources (May et al., 2014). People in deprived areas are more likely to have multiple health conditions at a younger age, including mental illness (Marmot, 2020), but restricted physical, social and financial resources with which to manage care (Shippee et al., 2012). When people have high levels of health need and low access to resources, there is a high level of treatment burden, described as ‘the personal workload of healthcare, including treatment and self-management of chronic health conditions, and the impact of this workload on patient functioning and well-being’ (Eton et al., 2017, p. 450). High treatment burden is associated with lower treatment and adherence and lower quality of life (ibid) but research that looks at non-engagement with mental health services typically addresses service-user factors (Filippidou et al., 2014) rather than systemic issues. It can be especially complex for parents to engage in healthcare as they manage their own health and the health, development and educational needs of their children and other life activities (Solantaus et al., 2015). Parents, especially single parents may lack time, money, and childcare to attend mental health appointments, a complication that is often poorly accommodated but highly influential on treatment access (Department of Health and Social Care, 2018). However, fear of stigma and child removal can be a particularly powerful concern deterring parents with mental illness accessing services (O’Shaughnessy et al., 2015).

There are significant issues of service level access and capacity impacting accessibility as well (Hansen et al., 2021; Kiely, 2021). Services are under pressure from rising levels of need since the policies of austerity (Barr et al., 2015) and the pandemic (Shum et al., 2021), and need is predicted to rise again in response to the cost-of-living crisis (Chakravorty, 2022). At the same time as rising levels of need, there have been falling resources with which to respond, described as a ‘perfect storm’ (Lowndes and McCaughie, 2013) or a ‘double blow’ (Kiely, 2021). People have felt the cumulative impacts of pressures from increasing welfare restrictions and stagnant or falling wages in lower-income jobs, alongside cuts to the services that they need to protect and promote the mental health and wellbeing of themselves and their families. As a result, there can be lengthy waits and increasingly complex and restrictive referral criteria for public mental health services (Kiely, 2021) with private mental health services unaffordable to many. Recognising the impossibility of meeting the demands placed on mental health services is one of the reasons given to improve attention to and investment in, public mental health which was introduced in chapter 1 and considered in more depth next.

2.4.2.2 Public Mental Health

Public mental health is chronically under-funded, even within the wider under-funded area of mental health, with funding typically prioritised for crisis care above prevention in the UK (McDaid and Park, 2022). However, when factors that precipitate and exacerbate mental illness are ignored, resources aimed at symptoms are of limited effectiveness (Barr et al., 2015). Literature pertaining to key areas of proposed action to promote public mental health are introduced below.

Given the well-established links between poverty and mental health, action to redress household financial concern is proposed as a strategy for promoting mental health and wellbeing (Marmot, 2020). However, research has typically described links between mental illness and financial stress, with remarkably little research exploring the efficacy of interventions. Another well-established risk factor for poor mental health is loneliness and social isolation (Leigh-Hunt et al., 2017) and promoting social connection has been described as beneficial for mental health and wellbeing, (Feeney, 2019). However, there is insufficient evidence about the effectiveness of supporting positive social connections to promote mental health or prevent mental disorders (Flores et al., 2018). Furthermore, there is concern about insufficient public health research that explores place-based factors influencing loneliness (Qualter et al., 2020). Therefore, whilst supporting financial security, social engagement, and access to spaces of community interaction are promising strategies to promote mental health and wellbeing at population level, gaps in the evidence remain.

There is a strong body of evidence to support public mental health measures which target children and young people (Marmot, 2020). At least half of mental disorders (except dementia) develop before a child reaches the age of 14yrs (Mental Health Taskforce, 2016) leading to a high prevalence rate and so there are calls to invest in mental health promotion and early intervention for children and young (Elliot, 2016). Given that so much of a child's early experience is connected with their parents, this has attracted significant interest in the actions of parenting, although as already noted, not always with corresponding levels of support (Marmot, 2020, Greg, 2010, Harker and Martin, 2012).

2.4.3 Supporting Parents with Mental Illness

Services and interventions intended to support parent mental health and treat parental mental illness, bring together threads from parenthood services, mental health services, and public mental health approaches, as there is an explicit intent to promote mental health for children, by treating mental illness in parents. As noted earlier, children who have a parent with mental illness are more likely to develop problems with mental health (Reupert and Maybery, 2016). Some support programmes to promote mental health for these children have been developed specifically for children and young people, often including peer support and psychoeducation about mental health (Bee et al., 2014) but the focus here is on strategies that seek to promote mental health and prevent or treat parent mental illness (Reupert and Maybery, 2016).

There has been growing recognition of the criticality of supporting perinatal mental health for mothers and recently expanded specialist services for this population (Megnin-Viggars et al., 2015). However, new fathers receive poorer access to specialist services than that of mothers (Wong et al., 2016) and the psychological ramifications of experiences for LGBTQ parents have been described as 'under-recorded, under-researched, and under-heard' (Darwin and Greenfield, 2019, p. 341). Furthermore, the welcome improved attention from mental health services for this period has not been matched with similar levels of focus for parents of older children (Bee et al., 2014). However, parenting children at any stage, is a key component of identity and motivating factor for many service-users to address their mental health (van der Ende et al., 2016) and many would like mental health services to recognise and support their parental role (Coates et al., 2017). Better support of parenting needs within adult mental health care facilitates improves mental health outcomes for parents (Nicholson et al., 2015; Solantaus et al., 2015) and reduces the likelihood of a child being removed from parental care (Bassett et al., 2001; O'Shaughnessy et al., 2015). For example, women make 'greater progress toward recovery' (Hine et al., 2019, p. 7) when their motherhood role is specifically addressed by mental health care. Parenting support could be offered by mental health professionals within their core role (Hackett and Cook, 2016; Solantaus et al., 2015). However, parents often fear discussing parenthood, through worry about child protection (O'Shaughnessy et al., 2015) and so it requires sensitive discussion but mental health service staff often feel uncomfortable, ill-equipped and inadequately supported to address the parenting role of service-users (Maybery et al., 2015a). The neglect of parenting in adult mental health care is a lost opportunity to offer effective services for adults and reduce the risk of mental health problems for children (Solantaus et al., 2015).

There are 'manualised' programmes specifically tailored for the needs of parents with a mental illness, implemented internationally. Examples include Family Options and Let's Talk about Children (Reupert and Maybery, 2016). Furthermore, there are examples of isolated programmes offered by individual services, such as parenting skills programme developed by Australia occupational therapists (Bassett et al., 2001), in the USA, a peer support program between parents with mental illness (Nicholson et al., 2015) and in the UK, courses are offered for parents with an anxiety disorder in the 'flourishing families' project (https://www.flourishingfamiliesclinic.nhs.uk/). Generic parenting programmes have also been adapted specifically for this population, such as Triple P (Coates et al., 2017). However, despite efforts, such as the SCIE campaign 'Think child, think parent, think family' (SCIE, 2012) to introduce systematic changes, offerings for parents with a mental illness in the UK remain poorly defined, inconsistent, and lacking in most areas (Hackett and Cook, 2016). Parents with mental illness therefore, may be left without the support they need.

2.5 Conclusion

The literature gives insight into complex environments in which parenthood is situated and how these environments influence parent mental health and wellbeing in positive and harmful ways. It has also identified areas for further consideration. Parents are often hesitant to share the difficulties that they experience at home, particularly parents who fear how their parenting will be judged, such as parents with mental illness. Because of this their struggles can be hidden. There has been welcome increased attention to *maternal* mental health in the perinatal period but less attention for fathers in this period and the mental health needs of both parents in relation to later stages of child-rearing. Furthermore, the impacts from the pandemic and latest cost-of-living crisis on life on parent mental health and wellbeing, is an emerging area of interest.

The importance of ‘child-friendly’ spaces to access in the community has been highlighted, but also reports about parents finding their neighbourhoods hostile to parenting needs and so, there is interest in where parents find spaces of community. This interest extends to parents’ use of technology to build community, which has been well explored for parents of infants but given less consideration for parents of older children. Of particular concern, are the lack of studies that explore loneliness amongst parents, especially given the associations with poor mental health. In addition, it has been shown that societal pressures on parents are intense and there is concern about the impact of such messaging on parent mental health and wellbeing, as well as their confidence to reach out for support from voluntary and/ or public sector services.

With regards to the service landscape, the many closures, cuts, and pressures have been introduced across family-focused services and mental health care. In addition to longer-term cuts though, parents also experienced temporary closures through the pandemic. Investigating experiences of closures during the pandemic can highlight ways in which such services ‘usually’ impact mental health and wellbeing. Furthermore, this research is interested in the relationships between different parts of the support landscape and exploring how changes in one area influence practice in another.

In summary, parent mental health and wellbeing is impacted by many factors, often experienced unequally. This research seeks to develop understanding of these factors alongside barriers and facilitators to accessing support that all parents need. It does, after all, take a village to raise a child.

Chapter 3 Methods and Results of Demographic Participation

3.1 Introduction

In this chapter I introduce the methods adopted and also the influences that shaped them, summarised below in Table 1.

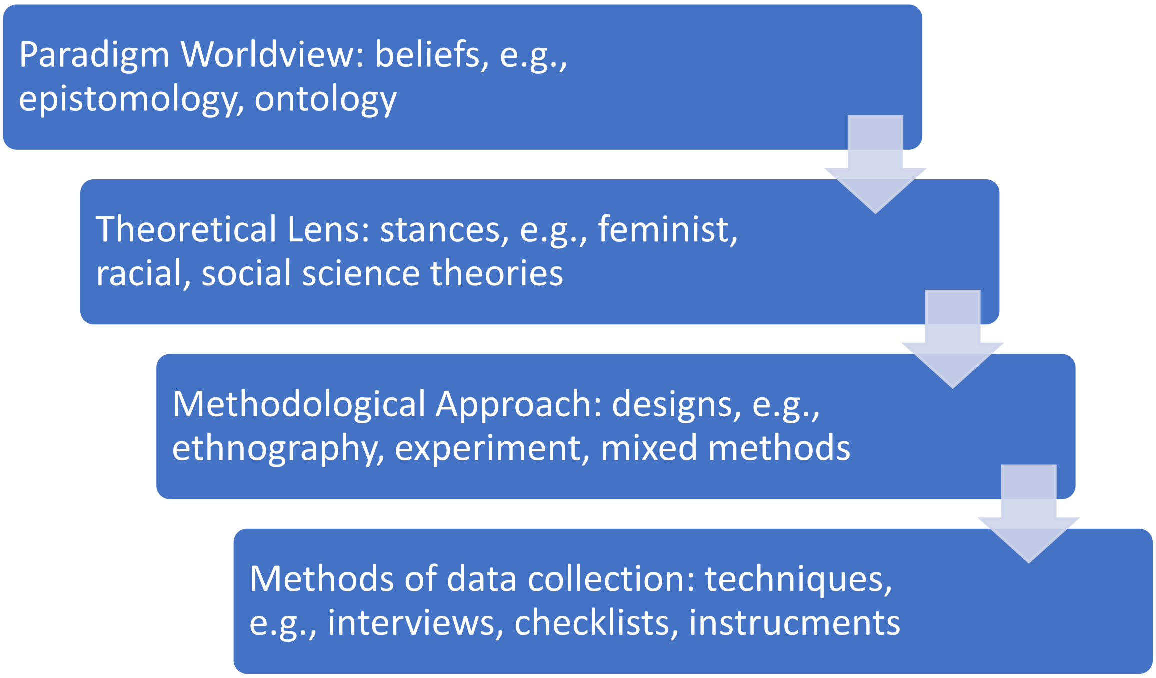
Table 1 Methods Summary

Method	Population	Location	Dates of data extraction	Number
Social Media Analysis	Parents	UK based website but international membership	Data extracted June 2020	N=829 posts (from 71 threads)
Mixed Methods Anonymous Online Survey	Parents	UK-wide	January – May 2021	274 survey responses
Asset Map and Field Notes	Parent Support Services	Case Study County of Hampshire	January – June 2022	288 service listings
Semi-Structured Qualitative Interviews	People who work or volunteer with parents	Case Study County of Hampshire	May – August 2022	13 interviews

A choice has been made to write this chapter in the first person to overtly 'position' myself in this project, an approach adopted by other, particularly feminist, authors (see for example, Ekinsmyth et al., 2004; Luzia, 2010). The relevance of this feminist-inspired positioning will be considered later in the chapter. As the title reveals, this chapter will also present demographic details of participants from. The rationale for this unusual decision is given later but in brief, was modelled on other research (O'Cathain, 2009) and chosen so that the findings chapters could be presented thematically, following an integrated thematic analysis which combined data from all methods, rather than separated by method.

The first part of this chapter is structured according to the 'Four Levels for Developing a Research Study' that Creswell and Plano-Clark (2018) adapted from Crotty (1998). Figure 1 below shows a recreation of the Creswell and Plano-Clark (2018, p.35) figure:

Figure 1 Levels of Developing a Research Study (Creswell and Plano-Clark, 2018)



3.2 Worldview/ Paradigm

Pragmatism 'is a philosophy focused on practice' (Harney et al., 2016, p. 318) with a focus on 'what works' and real-world practice' (Creswell and Plano-Clark, 2018, p.37). This suited my reasons for beginning a PhD, which was grounded in my experiences from clinical practice as an occupational therapist and keenness to contribute towards research that identifies issues of concern and explores potential solutions. Indeed, perhaps it was my clinical background that directed me towards pragmatism.

Occupational therapy has a long association with pragmatism, with Morrison arguing 'Occupational Therapy is pragmatist from its beginnings' (Morrison, 2016, p. 301). Pragmatism is also a guiding force in public health, with an embedded concern for achievable action with a discernible impact upon health at a population level (Horwood et al., 2022). Furthermore, I considered pragmatism an appropriate paradigm under which to explore the experiences of the everyday joys and challenges of parenthood, which frequently involve trying to manage complex situations and competing demands within varying constraints (Pedersen, 2016). During the course of this PhD study, I grew to appreciate how my life and my own role as a parent, as well as my research, was heavily influenced by pragmatic leanings and never more so, than during the COVID-19 pandemic when, as like so many others, I combined work, home-schooling, and elder care responsibilities in imperfect but functional solutions (expanded upon in the subsequent reflexive position statement). One of the key principles of pragmatism, is to be 'adaptive and contingent' (Hepple, 2008, p. 1531) and this proved to be critical as government restrictions were in force during much of the data collection. A pragmatic approach meant that methods would change (as mentioned in section 1.4). Therefore, a pragmatic worldview helped me focus on the area of research interest whilst retaining an open mind about how to conduct my enquiry (Johnson and Onwuegbuzie, 2004). However, it has been suggested that pragmatism is a less established in human geography, although with emerging and significant potential, particularly when applying geographical research for societal benefit (Harney et al., 2016). The appraisal that pragmatism is not used widely in human geography but has potential, did not discourage me but rather encouraged me to follow my pre-disposition to pragmatism to hopefully contribute towards this emerging field.

3.3 Theoretical Lens

At the next stage in this process, a more specific theoretical position is adopted (Creswell and Plano-Clark, 2018). Reflecting on the literature that helped shape this research I could see multiple influences, but noted that many key influences, were feminist geographers exploring issues of parenthood and 'everyday' home-life. Examples include Eleanor Jupp, Sophie Bowlby, Jane Franklin, Sarah Marie Hall (Jupp et al., 2019), Alison Blunt, Robyn Dowling (Blunt and Dowling, 2006), Carol Ekinsmyth and Sarah Holloway (Ekinsmyth et al., 2004) amongst many others. I was interested in how these feminist authors explored, challenged and re-imagined concepts of care in gendered practices in which women often bore disproportionate responsibility, but I was also interested in the experiences of fathers, not least because if caring is to be shared more equally, we need to understand issues impacting women and men. I discovered male as well as female geographers and other social scientists critically exploring fatherhood from a feminist framework and raising issues and aspirations that I was sympathetic towards (Aitken, 2000; Bourantani, 2018; Brooks and Hodkinson, 2020; Doucet, 2011; Tarrant, 2021). This provided further confirmation that my research would be informed by a feminist theoretical lens, although in keeping with the overarching pragmatic framework, I would not focus my reading solely on feminist authors.

3.4 Methodological Approach

3.4.1 Multi-perspective research

Multi-perspective interviews refers to research in which different members of the same social system are interviewed separately, and then their accounts are analysed together (Vogl et al., 2019). To address the questions of this research, I wanted to incorporate experiences of giving and receiving support. A focus on the experiences of only one group or the other would not suit the 'whole of village' ethos central to this work. It was an approach adopted by Macpherson et al (2021), whose research participants included people with learning disabilities as well as people working in the sector, and Thompson et al (2022), who interviewed both families and the service-providers who supported them with access to food in the pandemic. As shown in Table 1 below (summarised from Vogl et al, 2019 and Farmer et al, 2006) it is possible that different stakeholders may share or hold differing views on common subjects (in this case, all pertaining to parenthood but from both parent and support provider perspective). It is important to emphasise that in qualitative research, divergent accounts are not problematic, on the contrary, it can be in differing accounts that understanding of social experiences can be most richly developed.

However, in all situations, the relationship between methods forms part of the analytic enquiry, creating an additional depth of exploration (Farmer et al., 2006). In the instance of this research, the purpose was to explore accounts of support providers and parents regarding the issues that impact upon parent mental health and wellbeing and equity in access to support.

Table 2 Relationships between data (Farmer et al., 2006; Vogl et al., 2019)

Convergence: data from different methods reveal similar findings.
Complementarity: data may be different but relates broadly to the same issue and by combining data, a richer understanding of the phenomenon can be developed.
Dissonance or divergence: data gives fundamentally different findings.
Silence: one or more data set does not contribute data towards a given point

I was persuaded by the value of engaging multiple-perspectives in my research and my initial plan had been to interview service-users and service-providers from a mental health service. However, with the COVID-19 pandemic, mental health services that I had begun to approach were so busy coping with the pandemic they felt unable to engage in the research. Furthermore, the internship with Hampshire County Council that was scheduled from April 2020, and where I hoped to make contacts with services, was cancelled. Therefore, I could not engage in traditional multi-perspective interviews but was still keen to incorporate multiple voices in the research. Farmer et al (2006) combined interview data with document analysis, demonstrating the possibility of including broader methods. I would therefore, need to explore alternative methods to capture parent and support-provider 'voice'. The methods selected to achieve this purpose are detailed later in the chapter but first, another methodological decision is introduced, which was to use mixed methods.

3.4.2 Mixed-methods

There have been many definitions of mixed-methods research but typically it refers to research which includes qualitative and quantitative components (Johnson et al., 2007), allowing for 'multiple ways of making sense of the social world' (Greene, 2007, p. 20). In everyday life people intuitively gather and integrate information from quantitative and qualitative sources (Creswell and Plano-Clark, 2018) but in academic research, there has been tension (Johnson and Onwuegbuzie, 2004). However, such divisions limit opportunities in knowledge:

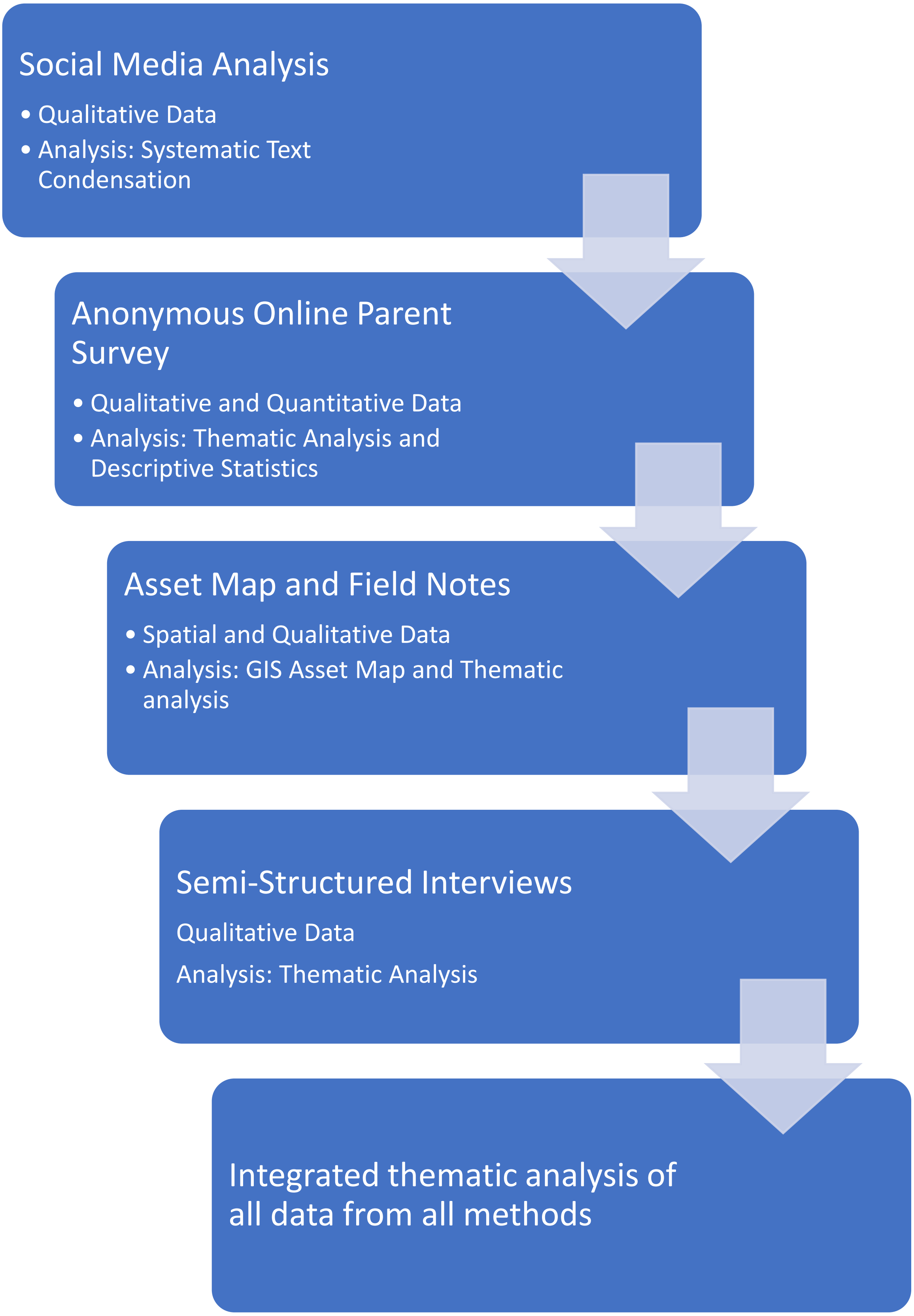
> We are social, behavioral, and human sciences researchers first, and divisions between quantitative and qualitative research only serve to narrow the approaches and the opportunities for collaboration (Creswell and Plano-Clark, 2018, p.13).

This research was intended to explore experience and so lent towards a qualitatively driven enquiry (Hesse-Biber et al., 2016). However, parents are notoriously time-poor (see for example, Evans et al., 2017) and never more so, than during the pandemic (O'Reilly and Green, 2021) but qualitative methods can be time-consuming (Ives and Damery, 2014) which could limit participation. There are *some* quantitative methods, for example Likert-scales questions in a survey that can provide a relatively quick and easy way for participants to express their opinions, emotions, and experiences and as such, are more likely to be completed by larger numbers of participants (Powell, 2014). Quantitative methods could also add context to the qualitative data, which whilst not representative, could add interest. Furthermore, combining qualitative and quantitative methods provides opportunity for exploration of points of similarity and difference in a manner not dissimilar to that described previously, regarding multi-perspective research and as such, adding to the 'completeness' of the study (Tembo, 2014). Therefore, a quantitative component was considered as enhancing the breadth and depth of exploration on this topic. In addition, I wanted to explore what supports were being provided, where they were situated, and who could access them (see section 1.5) and therefore, needed to incorporate an investigation of the spatial distribution of sites of support (Martin, 1999).

It can be seen therefore, that a mixed-methods approach was justified for the purpose of the research but with a dominant qualitative paradigm, embedded with quantitative elements. This balance is expressed with a capitalised QUAL and a lower case quan (i.e. 'QUAL quan') to visualise that the quantitative aspects are embedded in a qualitatively dominant study (Hesse-Biber, 2016). Pragmatism (Tashakkori and Teddlie, 2010) and indeed feminism (Sweetman et al., 2010) are associated with, and well suited to, mixed methods. This reinforces that there was an appropriate alignment between my worldview, theoretical lens, and planned approach.

There are challenges to working with mixed methods (Tembo, 2014), not least the logistics of working with large amounts of disparate data which can be time-consuming and complex (Creswell and Plano-Clark, 2018). Many concerns have focused on how qualitative and quantitative methods are founded in different ideologies that can appear 'purportedly incompatible' with one another (Elwood, 2009p.94). That is why mixed-methods research is increasingly conceptualised as going beyond the combination of quantitative and qualitative research, and becoming an approach of its own, described as a '3rd way' (Tashakkori and Teddlie, 2010). In essence, the argument is that the 'whole' of mixed methods is greater than the sum of its (quantitative and qualitative) parts (Johnson et al., 2007). Mixed methods can follow either a fixed design, in which methods are planned prior to research commencing, or an emergent design where methods develop in response to findings at each stage (Creswell and Plano-Clark, 2018). This research had an emergent design, shaped by what was learnt and what was still unknown from each stage of data collection, but also by what was possible during the COVID-19 pandemic. Therefore, after each stage and initial analysis, the findings, limitations and ongoing 'gaps' were considered alongside the changing COVID-19 restrictions, and the next method was planned in response. This process is introduced below in Figure 2.

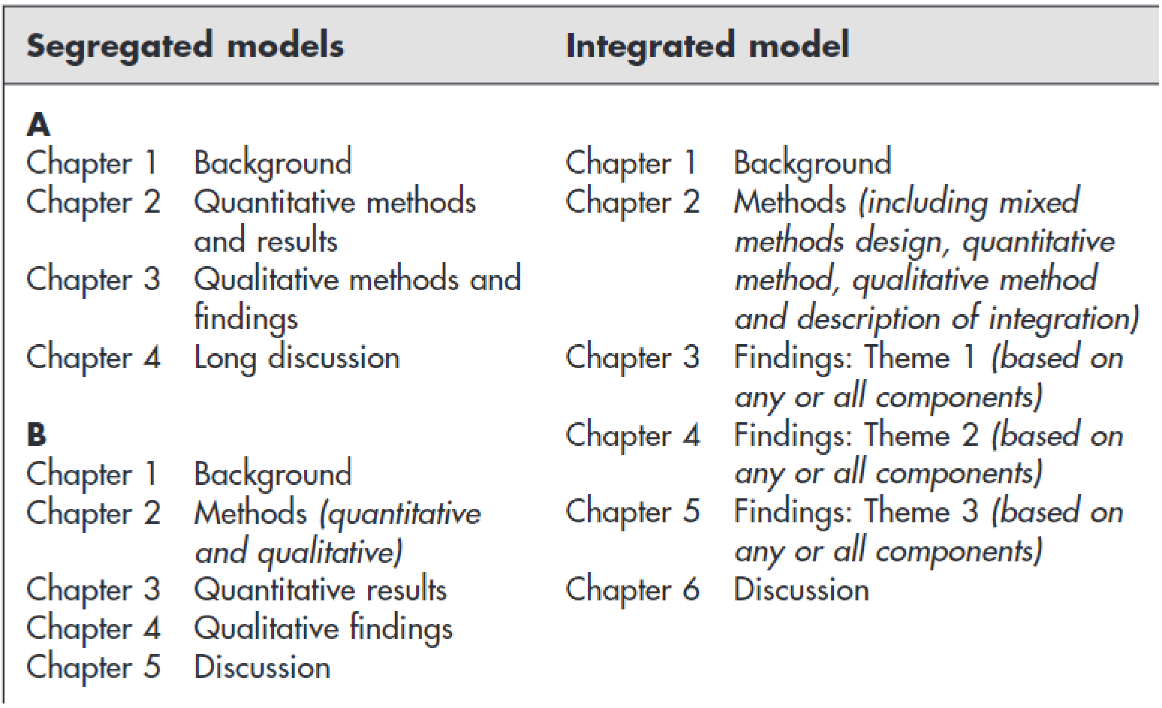
Figure 2 Methods and Analysis



3.4.3 Communicating Mixed and Multiple Methods

A challenge is how to present mixed-methods data (Elwood, 2009) which also relates to presenting data from multiple-methods. One option is to analyse qualitative and quantitative data separately, and then combine analysis at the discussion stage (Tembo, 2014). The initial plan for this thesis had been to analyse and present each method in separate chapters and then consider the relationships between them in a final discussion. However, it is suggested that richer findings can be developed by integrating quantitative and qualitative data *within* the analysis process (Onwuegbuzie et al., 2011) and given the associations that I was noticing, I moved towards an 'Integrated Model', in which all data would be analysed collectively and presented thematically, rather than divided methodologically. These two options are shown in Figure 2 below:

Figure 3 Segregated and Integrated Models Screenshot (O'Cathain, 2009, p.146)



Segregated models		**Integrated model**	
A			
Chapter 1	Background	Chapter 1	Background
Chapter 2	Quantitative methods and results	Chapter 2	Methods *(including mixed methods design, quantitative method, qualitative method and description of integration)*
Chapter 3	Qualitative methods and findings		
Chapter 4	Long discussion	Chapter 3	Findings: Theme 1 *(based on any or all components)*
B		Chapter 4	Findings: Theme 2 *(based on any or all components)*
Chapter 1	Background		
Chapter 2	Methods *(quantitative and qualitative)*	Chapter 5	Findings: Theme 3 *(based on any or all components)*
Chapter 3	Quantitative results	Chapter 6	Discussion
Chapter 4	Qualitative findings		
Chapter 5	Discussion		

The two approaches, of segregated of integrated analysis, are further demonstrated figuratively below. Figure 4 illustrates a segregated approach whilst Figure 5, visualises the actual approach of integrating data at analysis.

Figure 4 Segregated Model of Analysis

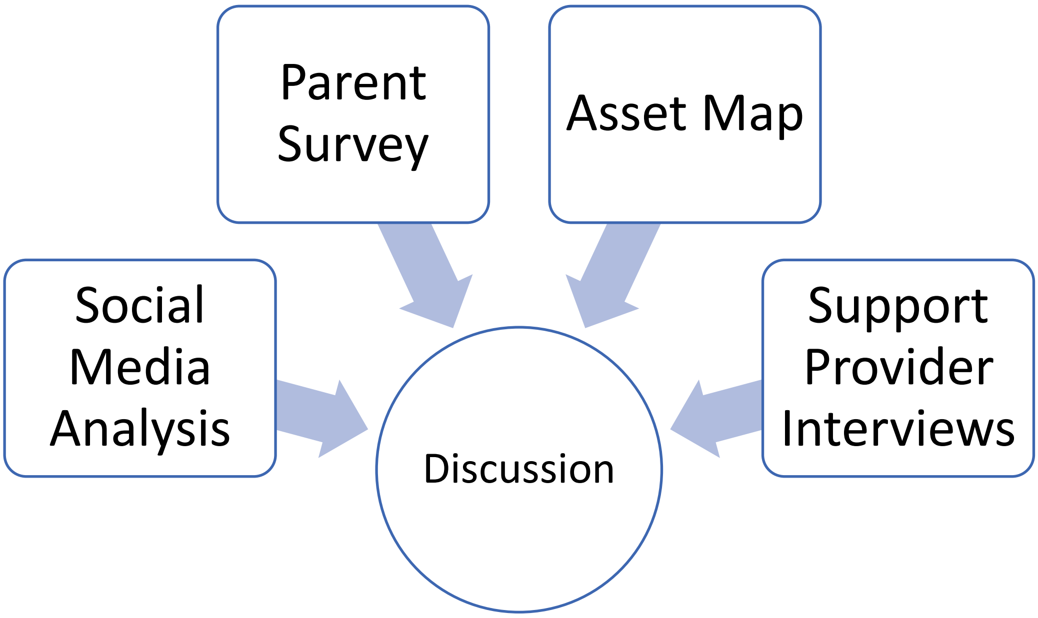
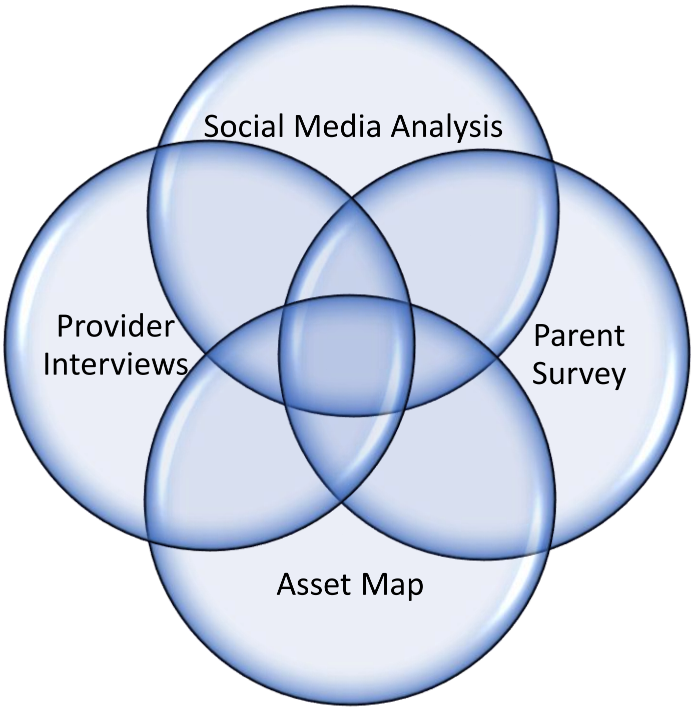


Figure 5 Integrated Model of Analysis



Communicating the findings from a multi-perspective and mixed-methods study in an integrated fashion sometimes requires stepping outside of usual conventions of presentation (O'Cathain, 2009). In this research, the findings are presented thematically, across the environments of Home, Community, and the Service Landscape. Demographic details of participants and quantitative data from the survey Likert Scales, apply to each of these chapters and as such, could not be presented in just one. Therefore, I followed the approach of O'Cathain (2009) by presenting demographic results immediately after the methods description, where that detail applies across chapters. In addition, Bar Charts showing the Likert-Scale results are available in Appendix C.

3.5 Methods

3.5.1 Method One: Social Media Analysis

3.5.1.1 Rationale and ethics of social media research

The first stage of research was conducted during the initial COVID-19 outbreak and first national lockdown. The unprecedented challenges damaged attempts to establish connections with mental health services and I needed a method that would allow me to explore perspectives of parents experiencing mental health problems that was socially distanced and unobtrusive. Given the widespread use of the internet in UK households, conducting the research online appeared to be a promising alternative (Walker, 2013). In addition, social media analysis was of empirical interest as an avenue of mental health peer support that remained accessible during the pandemic whilst so many traditional pathways of support were disrupted. Previous studies of parenthood revealed the relevance of analysing anonymous posts in online forums (for example, Brady and Guerin, 2010; Jaworska, 2018) particularly when exploring sensitive topics (Benford, 2014). However, questions are raised about the ethics of doing so (franzke et al., 2019; Lehner-Mear, 2020) which I needed to consider in some depth and are explored next.

To analyse posts required permission from the Mumsnet site administrators (which was granted as per university ethics, 57828) but did not require permission from individual contributors. Social media posts have been used without individual consent by previous researchers under the justification that it has been posted for an open audience (for example, Holt, 2011, Pedersen 2016). However, posts are written for peer discussion, not research analysis, and although available in the public domain, the researcher is not the 'intended public' (Mackenzie, 2017). I was concerned about contributors holding an *expectation* of within-group privacy (franzke et al., 2019) and that contributors may feel anger, mistrust, and even withdraw from a previously valued social media site (Lehner-Mear, 2020) should they discover their posts used in research. Indeed, people with mental health problems can find it difficult to develop trust in online communities through fear of how their posts may be used or that they become identifiable to people known to them (Goodings and Tucker, 2019, p.207). I did not want to jeopardise the perceived safety of a site by using posts directly without individual consent. Contacting post authors for permission (as in Mackenzie, 2017) was infeasible given the numbers of users and time-lapsed from thread creation, which was sometimes many years. It was also problematic given the interest in 'hidden' perspectives (Lehner-Mear, 2020, Jaworska, 2018). Most importantly though, it carried risk of distressing users. It was therefore deemed inappropriate to contact post authors individually, or use their words without permission, and so alternate ways of respecting and protecting users were required. The Association of Internet Researchers promote a nuanced approach (franzke, 2020) and reflection on these concerns directed a process of 'negotiated ethics' (Con and Cox, 2012) to develop the method and present the findings.

3.5.1.2 Method

Mumsnet was selected as the site of this research. Mumsnet, is a large parenting website based in the UK, although with international membership, which hosts popular open-access anonymous discussion forums, including a space dedicated for mental health. On this forum, Mumsnet members anonymously post questions/ comments and receive replies. Previous research referred to supportive, if somewhat forthright Mumsnet communities (Jaworska, 2018, Mackenzie, 2017, Pederson, 2013, 2015, 2016) giving precedence that this was an appropriate environment for exploring peer-support. I was concerned though, that the reported demographic of Mumsnet users was 'female, heterosexual, middle-class' (Mackenzie, 2017, p.298), and too limited for a research question about inequality, but preliminary readings revealed posts from men, people of all ages, 'non-traditional' families, and many facing complex health and social circumstances. I therefore felt this could be partially mitigated with purposeful sampling of which posts to include (described in more detail below). The social media analysis offered more than an opportunity to read descriptions about parents' experiences of support (or lack thereof) and impacts upon mental health and wellbeing in an everyday setting; it provided a site to observe exchanges of care and support between parents in online spaces too.

Having selected the site, I engaged in a period of 'immersion' (Lehner-Mear, 2020), reading multiple threads from the Mumsnet mental health site. This helped build familiarity with the language, etiquette, and convention of this online space. It was also during this time that I established approval from the study from Mumsnet and my university ethics board.

The next stage was to select which threads to extract. I used an online random date generator (https://www.random.org/calendar-dates) to choose 4 dates in each month of a 12-month period (48 dates in total). The randomly generated dates were reviewed and adjusted slightly to ensure that they included 12-14 weekend days, at least one date in school holidays in each month where applicable, not more than 2 dates in any 7-day period, and no date within 2 months of data collection. The intention was to include threads written at different times to give temporal range. Gathering data from a 12-month period helped to disguise the relatively small number of included threads from a vast and changing data source. Only posts that had had no new contributions in at least two months were used because this allowed time for posts to be removed if they violated Mumsnet guidelines or were regretted by the poster. It also managed the discomfort of 'lurking' (reading posts but not responding). Given the distress communicated within these posts it felt uncomfortable to read active discussions without offering support, particularly as some appeals had limited or no responses. Once the 48 dates had been decided, the opening posts of all threads concluding on selected dates were reviewed for inclusion criteria:

Inclusion criteria: the original poster identified as raising/ intending to raise children and that they, or a person they shared child-rearing with, self-described problems with mental health including (but not limited to) low mood, depression, anxiety, bipolar affective disorder, schizophrenia, or personality disorder.

The opening posts were reviewed without software or search features, to capture material equally available in the public domain. Inclusion criteria was screened by reading in full the opening post rather than by title because preliminary readings established that inclusion criteria was often not evident from the title. Having read all posts concluding on each date, I chose 1-2 threads that most closely aligned to research objectives and represented as diverse a range of characteristics as possible. For example, posts were purposefully selected where possible to include OPs (original posters) who identified as male, in a same-sex relationship, as a single parent, and facing significant financial hardship. Selected threads were captured in NVivo. Most threads contained the entire discussion in one page (25 posts or less) but some continued over multiple pages. In this instance all pages were read but only subsequent pages with new points of interest were captured to manage data volume and early familiarisation with the site had shown that longer threads often contained repetitive interactions.

Once extracted, analysis of the posts began. However, as noted, I was concerned about using a form of analysis that would require the use of quotes. I therefore used systematic text condensation for the initial analysis (Malterud, 2012), having been introduced to the approach in another online ethnography (Bergene et al., 2017). This approach allowed an in-depth analysis, not dependent on sharing direct participant quotes. However, it is not explained in full here as was only used for the initial analysis because (as discussed in section 3.6.2), integrating the social media analysis with other forms of data addressed this concern. In the final presentation of findings, social media data is presented as summarised vignettes, sometimes also using short generic phrases (as in Lehner-Mear, 2020).

3.5.1.3 Demographic Findings

81 threads were initially extracted and 71 discussion threads were finally included for analysis (10 threads pertaining to prospective parenthood and bereavement were later removed to refine the research focus on child rearing aged 0-19yrs). There was a range of 1 – 50 included posts per thread, with a combined total of 829 posts analysed. Demographic data is restricted to what was in captured posts and therefore, limited. Most (but not all) identified as female, where this information was given, but gender was often not stated. Age was rarely given but when it was, spanned early adulthood to retirement. Sparse data were available for ethnicity or location, although with some urban and rural references in the UK and a minority outside the UK. Financial circumstances varied; many described socioeconomic strain but others described financial security. There was some diversity in partner-status in so much as approximately a quarter of original posters described being a single parent, about half referenced a partner (although often alongside relationship stress) and about a quarter did not mention partner status. However, references to non-heterosexual relationships were rare. Most threads began and concluded within a matter of weeks but some began months or years previously and had been reactivated by a newer contribution within the data collection period.

3.5.1.4 Limitations

The analysis does not purport to be representative. It excludes those without/with limited digital access, those that do not share online and those that use other platforms (Walker, 2013). The diversity of voices is unknown but appears to have been predominately, although not exclusively, heterosexual women. Efforts to achieve temporal range were only partly successful because often threads continued over multiple days or longer and so for example, a thread that began in school holidays may conclude during term time and therefore be missed from attempts to capture issues pertinent to school holidays.

3.5.2 Method Two: Anonymous Online Survey

3.5.2.1 Rationale

The social media analysis captured powerful accounts from parents in emotional distress. However, given the broader focus of this research, I also needed to capture ‘everyday’ experiences of parenthood (Blunt and Dowling, 2006; Franklin, 2019; Hall, 2019; Middleton and Samanani, 2021). I therefore wanted to ask parents about the day-to-day activities of parenthood, the spaces in which those activities took place, and the perceived influence that these experiences had on their mental health and wellbeing. Whilst planning the second phase of data collection though, the UK was experiencing ‘Lockdown Two’ (November 2020), meaning remote and minimally obtrusive methods were preferable and as such, I would still be reliant on a method that could be conducted online (Walker, 2013). Furthermore, the social media analysis had reaffirmed that anonymity could be a useful tool in gathering parent perspectives. However, I did want to be able to directly quote parent voice and so needed a method with an explicit individual consent process. Considering these issues and requirements led me to approach the next phase of research with an anonymous online survey (Powell, 2014).

3.5.2.2 Method

Questions for the survey were developed from the literature, initial analysis of the social media data, and from feedback from eight parents (within and beyond the authorship team) who gave feedback on preliminary versions of the survey. From this iterative process, a final format was established with 25 Likert-scale questions, nine core free-text questions, and 12 multiple-choice demographic questions (Appendix B). Following approval by The University of Southampton ethics board (ref 62637) the survey was constructed in SurveyMonkey (strategically chosen due to supervisor’s prior experience of high acceptability with potential participants) and disseminated to a volunteer sample via the website Mumsnet and research team Facebook and Twitter accounts/ groups from February-May 2021, with intermittent re-posts to boost the response. The recruitment relied on volunteer and snowballing sampling, so the resulting sample is not representative of the wider population. Participants were provided with a Participant Information Sheet and had to ‘click’ a consent button to access the survey (Appendix A). Consent was the only response that was required, with other questions give the option of ‘prefer not to say’ (quantitative data) or to leave the qualitative boxes unfilled. Quantitative responses were analysed in SPSS and Excel. Qualitative data were analysed using thematic analysis in NVivo and ‘by hand’, described in more detail below (Braun and Clarke, 2022).

3.5.2.3 Response and Demographic Findings

291 parents consented to begin the survey but 17 answered no more questions. With the exception of ‘Any other comments’, there was a median response of 188 (range 174-202) for core qualitative questions. 218 respondents gave demographic data as shown in Table 3, below. Please note, that the category for age of child(ren) sums to more than 100% because many parents had children of different ages, in different age brackets. For example, 50% of respondents had a child aged 6-11years, but some of these parents would have also had children in younger and/ or older age brackets as well. Similarly, vocational status also sums to more than 100% as some parents chose more than one category (for example, worker and student).

Table 3 Demographic Details of Survey Respondents

Question	**Total = 218**	
Number of Children	Number	Percent
One	82	37.6%
Two	108	49.5%
Three	21	9.6%
Four	6	2.8%
Prefer not to say	1	0.5%

Ages of Children		
0-5yrs	93	42.7%
6-11yrs	109	50%
12-17yrs	88	40.4%
Prefer not to say	1	0.5%
Residency of Children		
Live with you all of the time	195	89.5%
Live with you some of the time	13	6%
A mixture (at least one child lives with you all of the time and at least one child lives with you some of the time).	7	3.2%
Prefer not to say	3	1.4%
Gender (self-described)		
Female	180	82.6%
Male	38	17.4%
Other	0	0
Age		
20-29yrs	7	3.2%
30-39yrs	71	32.6%
40-49yrs	120	55.1%
50-59yrs	19	8.7%
Ethnicity		
Asian/ Asian British	9	4.1%

Black/ Black British	2	0.9%
Mixed	6	2.8%
White/ White British	195	89.6%
Other	1	0.5%
Prefer not to say	5	2.3%
Relationship Status		
Heterosexual Partner	179	82.1%
Same-sex Partner	6	2.8%
Single	28	12.9%
Other	3	1.4%
Prefer not to say	2	0.9%
Location		
England	192	88.1%
Northern Ireland	1	0.5%
Scotland	19	8.7%
Wales	6	2.78%
Urbanicity/ Rurality		
Rural; countryside or village	47	21.6%
Urban: town or city	171	78.4%
Longevity to the area		
Grew up within roughly 10 miles of where currently living	87	39.9%

Did not grow up within 10miles of where currently living	123	56.4%
Moved a lot as a child/ grew up in no fixed area	7	3.2%
Not sure	1	0.5%
Disability or Long-Term Health Condition		
Yes	41	18.8%
No	175	80.3%
Prefer not to say	2	1%
Vocational Status		
Stay at home Parent	27	12.4%
Carer	13	6%
Part time Worker	72	33%
Full time Worker	111	50.9%
Student	38	17.4%
Volunteer	5	2.3%
Other	3	1.4%

3.5.2.4 Limitations

There were changes that I would make to the survey based on what was learnt from analysing the responses. I particularly regretted not asking if parents were raising a child with additional needs, although many qualitative responses did refer to this. However, the main limitation in the survey was that many demographic categories were under-represented, including men, young parents (age 18-29), and residents from parts of the UK other than England. Given that most respondents were from England, it was relevant to contextualise findings according to demographic data collected in the 2021 Census English and Welsh data. Parents of an ethnicity other than white were under-represented, with 89.6% of survey respondents identifying as white, compared to 81% of the census population (Garlick, 2021). In the survey, 2.8% were in a same-sex relationship and whilst the survey did not record single LGBTQ parents, this figure is slightly below the 3.2% of people who identified as gay, lesbian, bisexual or another sexual orientation in the census (Roskams, 2021). Finally, 15% of families were lone-parent families in the census (Sharfman and Cobb, 2021), which is slightly above the 12.9% of single parents recorded as participating in this survey. Of further note, 84% of lone parent households identified in the census, were headed by a mother (ibid). In this survey, 2/28 (7.1%) identified as single fathers, but only one had children living with him all the time. The response rate was not known as the analytics of how many people viewed the advert, was unknown (Walker, 2013).

3.5.3 Method Three: Asset map

3.5.3.1 Rationale

In the social media analysis and survey, parents described places that helped their mental health and wellbeing. A number of parents said they valued Children's Centres but I understood that many had closed, and many described the value of various baby and toddler groups that I believed to have been disrupted during COVID-19. Therefore, I was interested to try and explore what was *actually* available to parents in a given area at the current time. I was also interested to explore how accessible information was about local supports to someone without the advantage of local knowledge through other networks. Therefore, I chose to create an 'asset map' (Morgan and Ziglio, 2007) of community-based parent support resources in the case study county of Hampshire, from information that I could find from open access online sources. Using online sources to develop the asset map meant that it would not be impacted by pandemic restrictions, which were still a consideration when the method was planned, although were easing by the time asset mapping began (January–June, 2022).

3.5.3.2 Introducing the Case Study County

Focusing parts of this research on a specific area (as in Thompson et al., 2022) allows for a deeper exploration of issues, contextualised within features of that environment. As was introduced earlier, Hampshire County Council had expressed interest in this research and it was relevant to therefore base the asset map within that region. Initially the intent had been to focus on one District Council area, but discussions with the Council about interest for the whole council area encouraged me to broaden the case study boundaries. Within the Hampshire County Council area there are areas that experience high levels of deprivation such as Havant, Rushmoor and Gosport (Hampshire County Council, 2016). The Leigh Park area in Havant is the most deprived area in Hampshire and is in the 10% most deprived areas in the England (IMD, 2019). However, there were also high rates of deprivation noted in the other parts of Hampshire as well, in Southampton, Portsmouth and Isle of Wight (ibid). Therefore, the asset map expanded again to include all of the county of Hampshire, including these additional council areas, to ensure that a number of areas with high rates of community-level deprivation were incorporated.

3.5.3.3 Method

The asset map of places offering support and services to parents in Hampshire was constructed in ArcGIS Pro. Please see section 2.4 for an explanation of the term ‘offering’. Data for the asset map was identified from an online search in accordance with the inclusion criteria shown below in Table 4. For further explanation, it will be noted in the inclusion criteria that cost for attendance was set at £2 to attend for a parent and two children. This decision was taken in response to the varying approaches to charging for attendance, which could be per adult, per child, or per family (considered further in section 6.4.4.1). Even without factoring in different household budgets, what was ‘low-cost’ for one family could cost more for a larger family, which introduced a practical challenge. I therefore made the pragmatic decision to base my criteria on the ‘average’ family size (Sharfman, 2022), although rounding up slightly in recognition of the particular strains facing large families in financial precarity (Loopstra and Lalor, 2017). £2 is recognised as a cost still prohibitive to some parents but had the search only focused on completely ‘free’ offerings, it would have excluded many potential sites of low-cost support.

Table 4	Asset Map Inclusion Criteria

Inclusion	Exclusion	Rationale
Offering has a physical permanent location and identifiable postcode within Hampshire (including Southampton, Portsmouth and Isle of Wight)	Offering does not have a physical permanent location and identifiable postcode within Hampshire	Postcode location required to visualise location base on the asset map. Virtual offerings and ‘roaming’ offerings could not be located to one place on the map
Offering is by statutory or voluntary organisation	Offering is provided by private enterprise/ business	Parents with financial means to pay for private offerings have access to broader range of options. The research focus on inequality means that it is critical to consider access to support for those with limited financial means.
Offering can be accessed by a parent and 2 children for £2 per session or less	Offering costs more than £2 per session by a parent and 2 children	As above
Offering provides support specifically for parents (for example,	Offering does not provide support specifically for parents	Many ‘parent support’ options actually describe support for children with

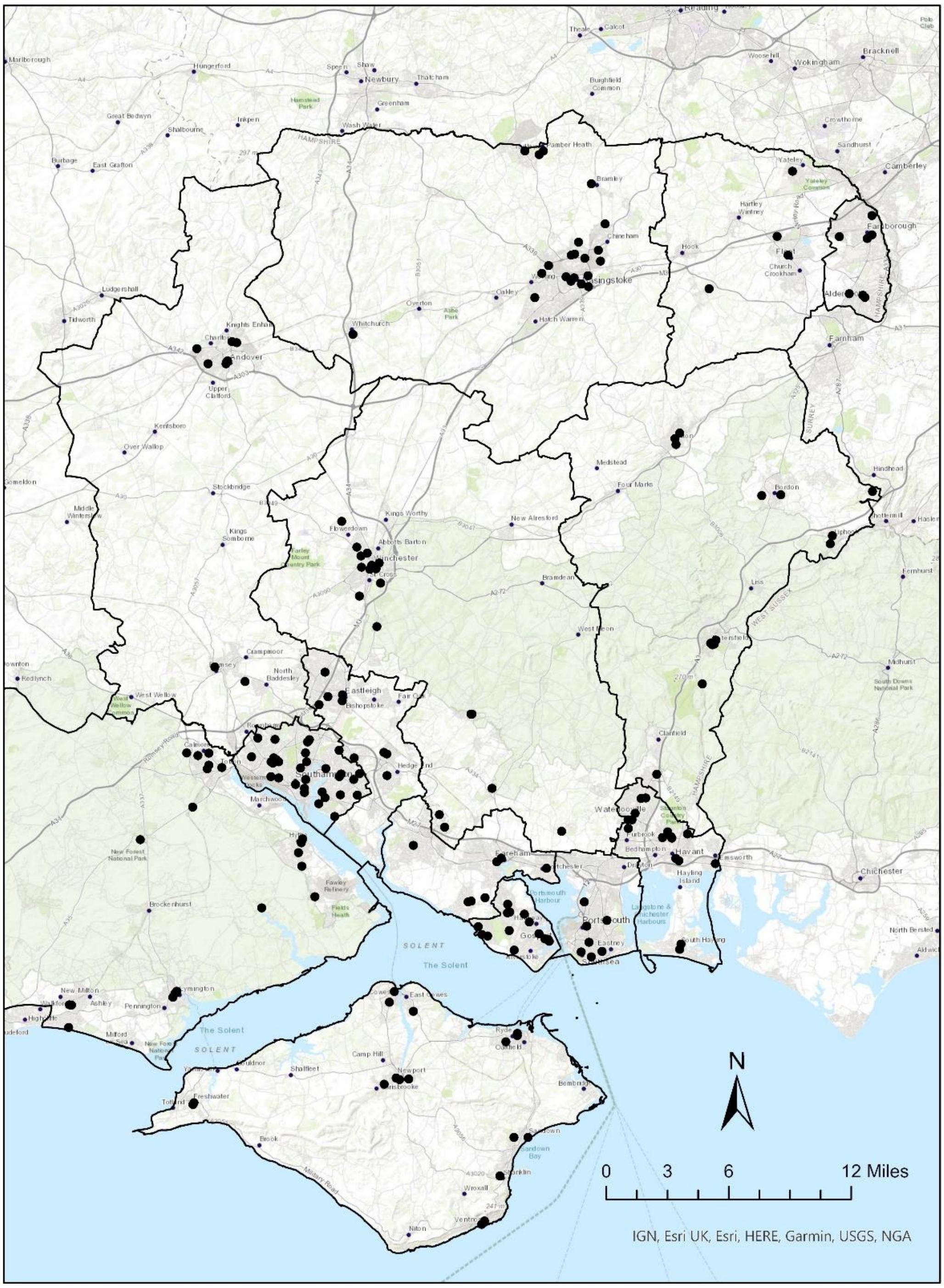
through peer support, emotional care, or practical assistance) which is targeted towards parenthood.		no direct offering for the parent. Other generic offerings are recognised as supporting parents (for example, food banks) but do not specifically focus on parent needs and the map would been confused by including all these generic offerings.
Offerings provides support for parents of children aged 0-19yrs	Offerings provide antenatal support or support for parents of adult children	Pre-natal care and parents of adult children beyond the scope of this research. Hampshire County Council (see section 1.1) specifically requested inclusion of offerings for parents of teenagers having identified this as a priority need and gap in current understanding

Where complete details were not available online, an email was sent to the service, requesting clarification of the missing service details. These additions and amendments were then added into the development of the asset map. A WordPress website page (https://parentsupportresearchhampshire.wordpress.com) was created to show an image of this preliminary asset map and give the names and postcodes of all offerings identified to date. Details of the preliminary asset map and WordPress site were then shared with Hampshire County Council and online via the research team (comprising the supervisor panel and myself) Twitter accounts to seek community consultation in June 2022. During the development of the asset map, I recorded phenomenon of interest in my ‘field notes’. These field notes contributed as an additional data source for contextualising and commenting upon the process and findings from developing the asset map.

3.5.3.4 Demographic Findings

The asset map as shown below in Figure 5, has 288 has listings. If a service had multiple offerings (for examples, similar groups but held on different days) this was listed as one offering. However, services that worked across different locations were listed separately by each location. Venues that hosted multiple different services, were listed separately by service. The spreadsheet listing all offerings is given in Appendix D.

Figure 6 Asset Map of Identified Parent Support Offerings in Hampshire



● All services

☐ Hampshire

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Contains OS data © Crown copyright and database right 2023

3.5.3.5 Limitations

Attempting to establish the availability of local supports through internet searching via a generic search engine (Google) proved to be limited, with a number of these concerns given greater attention later. Furthermore, sharing the map with Hampshire County Council and posting the map for community consultation on Twitter was unsuccessful in attracting responses. Although the asset map provided interesting information about some community supports, and the field notes were a valuable additional source of data, I could not establish geographic or demographic ‘gaps’ because listings were known to be incomplete. In short, although the asset map was helpful in exploring some of what *was* available, it did not establish what was missing. Whilst to an extent the problems that I experienced reflected problems in information dissemination (addressed later in the thesis), the scope of enquiry (both in terms of geographic reach and specification of parent support ‘offerings) was, on reflection, too broad. For further research, I would recommend focusing on a smaller geographic area and also, on one designated ‘type’ of parent support offering, such as support groups, and supplementing online searches with communication with local stakeholders.

3.5.4 Method Four: Interviews with Support Providers

3.5.4.1 Rationale

By this point in the study, I had explored parent perspectives and now needed to engage with support providers (see 3.4.1 and for example, Macpherson et al., 2023; Thompson et al., 2022). Indeed, whereas previously I had a focus on breadth of experience, I was now seeking more depth, and a more interactive process to allow discussion about these emerging areas of interest and concern. Semi-structured interviews with people who worked and/ or volunteered in parent support roles was chosen (Ives and Damery, 2014). By waiting until this later stage to do so, I was able to use preliminary analysis from earlier methods to inform the questions that would be raised, inviting their perspective on issues identified from parent-accounts and the asset map development. Questions were developed again from the literature, analysis of earlier stages of the research, and in supervision. In addition, A pilot interview was carried out with someone known to me who was previously involved in facilitating parent support offerings. Their data was not used in the subsequent analysis but their feedback was used to test and revise the interview guide (Appendix G).

The interviews (ethics number 70469) were conducted May – August 2022, after COVID-19 restrictions had been lifted. However, there was still COVID-19 uncertainty when the interviews were being planned. Therefore, the interviews were conducted remotely via Microsoft Teams which had been favoured by the University of Southampton for much of the study period. I would have had greater concern conducting interviews via Teams had there been an intent to also interview parents and may have needed to consider other means, such as the telephone (see Thompson et al., 2022) to promote accessibility. However, given the recruitment of workers and volunteers and the high use of online mediums by organisations during the pandemic, I was reassured that meeting online would be widely acceptable and accessible for interviewees and also, hoped that the approach would be minimally intrusive and time consuming within their busy schedules (see also, Walker, 2013).

3.5.4.2 Method

During the development of the asset map, organisations were purposively selected to invite one or more employee(s) or volunteer(s) from that service to take part in a semi-structured interview. The services were purposively selected to represent a range of organisation structures (statutory and charitable) and a range of parent needs. Emails were sent in ‘waves’ as shown in Table 5 below, to constantly re-adjust recruitment invitations based on previous responses. The invitation included details about the study and contact information for the research team. Those that responded were thanked and sent a participant information sheet (PIS) and consent form (Appendices E and F). Services that did not reply within one month were sent one follow-up reminder and if there was still no reply, no further contact. Interviews went ahead when consent forms had been returned and inclusion criteria verified. Some organisations with multiple branches shared the invitation across sites and therefore, more than one person from an organisation agreed to interview.

Inclusion Criteria: employee or volunteer service-providers involved in the managing or facilitation of a service offering support to the mental health and wellbeing of any parent in Hampshire.

Table 5 Invitations for Recruitment Schedule

Date sent	No. of invitations sent	No. of organisations responded	No. of interviewees agreed
17.03.2022	10	3	3
24.03.2022	6	1	3
29.04.2022	13	3	3
05.05.2022	6	1	1
16.05.22 - 18.05.2022	13	1	3
Total	48	9	13
Response Rate		18.75% of contacted organisations	Unknown number of individuals

3.5.4.3 Transcription

The interviews were conducted via Microsoft Teams and as such, the first level of transcription was performed automatically by Microsoft Teams. These transcriptions were then reviewed and corrected. 'Interviews were then transcribed', is a phrase often read in qualitative research but rarely expanded upon. However, it is a key part of the process and decisions made at this stage can influence later analysis (Oliver et al., 2005). There is a continuum of approaches to transcription, from 'naturalised' to ‘denaturalised’ (Oliver et al., 2005). Naturalised approaches seek to document non-verbal features such as utterances, intonations, and gestures, whilst de-naturalised approaches do not include these features (Oliver et. al, 2005). The purpose of transcription for this research was primarily semantic (Byrne, 2022). That is to say, that as a researcher I was interested in the participants’ own interpretations and meanings of their words rather than trying to identify ‘hidden’ meanings beneath the words (a latent approach, Byrne, 2022). This fitted with the research purpose and pragmatic interest in issues of ultimate relevance to policy and practice. Therefore, this research lent towards denaturalised transcription and as such, did not record which syllables in a word were vocalised differently, did not record the length of pauses, did not document general hand movements or facial expressions (they were included if specifically relevant to the communication), and did not include every ‘umm’. However, grammar was not corrected, and slang remained in place, so as to still represent the precise words that were spoken. The coding of these transcripts is described later in section 3.6.2.

3.5.4.4 Demographic Results

As the empirical chapters are organised thematically, I have chosen to present the characteristics of the organisations within this chapter. Table 6 below shows characteristics of the organisations represented by interviewees, generically termed support providers. The providers were given a pseodnym which is used to identify them in the data; Alex, Eden, Ellis, Lesley, Mic, Nic, Niya, Riley, Robin, Sam, Sasha, Terry and Toni. Gender neutral names were selected to protect the anonymity of the only interview participant who identified himself to be male. Given the small sample and concerns about identification (discussed in more detail below in 3.5.4.5) limited information is given in the course of the Findings that would link a pseuodnym to a particular type of offering where identification from such details would be possible.

Table 6 Characteristics of Interviewee Organisation

		No. of organisations represented	**No. of interview participants**
Type of organisation	Public Sector	2	6
	Charity or Faith Group	7	7
Participant role status within organisation	Employee	5	9
	Volunteer	4	4
Offering access criteria	Universal Access	4	6
	Targeted by Need	5	7
	Total	**9**	**13**

3.5.4.5 Limitations

I had chosen to do purposive sampling to ensure interviews were with service providers from a range of offerings and had focused on a small geographic area to connect this data with the asset map as previously described. I hoped that personal invitations to interview and knowing that it was related to their own region, would increase motivation to take part and be a more successful recruitment strategy than an open invitation on social media across the UK. However, the response rate was lower than hoped for (less than 20% of contacted organisations responding positively) and there were challenges from the localised approach. Email invitations were sent to a central email address with a request for it to be shared with the team. That meant sometimes managers were aware of, perhaps even nominated, participants to take part. It is not that this is inherently an issue, many were positive about their managers, but it can compromise anonymity. Furthermore, I realised how hard it is to de-identify certain types of service, that are the only providers of that specific offering in an area. Although when coding the data, I could explore the full depth of what was shared with me, the targeted recruitment strategy made it harder to protect anonymity of individuals and services when it came to sharing detail from the data. There were some rich quotes that I did not share as it would have been possible for people familiar with services in the area to identify the service and perhaps even individual. Had I opened up recruitment to volunteers nation-wide, this would have been less of an issue. However, it would then have lost the focus of the case study area and link with local government.

I did not interview NHS employees. Given my interest in localised levels of community support, I thought it appropriate to focus on social care and community levels of support but the intersection with NHS services such as CAMHS, IAPT, adult mental health services, perinatal mental health services and the Family Nurse Partnership were mentioned frequently by community partners. Interviews with NHS providers would be an area of recommendation for future research.

3.6 Bringing the Methods Together: an integreated approach

The rationale for integrating the methods at analysis was introduced above. It is now explored in more depth, along with other factors pertaining to all methods and the process of bringing these different data strands together.

3.6.1 Sample Size Justification

Samples sizes for the different methods were given above but justification for these sample sizes, need to be considered as a whole. Sample size for the asset map was set for the case-study county of Hampshire because of the long-standing interest from Hampshire County Council (section 1.1) but any larger area would have taken a disproportionate amount of time and resources to develop. Indeed, on reflection even this area was larger than would have been optimal (section 3.5.3.5). With regards to the quantitative element of the survey, I re-visit the purpose of this data. In quantitative research there is generally an expectation of a sufficiently large and representative sample from which to generalise results to the wider population (Gray and Payne, 2014). However, in this research, the goal was to add contextualisation, not generalisation, and therefore, sample size for the survey was informed by qualitative considerations discussed below.

Sample size in qualitative research has been subject to considerable debate. When novice researchers look for guidance about sample size, they are told 'it depends' (Baker and Edwards, 2012) but what does it depend on? Malterud et al (2016) argue that it depends on 'Information Power', a play on words from the quantitative concept of statistical power. The concept described was based on qualitative interviews but I found applying the principals worked well with other qualitative methods too. Therefore, I consider the five elements of 'Information Power' in relation to the social media analysis, qualitative data in the parent survey, and provider interviews (Malterud et al., 2016). The field notes from developing the asset map are not considered here as they were not subject to sample size considerations in the same way.

The first consideration of 'Information Power' (Malterud et al., 2016) relates to the study aim. A wide aim will need more qualitative data than a narrow aim. The aim of this research project was broad and therefore, a large volume of data was needed.

Secondly, a sample specifically selected to represent a range of characteristics could be smaller than a sample gathered by convenience and in effect, the researcher hopes to capture diversity of experience through weight of numbers. In the social media analysis, the only pre-selection was that parents posted in the dedicated mental health section of the 'Talk' discussion forum. Therefore, it was guaranteed to capture experiences from parents experiencing mental health problems but to capture other characteristics such as gender, relationship status, and financial circumstances, a large sample was necessary. In the survey, the specificity of experience was broader still – open to any adult raising children in the UK. In order to capture diverse voices in this method, a large sample would be needed. By contrast, support provider interview participants were purposively recruited, so could have a smaller sample.

The next consideration relates to the role of developing theoretical positions. Studies working to develop an existing area of theory can make a meaningful contribution with a sample size smaller than a study which is seeking to develop new theoretical areas. In this study the research goal was focused less on advancing theory than it was concerned with practice. Therefore, a larger sample than indicated by other considerations would not be required for theoretical purposes.

The Information Power framework moves on to address the 'Quality of the Dialogue', which is described below:

> A study with strong and clear communication between researcher and participants requires fewer participants to offer sufficient information power than a study with ambiguous or unfocused dialogues (Malterud et al., 2016, p.1755).

This point is clearly directly related to interview data but again, I found it useful to apply the principal more broadly. In summary, the 'quality of dialogue' was weakest in the survey data as parents responded to questions with brief answers that could not be expanded. This then, would suggest the need for a large sample. The social media analysis was interesting as it was a naturally occurring dialogue between parents. Without any opportunity to 'direct' the dialogue though, it was likely that a fairly large volume would be required to capture sufficient points of interest. However, interviews were conducted with purposively recruited subject experts who had the potential to provide rich information specifically tailored to the subject matter. Once again, there was rationale to defend a small sample of interview participants, where the 'quality of dialogue' would be strongest.

Finally, the analysis strategy. When looking for patterns and interest across cases, more data is required. I applied the principal to consider how the balance of methods would integrate at analysis. Whilst I accepted each method would make a different contribution, I did not want one method to dominate extensively over another. Therefore, data with less detail (i.e. from the survey) needed to be present in greater numbers than richer data (i.e. from the interviews) if it was to make a meaningful contribution within the final analysis. In summary, these considerations directed me towards large sample sizes for the social media analysis and survey but a smaller purposive sample for the interviews.

3.6.2 Integrated Thematic Analysis

The main approach to analysis was thematic analysis, which is widely used in qualitative research (Braun and Clarke, 2022). However not all data collected in this research was qualitative. With regards to the asset map, 'field-notes' were summarised and then treated as qualitative data. However, there were also the Likert-Scale survey questions, which were relevant, thematically, across each of the three empirical chapters. I applied thematic codes to summarise findings from each of the Likert-scale questions, such as 'many parents are lonely' was allocated to the Likert-scale question about loneliness (a style of qualitizing, see Onwuegbuzie et a., 2011). These codes provided markers with which to thematically 'locate' the quantitative data, to be integrated with qualitative data. This allowed me to consider the quantitative data alongside qualitative data *within* the analysis stage (Onwuegbuzie et al., 2011) and ultimately, present the data together as well.

Although described in six steps, Braun and Clarke (2022) emphasise that thematic analysis is not linear and the stages are re-visited frequently. That was certainly true, as the data built in layers through the different methods, with later forms of data collection often spurring a return to themes developed during earlier stages of the research. Therefore, although described within the well-established six-phase process (Braun and Clarke, 2022) it should be stressed that it was an iterative process that incurred at each stage and was re-visited regularly.

Familiarisation: With the social media analysis, survey data and asset map notes, familiarisation was approached by reading and re-reading the data (already in written form) many times. As noted above, the social media analysis had also been subject to systematic text condensation as a preliminary analysis, prior to the thematic analysis, and so I had achieved a high level of familiarisation with this data.

With the interviews, familiarisation also included listening to the recordings a number of times, transcribing the data and taking notes from re-listening to the recordings.

Coding: My approaches towards coding developed and included using NVivo, Word, and paper and pens. In essence though, in keeping with Braun and Clarke (2022) guidance, each section of text was read and given a code based on my interpretation of the core meaning. Braun and Clarke (2022) recognise that researchers bring pre-existing areas of interest and knowledge to the coding process and (as discussed further below), my choice of codes is recognised to have been influenced by my prior experience, reading, and the research questions. Nevertheless, I aimed to keep this stage of analysis 'open' and generate codes that were descriptive of small pieces of data. This generated literally hundreds of codes which were reviewed and condensed where possible, before starting to combine the codes to build the themes, a process discussed regularly with supervisors.

Generating Initial Themes: By the time I came to analyse the interview data and conduct the integrated analysis, I had delineated three environments of interest from earlier phases of the research: home, community, and service-landscape. I had also identified interest in the resources of relationships, space, time, and money. Therefore, I initially 'sorted' the codes by these categories. This deductive was not in keeping with the Braun and Clarke method. However, Braun and Clark emphasise that there are many approaches to thematic analysis and one of the most important elements is to be transparent and reflexive (2022). In reality, I could not 'switch off' what I had learnt from earlier stages of the research and nor did it feel appropriate to try. Furthermore, the areas of interest provided some boundaries within which to manage what had become a large data and as such, proved to be a useful first stage.

Developing and Reviewing Themes: Once the large number of codes had been deductively 'sorted' as described above, I returned to a more inductive process of developing themes from within those delineated boundaries, which I did flexibility and pragmatically. Where interest developed that crossed the boundaries between segments, I was willing and interested to develop that. For example, it will be noted in Chapter 5 that the key resources of time and money are woven through vertically rather than providing the structure of the themes, as this suited the data better. This iterative process proved valuable in both providing a structure to guide the analysis but also the freedom to develop points of interest.

Refining Themes, and Writing Up: From this process, the final themes were developed and as already described, written up in three findings chapters, focused on Home and Household, Communities of Support, and Service Landscape. The data that was integrated for each chapter to develop the themes is shown below in Table 7. As shown, all sources contributed towards each chapter except the asset map, which was only used in Service Landscape.

Table 7 Data Integration by Chapter

	Home	Community	Services
Social Media Analysis	✓	✓	✓
Parent Survey	✓	✓	✓
Asset Map and Field Notes	✗	✗	✓
Provider Interviews	✓	✓	✓

As discussed previously (section 3.4.1), when conducting multi-perspective research, the researcher needs to consider the extent to which there is convergence, complementarity, dissonance, and/ or silence across the findings (Farmer et al., 2006). I have aimed to make explicit which methods contributed to that theme and in what ways, and consider where there was convergence, complementarity, and/ or dissonance between the findings generated from the different methods.

3.6.3 Reflexive Poistion

Braun and Clark (2022) emphasise the importance of relexivity in qualitative research. Some references to my positionality have already been made, such as that I am a parent, have had elder care responsibilites, and worked as an occupational therapist in the UK and Australia. These points are relevant to my approach to the analysis process which I now expand further. It is important to acknowledge my points of privalige. I am not from an ethnic or sexual minority group, I grew up financially secure and with support to access a good education, am married to a supportive partner, and neither I nor my children, have chronic health conditions. I have worked closely with many parents who have lived experience of the challenges described in this thesis but limited lived-experience of many of these difficulties myself. However, I have been lonely as a migrant with a baby, away from my own supports of family and friends, I have a hidden disability (hearing impairment) that makes it more difficult for me to access some environments, and I did feel a close personal connection with many of the everyday emotional and logistical challenges of parenthood (and motherhood specifically) described in wider literature and detailed in the data. This connection would have influenced my interpreation of both the literature and the data and the stories that I drew from it. Finally, my experience of working in healthcare and long-standing interest in public mental health was influential, particularly when engaging with literaure and data about service-provision. My motivation to engage in a PhD was to learn about and develop research supportive of health and wellbeing and this pragmatic framework was a constant influence throughout the research process.

3.6.4 A note about Quotes

Substantive quotes are not used from the social media analysis as discussed (section 3.5.2). When providing substantive quotes from parents who responded to the survey, this is detailed as ‘P’ (for parent), their allocated identification number (range 1-293), gender as described, and age-band. When providing substantive quotes for the provider interviews, their pseudonym is given but no more detail (section 3.5.4.5). With the large amount of qualitative data to be presented, a decision was made to integrate some (generally) shorter quotes into the body of the paragraph text without identifying details to preserve the flow when reading. However, an indication of which data source the quotes were drawn from and if it is the persepctive of a parent, support provider, or both, is given where relevant.

3.7 Conclusion

This chapter has explored the framework for the development of the methods used in the PhD and introduced each of those methods alongside the rationale but also limitations, of each approach. Unusually, this chapter has shared some demographic details and presentation notes, to allow the subsequent empirical chapters to be presented thematically. We now move to the first of those chapters and explore how the home and household influences parent mental health and wellbeing.

Chapter 4 Home and household

4.1 Introduction

This is the first of three findings chapters, which present the analysed data according to three key and interconnected environments of the metaphorical village, pertaining to parent mental health and wellbeing. Through these findings chapters it will be demonstrated that parental mental health can be negatively impacted by pressures at home (chapter 4), so parents seek support from informal communities of extended family, friends and neighbours but face barriers to supportive relationships and community spaces (chapter 5) and furthermore, struggle to access formal support from statutory and charitable services, in a diminished service landscape (chapter 6). It can be seen that the findings chapters move from micro to macro environments, as the sphere of influence gets broader.

Mental health begins at home. Positive experiences of home can support mental health and wellbeing but when parents cannot find solace at home, they literally *live with* tensions that can impact mental health. Furthermore, home provides the foundation on which parents build access to community and engagement with services and therefore, is an appropriate place in which to start. Sections exploring 'positives' draw heavily on survey data, whereas sections that consider difficult experiences incorporate social media analysis and interviews as well. This chapter (and subsequent empirical chapters) are focused solely on findings from this research and do not include wider literature, which is introduced in Chapters 7 and 8. Throughout this chapter (and indeed subsequent empirical chapters), the following descriptive statistic from the survey is to be borne in mind; 44% of parents reported feeling 'stressed or overwhelmed' every or most days, whilst another 48% felt that way occasionally. Only 7% were rarely stressed or overwhelmed and only 1 parent (out of 273) said they 'never' felt that way. Whilst the survey was distributed during a pandemic lockdown, these figures suggest widespread experiences of stress that can be damaging for mental health and wellbeing.

4.2 Household Relationships

Household is a term that describes a group of people (usually but not always with familial ties) who live together. This chapter considers how the needs of, and relationships between, members of a household are 'held' together (in helpful or harmful ways) at home. Interest is centred around the relationships between parents and children but touches on other household relationships at home as well.

4.2.1 Love and Pride

Parenthood can bring joy and contribute positively towards mental health and wellbeing. 82% of surveyed parents enjoyed doing things with their children every or most days, and 17% did so occasionally (Appendix C). The home was a central location for enjoyment of these 'everyday simple things', such as, 'art & craft activities…, bedtime stories', 'eating dinner together whilst watching tv and chatting, 'story time, bath time, cuddles, movies snuggled up', 'baking and cooking with the children', 'family dinners, film nights', 'laughing around the dinner table', and having 'laid back days in playing with toys or games'. In the quote below, a parent exemplifies how the home can be a conduit to shared activity:

> Bonding with the children as they get older. Teaching them to cook and getting them to help out around the house more. Real life experience (P145, female, 40-49yrs).

Even during lockdowns, parents described enjoyable activities at home. For example, one survey respondent enjoyed 'having time at home because nowhere to go so making things and being creative'; another said that the lockdowns allowed 'opportunity to spend more time together with the kids'. As a result, some relationships strengthened and parents felt 'quite bonded with [the children] by the experience'. These comments can be interpreted to show the support towards positive mental health from these good interactions in the home.

There was temporal context to these shared experiences as activities that parents enjoyed with children changed over time. Some parents held fond memories of 'the toddler years' and enjoyed 'when they [the children] were little'. Others enjoyed opportunities to ‘do more grown-up things’ and ‘interact more’, as children grew older. Many parents though, commented that it was the ‘journey’ of parenthood that they enjoyed, valuing different aspects of different stages. Throughout that journey, was delight from watching their child develop and seeing ‘the person they are becoming’. For example, parents said that ‘watching my children succeed’, and ‘watching [my child] develop and learn’ was a ‘privilege and joy’.

Surveyed parents frequently described love for, and by, their children. One parent said, ‘it’s wonderful having so much affection [from children]’ and another commented that their children ‘tell me they love me every single day’. Such love and positive emotional response was also identified in interviews, as shown below:

> They love it you know, if they’ve [the child] brought a picture home and it's like ‘I love mummy, she's the best’, you know? And they'll go [touches heart] ‘ahh, she’s done this beautiful picture’ and they’re really delighted’ (Sasha, support provider).

In the social media analysis, love for children was often described as ‘the only good thing’ in life and sometimes, the only reason to keep on living. A number of parents said online that they would commit suicide if not for the love of their children. Love of children was also given as a reason to seek mental health care and sometimes, to make lifestyle changes. Similar examples were shared at interview, such as in this quote:

> She had this big tattoo put on her arm, that sort of told the story of her addiction and the way she'd come out of it. And then at the bottom of her arm, was a beautiful picture of her son…. And then every time she was tempted to go back on drugs, she'd look at her arm. It worked (Nic, support provider).

Even in times of great distress, or perhaps especially so, love for children could promote positive action in support of mental health and wellbeing. These observations are not intended to romanticise challenging situations and as explored later (sections 4.2.2 and 6.4.1.2), parenthood can bring challenges to mental health and help-seeking. However, it is important to recognise positive influences.

There was pride in parenthood, and over 65% of surveyed parents felt proud of how they were raising their children every or most days, whilst another 28% felt proud of how they were raising their children occasionally (Appendix C). Qualitative comments, such as this quote, reaffirm the point:

> Seeing my children happily engaged in things that they enjoy. This makes me happy and feel I have achieved as a parent (P144, female, 40-49yrs).

In the social media analysis (written in periods of mental distress), some parents felt that raising their children was the 'only thing' they were doing well. Many parents said 'despite' their own psychological distress, they 'prioritised' and 'protected' their children and ensured that their children felt loved, as well as meeting the child's physical needs, and they were proud of this.

The partner relationship and relationships with other household members and visitors, could also be supportive of mental health and wellbeing. A partner is not necessarily the other biological parent and partners do not always live together. However the relationship was structured though, many parents spoke positively about their partner. For example, one survey respondent described a favourite time as, 'the moments I have grabbed with my partner by ourselves'. When supportive, this relationship could be protective against life stressors, such as during the pandemic:

> Trying to study full-time and be a full-time parent has been very hard. Luckily my husband has stepped up massively and does most of the childcare duties now (P290, female, 20-29yrs).

Many parents in the survey would speak to a partner if they needed mental health support. In the social media analysis, there were comments about a partner being 'very supportive', 'nothing but supportive' and partners providing practical and emotional assistance to facilitate access to mental health services.

In some circumstances (commonly in some cultures) grandparents live within the home as well. Although rare, there were some accounts of grandparents living within the household identified in this study. More typically though, other people entered the home as visitors. Many surveyed parents listed the homes of family members and friends as places that they found support. For example, one surveyed parent fondly described 'having a cup of tea with a mum friend in their kitchen or mine'. The home can therefore, 'hold' additional significant relationships which can bring positive influences on mental health and wellbeing. However, relationships are complex and challenges are considered next.

4.2.2 Under Pressure

4.2.2.1 Parenting Challenges

The parenthood role and parent-child relationship were typically important to parents. Indeed, the social media analysis had frequent references from parents wanting to be a 'good' or 'better' parent, or even 'the best [parent] I can be'. Problems begin however, when the parent holds a vision of what a 'good' parent is like or what a 'good' parent-child relationship is like, that does not meet their experience. Providers and some parents referred to a mismatch between expectations and reality:

> You expect so much of this little baby that you're giving birth to. It's this sort of unreal picture of what a child's gonna be, and there's no expectation that there might be a few problems on the way (Nic, support provider).

These high expectations and the desire to parent 'well', can lead to significant levels of worry. In the survey, 19% of parents said that they worried about their children so much it impacted their mental health most or every day, and another 36% said that they did so occasionally. The survey was distributed during COVID-19 and many parents were worried about their children emotionally, socially, and educationally during lockdowns. However, qualitative comments established that parents worry about many other issues, succinctly stated below:

> The worst aspect of parenting is the constant worry (P63, female, 40-49yrs).

Parents worried, 'am I getting it right' and equally, feared doing it 'wrong'. Parents were aware of the responsibility of parenthood and could sometimes find this overwhelming. One parent commented about 'the panic I feel at being needed so much'. When the high value of parenthood, the high (often unrealistic) expectations of parenthood (returned to in Chapter 5), and then worry about personal capacity, are combined, it can result in guilt and guilt was a term which appeared frequently in parent-accounts. Parents felt guilty following an argument with a child, guilty about their mental health condition, guilty for working, guilty for not home-schooling, guilty for children going to childcare, guilty for not taking children to certain places, guilty for not enjoying time with children, guilty for needing to themselves, and so forth. It was a pervasive and persistent emotion. Such ongoing negative feelings, over time, contribute negatively towards mental health and wellbeing.

Having explored emotional experiences in general, attention now turns to consider parenting activities, that can be challenging and impact upon experiences of being at home. During infancy, feeding and sleeping dominated concerns and whilst not exclusively related to the home environment (see section 5.4.2.1 regarding breastfeeding in public), they were often centred on the home:

> I mean specific to babies, I mean 'am I, you know, how's the feeding going? How's the sleeping going?' And, well, yeah, actually those are the two main things. … So feeding and sleeping (Ellis, support provider).

Feeding is considered first. Concern about a baby's weight was common but it was not only weight gain that created anxiety but also the breast-fed/ non-breast-fed 'divide', which was described as having 'a big rhetoric around it'. Breastfeeding was described by some mothers as a favourite stage of parenting. Others confidently described their decision not to breastfeed and why. However, for many mothers there was stress attached to breastfeeding attempts, with comments such as, 'breastfeeding was traumatic for me and I felt like a failure'. In the social media analysis, mothers expressed guilt for breastfeeding difficulties, as well as concerns about breastfeeding whilst taking anti-depressant medication. One of the support providers spoke about breastfeeding support with mothers who had issues ranging from cracked nipples to drug addiction. Not all mothers, therefore, could breastfeed but even when parents switched to formula feeding, there were concerns about which was the best brand, with one support provider commenting it can be 'a status thing… to feed your baby expensive milk'. We see then, two issues at play with feeding. One is the nutritional needs of the child but the other is mother's affective experience, particularly in relation to worry and guilt.

Sleep was another key activity for new parents, significantly impacting on experiences at home and influencing mental health and wellbeing. Although 46% of parents in the survey said that they currently slept well most or every day, the qualitative responses added context and parents frequently described the impact of current or previous sleep disturbance related to childcare tasks. It was an issue commonly discussed in social media posts, and connecting with the previous point, breastfeeding 'OP's (original posters) were often advised by other Mumsnet users, to stop breastfeeding in order to reduce sleep deprivation and improve mental health and wellbeing. The impacts of sleep deprivation on mental health and wellbeing are introduced from a parent and support provider perspective below:

> Interrupted sleep with baby and toddler [was a difficult stage] - it really impacts my mental health (P263, female, 30-39yrs).
>
> There's the role of sleep deprivation, for example in the mental health of new parents, is actually pretty significant… And we know about the impact of sleep deprivation on mental health (Toni, support provider).

A quarter of all respondents in the survey (25%) said that they 'rarely' or 'never' slept well and although usually associated with the postnatal period, this can impact parents of older children too. This point is returned to later when reviewing experiences of raising a child with additional needs who may have care needs at night.

With toddlers, difficulties experienced at home included teething, tantrums, toilet-training, and noise (managing such challenges in public spaces is explored in Chapter 5). The quote below gives a typical example:

> Takes off her nappy and [it] gets incredibly frustrating when she needs to wear it. But [she] just screams in my face for 39 mins because she can't tell me she's frustrated (P21, female, 30-39yrs).

As children grew, challenges changed with frustrations expressed about sibling arguments, homework, pack-lunches, behavioural issues, discipline and caring for children of different ages (especially when young and with a small age gap). As children became adolescents, parents struggled with, 'pre-teen attitude', 'teenage hormones', and noted that children became 'more combative' as adolescents. An example of these struggles, encompassing the often-mentioned challenge of 'screens' is given below:

> My son wants to be on his computer all day, you try to be a good parent and limit it but it is mentally draining having battles all day everyday - battle to do schoolwork, battle to stop him snacking, battle to turn off the PC and do something non electronic - everyday it is just draining (P270, female, 40-49yrs).

This changing dynamic at home, when parents felt they became 'bad cop', could damage enjoyment of that space, impact the relationship, and create parental stress. Such stressors may be little more than an annoyance for many but with potential to become more serious and have greater impact on mental health and wellbeing, as considered next.

There were parents seriously struggling with the parent-child relationship. When asked what they enjoyed about parenthood one surveyed parent wrote 'not much' and another said, 'I don't like being a parent'. However, it was in the social media analysis, where conversations were extended beyond short survey answers, that parents spoke most fully about significant parent-child relationship difficulties. Some parents said they might not love their child and some felt that their children did not love, like, or care about them. For example, parents made comments such as my child(ren) 'don't… even like me', 'just hates me', or they 'don't give a shit about me'. Some parents expressed regret for having had children, and relinquishing care was mentioned. The posts from parents in these situations, written anonymously to foster greater freedom of expression (see section 3.5.2.1), sometimes contained anger but often, great sadness. Serious problems in the parent-child relationship could negatively impact parent mental health and wellbeing in a cycle of distress.

Particular attention needs to be given to situations when children have additional needs. There can be strains on family relationships associated with the child's needs, for example managing the 'workload' of a condition or disability which critically, can involve care at night-time as well as during the day. The chronic sleep disturbance of parents of children with additional needs, was raised as a particularly testing concern for parents. For example, a Mumsnet post from a distressed parent refers to a child with additional needs 'screaming [until] 4am' and a provider talked about how parents of children with additional needs 'don't get the sleep, they don't get the breaks', meaning that time at home was rarely restful. Parents were described as 'physically tired,… mentally drained', with negative impacts on their mental health and wellbeing. However, it was not just mental strain but also sometimes physical risks of harm from children with additional needs that were discussed. One provider commented about children 'coming home [from school] overwhelmed and blowing up at their parents' whilst in the following example, a provider talks more specifically about behavioural issues experienced by some parents caring for a neurodivergent child:

> They're living with, I don't know the biting or the hitting or the lashing out, or the throwing of furniture (Nic, support provider).

These comments aligned with a social media thread in which parents of neurodivergent children described behavioural issues causing significant distress and sometimes physical harm to parents and the child's siblings, from violent 'meltdowns', which could involve being 'hit and kicked', 'punched…and screamed at'. Many accounts were described as taking place at home and as such, were 'hidden' from others from outside of the household. Child to parent violence was also described where children were struggling with their own mental health condition, as explained below:

> We've seen more and more sort of child on parent violence, you know, so children who just aren't coping and they, lashing out and that kind of thing, and that's a huge pressure (Eden, support provider).

Indeed, coping with child and adolescent mental health issues was described as a 'huge' issue for parents, including when the child was self-harming and/ or, expressing suicidal ideation. Another commonly identified issue was school refusal when the child, for reasons of their own mental health, was remaining at home rather than attending school. Such difficulties could then make it difficult for the parent to leave home (if the child needed supervision) impacting upon employment and subsequently income, creating further stress, arguments, and sense of confinement. Many providers said that they were seeing growing numbers of child and adolescent mental health problems and parents were struggling to cope, to the detriment of parents' mental health and wellbeing as well.

4.2.2.2 Partners

Another household relationship where tensions were commonly expressed, was with a partner. Issues in the partner relationship (particularly identified from the social media analysis), related to work, money, sex, childcare-distribution, domestic task distribution, emotional support, time dedicated to the partner relationship, and problems specific to managing lockdowns. Many issues were heavily gendered, with posts from females referring to disproportionate workload and lack of support from a male partner. However, as the quote below from the survey demonstrates, problems in the partner relationship were also impactful upon mental health for men:

> Balancing work pressures with home-schooling have been the single most difficult thing to manage during Covid. This has led to conflict between my partner and I that have caused additional mental strain and exacerbated impact on my mental health (P109, male, 40-49yrs).

The ending of partner relationships was discussed at some length. In the social media analysis, some parents wanted to leave their partner, others feared a relationship's end, and some considered leaving if 'better' for children. Single parents were faced with ongoing conflict with ex-partners, including managing fraught logistical challenges of children living between two homes. This point was also described in interviews, as below:

> Dad's had them and he's returned them not having dinner and not, you know, bathed, and deliberately, I think, kept school shoes and whatever (Sasha, support provider).

However, many single parents described an absence of the other parent who was not actively involved in raising the child, presenting different practical challenges on a parent coping alone and in turn, further pressure on mental health and wellbeing with risks of loneliness, financial precarity, and restricted opportunities for self-care.

Mental illness created challenges in partner relationships, evident most notably in the social media analysis. Original posters who wrote about their own mental health diagnosis, sometimes bemoaned a lack of support and understanding from their partner and said that difficulties in their relationship compounded their distress. Other posters gave accounts of their (usually male) partners who were experiencing serious problems with mental health and the associated feelings of frustration, helplessness and worry for their partner, their children, and themselves. The differences in responses to these scenarios (whether a poster described their own mental health problems or that of a partner) is explored later (section 5.4.2.2) but it can be seen that mental health problems can create strain in a relationship which in turn, exerts further pressures on mental health and wellbeing in a negative spiral of disagreement and distress. Some of those that talked about problems in the partner relationship also commented that this led to feelings of loneliness, a topic expanded in Chapter 5.

Returning to issues for families where children have additional needs, there was discussion about the pressure that this can create on relationships:

> They sort of go into this grief, which puts a hell of a strain on their marriage and any other relationships they have (Nic, support provider).

In the social media analysis and provider interviews there were comments about higher rates of partner relationship breakdown in families where a child has an additional need, such as it ‘breaks up a lot’ of couples and ‘unfortunately when you've got disabled child, a lot…are single parents’. In these examples, the intersectionality of factors which can be damaging to mental health and wellbeing are exemplified, with for example, high rates of relationship problems amongst parents who have children with additional needs and as such, lower levels of social support in scenarios where there are greater levels of need.

4.2.2.3 Parent Health and Wellbeing

Across the methods were examples of parents experiencing varying challenges to health and wellbeing. For example, in the survey 9% of parents said that they had a physical health condition, illness or disability that impacted their ability to do things with their children most days or every day, and another 14% did so occasionally. Furthermore, some parents added details in the accompanying free-text box. Responses included chronic health conditions (including long-covid), being partially sighted, and using a wheelchair. However, comments describing the impact of such conditions were limited and also in other methods, mentions of physical health conditions and disabilities were present but rare and as such, there is limited data for meaningful analysis of these challenges. More data were available (and indeed, the main focus of the research) regarding mental health and wellbeing, explored now in more detail.

Within the survey, parents shared diagnoses such as depression, anxiety, PTSD and many spoke about seeking mental health care (Chapter 6). However, most emotive accounts of parent mental illness were shared in the social media analysis. Parents posting to the mental health forum in Mumsnet did so in times of mental distress and used terms to describe their emotional state including struggling, exhausted, broken, empty, overwhelmed, drowning, drained, exhausted, clinging-on, stressed, scared, irritable, impatient, inadequate, terrified, sinking, fragile, confused, engulfed and angry. Specifically, parents with depression talked about lack of energy to engage with children. Parents with anxiety disorders described how anxiety for the welfare of their children ‘triggered’ their condition. A parent diagnosed with personality disorder referred to struggling with the noise and sensory overload of her young child, and there was an account of a parent with bipolar affective disorder engaged in risk-taking behaviours with children. Some parents who had mental health problems before having children, said that having a child when you have a mental health problem is the ‘worst you can do’. Parenting is hard. Parents with mental health problems can take good care of their children, but mental health problems can make it harder.

Some providers and social media posts discussed parents who have experienced trauma. One provider spoke about how abuse in childhood leads to altered brain development and parents being ‘wired [for] fight or flight’. This can make it hard to respond with patience to the everyday challenges in parenthood:

> The child says something, you know, … this will be like woosh [gestures arms reaching out], you know, like a big drama, you know, lots of things are said that are really nasty and hurtful. And then… you're up here [gestures hands in the air] before you know it. And it was over something so small (Sasha, support provider).

Another support provider spoke about the long and complex journey towards recovery that parents who have experienced trauma are faced with, as they try to address their mental health issues and manage demands of parenthood. Access and barriers to support for this process are explored in Chapter 6. There was widespread concern though, that parents who experienced trauma in their own childhoods, may lack protective social supports (Chapter 5) and that they and their children were vulnerable to further harm from a ‘cycle’ of unsafe relationships. Sadly, a number of support providers spoke about high levels of domestic violence and abuse in the communities they worked with and a number of social media posts also described current and historic domestic violence and abuse.

Sometimes, parents and children fled domestic violence and sometimes children were mandatorily removed from parental care if the court deemed the child unsafe to remain. Child removals are an emotive and contentious issue that are beyond the scope of this study to explore in depth but it is recognised as a highly traumatic experience for all involved. Furthermore, what was evident from accounts of both domestic violence and child removals, was that the legacy associated with unsafe household relationships can continue to influence mental health and wellbeing long after physically moving out from that space. Physically ‘moving out’ does not necessarily equate with mentally ‘moving on’.

The anonymous social media posts contained discussions about parents expressing suicidal ideation. As noted above, parents sometimes described children as a reason to keep on living but concerningly, parents also wondered if children would be ‘better off without’ them because of what they described as their perceived failings. This is a worrying turn from love of children motivating help-seeking for mental health, to negative thoughts about capacity as a parent becoming part of suicidal thoughts. There were also situations in which parents said they were ‘waiting’ for children to grow up and leave home, and that they intended to complete suicide at that point. In these situations, parents talked about keeping such thoughts and feelings hidden and it was only the anonymity of the social media platform, that encouraged them to share how they were feeling. These discussions demonstrate how social media analysis can provide insights into hidden thoughts and feelings of importance and provide access to a level of (peer) support considered further in Chapter 5 (5.2.1).

4.3 Homes Spaces and Being at Home

Typically, ‘being at home’ refers to someone physically located at home but *being* is also considered as an emotional experience (Chapter 2) and this dual perspective applies here, considering physical and affective experiences of ’being’ in home spaces.

4.3.1 Feeling at home

Colloquially, ‘feeling at home’ is a synonym for feeling comfortable, accepted, and safe in a space and within this study, there were examples where parents described feeling that way in their home. Indeed, a number of surveyed parents described ‘home’ as a favourite place, and some elaborated with additional details, such as in this quote:

> Home with my wife [is a favourite place] always secure (P5, male, 40-49yrs).

The love of home was tested during pandemic lockdowns but for some, being at home was welcomed. In the survey there were references to having ‘a nice house’ as a mitigation against lockdown stresses and many parents said they valued access to their home garden. The quote below exemplifies a sense of embracing a retreat to the home:

> [My mental health and wellbeing] has improved [in lockdown] not having the pressures to fit into a certain world or keep up with anything or anyone. I personally have enjoyed shutting the door on the world for a bit and just enjoying being me and being with my family (P251, female, 30-39yrs).

Such experiences are interpreted as having potential to enhance mental health and wellbeing by providing the physical space to mentally relax. However, being at home can be challenging.

4.3.2 Behind Closed Doors

Home as a haven becomes problematic if home is considered safe because outside spaces feel unsafe and this was certainly the case during the pandemic when lockdowns kept people at home worldwide. When parents had health conditions that made them clinically vulnerable, they felt particularly unsafe to go out:

> We're shielding, so basically anything outside has been much more difficult to access. It's been difficult to get out and feel safe (P100, male, 40-49yrs).

Being at home was not necessarily experienced positively and was often associated with an unwelcome sense of confinement, with parents feeling ‘suffocated’ and ‘trapped’. Part of this difficulty stemmed from lack of physical space to ‘get away from it all’ because there was ‘all of the family... under one roof all day’. In the survey, 43% of respondents said that they argued with household members more during lockdown and qualitative comments corroborated:

> Very difficult in the second lockdown (Jan-March) with [children] at home. Lots of stress, less sleep and losing temper more at everyone in the house (P105, male, 40-49yrs).

Another surveyed parent said there was ‘pretty much a behaviour argument everyday’ and many in the social media analysis also struggled with child behavioural issues during lockdown. One surveyed parent described how her son slept in her bed during the pandemic, meaning that she was never alone. As in the quote below, no opportunity to really *be* alone, took an emotional toll:

> I have had three episodes where I felt like I just wanted to cry and be on my own to sort my head out, but you can’t be (P270, female, 40-49yrs).

The situation was exacerbated in ‘lockdown three’ because it was winter. During ‘lockdown one’ the UK enjoyed good weather and many people made use of open spaces (although those without private gardens felt this absence keenly). However, ‘the cold wet weather’ of the third lockdown added to the confinement. As one respondent wrote ‘being indoors a lot over winter was difficult’ and another commented, ‘the limitation on what I can do with them, especially in the winter. It makes it much more stressful’.

Physically then, people were ‘stuck’ at home during COVID-19 but also ‘stuck’ metaphorically. They were stuck in relationships that were unfulfilling, stuck with jobs that they could not change, stuck in homes they could not move from, and stuck with COVID restrictions. The feeling of being ‘stuck’ took a toll on mental health and wellbeing. Parents felt ‘irritable and short tempered… worthless and demotivated’. One said they ‘mentally struggled’ and another wrote, ‘feel a bit crazy some days...’. Some parents described mental health conditions as having developed or deteriorated during the lockdowns, including depression, anxiety, PTSD and eating disorders. In addition, parents described physical health as having worsened from ‘too much snacking’ while working from home, drinking more alcohol, and doing less exercise whilst confined inside. Being ‘stuck’ therefore, could impact both physical and mental health and whilst being at home provided a physical space to retreat to, it was not necessarily a space to relax.

As pandemic restrictions eased, many parents were keen to get out but some were hesitant. In the social media analysis, a parent described anxiety of having to ‘face’ things that had been avoided in lockdown. In the survey, one parent said that 'returning to 'normality' has been hardest' and another responded, 'I have had greater anxiety about the easing of restrictions and the return to normal life'. The provider interviews were conducted after UK restrictions ended but some observed an ongoing preference for the safety of home:

> They have... been used to being at home and they're sitting at home. I don't know that, that's what some people are telling me, … Maybe they, maybe they're all happy and being at home, but I don't know, but I don't, don't know if they all are (Ellis, support provider).

Longer term reasons for parents to both 'hide' or feel 'stuck' at home are considered next.

Many parents indicated that parenthood generally required them to spend more time at home than would be desired, sometimes using the term 'stuck at home'. Single parents, particularly those on low-incomes, could feel particularly tied to the home. As one single mother described 'paying for a babysitter to even have an evening to myself is so expensive it's just not possible - it's relentless'. Parents also described feeling restricted to the home when caring for infants and toddlers. For example, one parent said that they were, 'trapped… in the house all day' with a baby and toddler, whilst another said that being 'alone in the house with a baby all day' had been the hardest time. It could be especially hard for parents having problems with mental health, as described by this mother:

> When my son was a baby [was a difficult time]. This was difficult for me as I had postnatal depression and could not face to go out. I sometimes felt nervous about going out just in case I could not cope with him if he cried or got distressed (P59, female, 40-49yrs).

Without negating the challenges of this period (particularly for those experiencing postnatal depression), it is recognised that the desire to 'hide' at home can lessen over time. When children have additional needs however, parents can experience longer term restrictions. One mother wrote a distressed social media post describing how she was 'home alone as usual' with her child with additional needs, in the survey a parent felt ‘trapped’ by a lack of support for her autistic daughter, and a provider noted that ‘when a parent [of a child with additional needs] is in crisis, they can't always leave the house’. Because going out with a child with additional needs can be so difficult, parents may avoid the experience and stay at home:

> And it's easier to stay at home and be calm and cool and. There was one lady came in with her child [with additional needs], he was about, oh three and a bit, and she hadn't taken him out at all into society, not even to the shops. She was sort of like agoraphobic and all sorts of issues because you've taken that long to do it (Nic, support provider).

Furthermore, parents of children with additional needs were impacted heavily by pandemic restrictions. One service provider who is also a parent for a clinically vulnerable child, had 18 weeks in which members of their household did not leave home at all, and described it as ‘just hell’. For many parents then, the positive influence of home as a place of safety is considered with caution if it is the relative safety of home in an unsafe wider world. This situation was not created by COVID-19 but the pandemic may have exacerbated it. There is ongoing concern for the mental health and wellbeing of parents staying home through fear of going out.

Physically hiding at home from external threats has been considered but now the role of the home as ‘hiding’ aspects of a parent’s life that they want to conceal from others is explored. For example, one provider spoke about families trying to hide the additional needs of their child, saying some parents, ‘don't wanna talk about it, they keep it all within house’. It is often the parents’ emotional state that is hidden though but hiding from people you live with is hard. One provider talked about parents living in multi-occupancy housing and having to share spaces with unknown others. More commonly though, parents were trying to hide distress from familial household members. There were descriptions of parents trying (and sometimes struggling) to find private spaces to retreat to, such as the bedroom, bathroom, or even sitting in the car to cry without being seen.

There may be a difference between a parent’s public persona and what would be seen at home. As one provider noted 'you don't know what goes on at home, do you'. Whether it was a hiding a bit of embarrassment about the mess, or something more concerning, issues could be hidden at home until somebody else entered that space. As one support provider noted you 'learn a lot from going into somebody's home' and in some circumstances, needs of the family became more evident from the appearance of home. However, one provider expressed concern that professionals sometimes judge parenting capacity more critically than is warranted, based on the appearance of an unkempt home. Furthermore, another provider described going 'into houses where you think, 'wow, this is this is lovely' but they're still struggling'. These examples appear to express opposite concerns, as in one situation parenting capacity is judged more critically based on a poor impression of the home and in the other, the family's struggles are 'hidden' beneath the appearance of a well-presented home. However, both express caution about misinterpretations of need drawn from impressions of the home. In summary, the home can be revealing and afford the (social or professional) visitor with information about family needs. However, there may be additional strengths or undisclosed difficulties that remain hidden under the home's façade and some support providers warned impressions of the home should not be over conflated with family need.

4.4 'Spending' Time at Home

Time has been an important feature weaving through this chapter. Affective experiences of time at home and the changes that occur in the parent and child relationship over time were examples. In this section, time is considered as a resource, and critically a finite resource, which parents 'spend' each day.

4.4.1 Parent Self-Care and Leisure

Previously we saw how parents value time spent on meaningful relationships. In the survey parents said that they valued 'anything where I have spent time with my children', 'time at home with my [partner]' and 'spending time with friends'. Therefore, time spent with children and others could promote wellbeing when spent on activities of choice and interest with shared enjoyment. We also saw previously that 'me time' mattered to parents. This could be time alone to rest, eat uninterrupted, and even just to go to the bathroom alone. However, ‘me time’ could be active too, with time to pursue interests and hobbies. For example, in the survey, a parent referred to going to the ‘golf course for my own sanity!’ and a support provider talked about the importance of parents making time for self-care:

> Some people need to be told, do you know what, it's alright to go and have a bath for 15 minutes. You know, it's alright to go walk the dog 20 minutes longer than you would normally do it. It's fine (Niya, support provider).

Similarly, posters responding to a distressed parent on Mumsnet, regularly promoted the importance of time spent on self-care and activities of personal fulfilment.

Many parents struggle to find time for themselves, though. In the survey, 44% of respondents said that they ‘rarely’ or ‘never’ had time for themselves and their own interests, with another 32% saying that they only did so ‘occasionally’. Qualitative comments complimented these figures with statements such as ‘[I] don’t get any time to do the things I need to, let alone the things I want to’. Some pressures would have been connected to the pandemic but looking at the qualitative data, it was evident that not all time-pressures were pandemic specific, as illustrated in this quote:

> Mums lack of time and difficulty having opportunity to prioritise looking after themselves. …. Looking after self (and relationship) and developing self, e.g. career come bottom of the heap (P43, female 40-49yrs).

There were comments across the social media analysis and survey about having to prioritise others. As in the quote below, this was not necessarily resented (sometimes it was) but it was significant:

> (I don’t begrudge this because being a mum is the best thing in the world) but I don’t do anything for myself anymore - it’s all about my son, where we socialise, what we do, I don’t buy clothes for myself, I don’t do the sports I used to love, I don’t really spend money on myself for anything (P270, female, 40-49yrs).

Single parents, frequently described lack of time to spend on their own needs, as expressed below:

> Being a single parent means just me relying on me … days when I don't get to have any time to myself! (P233, female, 40-49yrs).

Parents of children with additional needs also described a lack of time. One provider spoke about looking after children with additional needs as being 'so intense' that there is no time for anything else. Time for self-care and personal interests, were scarce for many and this could be damaging for mental health and wellbeing.

Given that parents are typically so busy, it may appear surprising that 26% of surveyed parents felt bored every or most days and another 36% were bored occasionally (Appendix C). However, boredom was not related to a lack of activity *per se*, but insufficient time for free-choice activities. Boredom was exacerbated during the lockdowns and there were multiple comments such as this:

> Everyday feels like ground hog day. It feels like there's nothing to look forward to, we can't plan anything. Weekdays and weekends end up merging into the same thing (P293, female, 30-39yrs).

Once again though, qualitative comments revealed long-standing issues. For example, one parent noted 'I find the daily grind difficult. The boredom and the repetitive nature' and such sentiments were echoed in the social media analysis with discussions about being bored and comments about the 'drudgery' of everyday life, taking a toll on parent mental health and wellbeing, not because parents did not have enough to do, but because they did not have enough time dedicated to activities of self-care and personal fulfilment.

4.4.2 Productivity (paid and unpaid 'work')

As has been seen, parents often felt that time for self-care and leisure was inadequate and so it is no surprise, that they felt a disproportionate amount of time was spent on 'productive' activities, including domestic tasks. Many parents, such as in the quote below, felt that demands to 'keep the house running' detracted from where they would prefer to spend time:

> When at home always feel like I should be achieving something - cooking, cleaning, garden, clearing out, work emails or other work. Makes it hard to enjoy being with kids at home (P43, female, 40-49yrs).

As well as the practical tasks, time was given over to the 'mental load' of managing family life:

> Not having a minute to think about my own needs, pressure as a mum to be 'in control' of all aspects of children's lives for e.g. Remembering all school events and things that are needed, dealing with emails from school, arranging school shoes and uniform- feels like this all falls to me (P41, female, 30-39yrs).

The quote above is an example of comments made by a number of women that domestic responsibilities fell disproportionately to mothers. Another survey respondent commented 'society still seems to accept mums often do bulk of childcare and home chores even if professional career/equivalent working hours'. However, whilst it is recognised that many women described disproportionate levels of responsibility at home, leaving little time for their own needs, it should also be noted that a number of male voices in the research referred to feeling time pressured from domestic responsibilities and some women did comment positively about the domestic responsibilities adopted by a male partner.

For many parents, a significant allocation of time beyond activities of home-life, was in paid employment and/ or study and there could be positive aspects to this. Time at work or study could be fulfilling, even enjoyable and provide a 'break' from home. As one parent noted 'I have always (and still do) want to work'. Indeed, not working also presented challenges. One surveyed parent said, 'I was lonely for quite some time as I gave up work for a while' and in the social media analysis, a group of stay-at-home parents discussed dissatisfaction with their routine. Furthermore, some providers talked about different household habits where there is long-term, maybe even intergenerational, worklessness:

> The norms are that they might stay up really late, you know, they don't go to bed, because it's a non-working household… trying to do visits in the morning is very difficult because they're not up (Sasha, support provider).

In this situation, with long-term unemployment, support providers noted that there were high levels of ‘apathy’, ‘anxiety’ and ‘hopelessness’ amongst parents and that support for change needed to take a long-term approach:

> When they're being pushed into job clubs and things like that, it puts them right back. So we've got families that probably haven't worked for ages and ages and ages and they don't even know how to get out of bed at the right time or what to wear each day. … I think you have to just look at the real basics before you move them on (Terry, support provider).

Work therefore could provide structure and fulfilment. However, the challenges of attempting to ‘balance’ or ‘juggle’ home and work were frequently described, particularly in the survey. 29% of survey respondents were rarely or never satisfied with their work life balance whilst a further 24% were only occasionally happy with the balance. Single parents in particular commented on struggling with this balance, with comments such as ‘work/family balance as a single parent [is difficult]’ and ‘being a single parent and studying full time is a challenge’. However, given the timing of the survey, comments were dominated by the experience of working during lockdowns and so specific focus is given to this extraordinary period next.

Some parents commented that they or a partner were ‘furloughed‘ from work, meaning that they were supported by a UK government scheme to pay their wages despite workplace closures, and that this was helpful in managing home schooling and other domestic activities. Most parents though, continued to work, predominately from home. A minority of parents talked positively about this experience. For example, one said that their health and wellbeing was ‘better, as I have more free time due to working from home’ and another said that now they worked from home they could ‘be around more and keep an eye on schoolwork etc’. Mentioned repeatedly by parents who valued homeworking was an appreciation for not commuting, which previously took ‘time out of the day’. Many did not want to return to previous working arrangements and welcomed the opportunity to integrate employment activities into home spaces.

These positive experiences are recognised but for many more, being a working parent in the pandemic was hard. Parents working from home described being ‘pulled in a number of directions’ but despite best efforts, still felt that they were ‘doing badly at work and parenting at the same time’, as expanded below:

> Feeling extremely overwhelmed and I feel that I have no time to myself as all my time is taken up by either work or childcare (often both at the same time) (P101 female, 30-39yrs).

When parents had young children, there was pressure to ‘entertain’ and ‘distract’ them which interfered with work. For older children, parents were expected to combine their jobs with home-schooling during school closures. Many described the ‘stress of home-schooling’, with terms such as ‘horrible’ and ‘relentless’ and said it led to ‘persistent challenges and arguments’. Many, such as this parent, were exhausted:

> Exhausted while trying to work two jobs and homeschool and study (P27, female, 40-49yrs).

Another parent said lockdown had ‘negatively impacted on my own mental and physical health hugely due to the stress of working from home whilst home schooling’. Overall, it was a tough time for many but for those with added layers of responsibility and pre-existing experiences of inequality, there were specific concerns and once again single parents, parents raising children with additional needs, and parents with their own health needs raised particular difficulties. Indicative quotes from these demographics are shared below:

> Struggle doing all the schoolwork on my own as a single parent as dad doesn’t do any of it (P255, female, 40-49yrs).
>
> Really stressed. Closed schools nightmare, especially with Sen [special education needs] child (P139, female 40-49yrs).
>
> Keeping daughter occupied while working, trying to keep up with her when I am in pain/fatigued (P101, female, 30-39yrs).

When asked in the survey what would promote parent mental health and wellbeing, multiple parents wanted to ‘get kids back to school’.

Variation in home circumstances and resources (for example, if another adult is present to share childcare or not) impacts upon the desirability of working from home but for many employment types, was not an option, such as many keyworker positions and lower paid jobs. During the pandemic keyworkers often maintained employment outside of the home. A minority stated that continuing to work as a keyworker meant minimal change or disruption to their life and some were able to access a school place for their child. Many though, did find it difficult:

> I have had to balance work and childcare/ home schooling without my usual support system for childcare. It has been a very stressful balancing act, not least because me and my husband are both key workers and my workplace were unsupportive with flexible working (P45, female, 30-39yrs).

Some keyworker parents described feelings of guilt and being ‘disheartened’ that they could not home-school their children, one keyworker parent lived separately from their child during lockdown and described this as ‘very difficult’ and many were scared about going into workplaces where they might contract COVID-19. It can be seen therefore, that juggling time between home and work was challenging for those working outside of the home as well.

4.5 Household Finances and Impacts on Mental Health and Wellbeing

4.5.1 Benefits and Pressures for the ‘Financially Secure’

Parents that were financially ‘comfortable’, perhaps even affluent, were described across data sets. A volunteer from a church described the church being ‘right slap bang in a very prosperous area’ and another commented about being in ‘quite an affluent area generally’. A number of social media posters referred to financial security. In the survey, parents described access to financial resources that helped during COVID-19. For example, one parent said that they had not been particularly impacted by pandemic restrictions because they were, 'very fortunate to still have my job… and not to have financial worries'. A well-resourced home environment could also help ease the lockdown pressures with facilities for in-home entertainment such as 'tv/on demand tv, internet - games and zoom'. However, many challenges in life can be experienced by anyone, regardless of financial position. In the quote below, Eden describes working with families that are not typically regarded as 'vulnerable families' (often associated at least in part with poverty), but facing a specific issue:

> Any child can have an additional need, can't they? Any child can suddenly not want to go to school or then being diagnosed as autistic, and that brings with it huge challenges for a family, and that's what we're finding I think more and more. So, you have your vulnerable families that come with one set of challenges. And then you have your others that are less vulnerable, but the situations they find themselves in are also very difficult (Eden, support provider).

Parental mental health problems were also experienced across financial circumstances. In the social media analysis parents struggling with mental health sometimes expressed guilt about feeling that way despite the 'lovely big house' or 'dream holiday' and recognised that others would financially 'love to be in my position'. Financial stress puts huge strain on mental health and wellbeing but financial security does not assure good mental health.

There were some pressures identified, that can be associated with maintaining financial security, such as working in high-income jobs and 'high-pressure jobs' to meet the financial needs of the family. In the social media analysis, some posters spoke about a partner who worked in a well-paid job which provided financial security but compromised family time. Achieving financial security could have a 'cost' related to stress and family wellbeing.

4.5.2 From 'Just About' to 'Not Quite' Coping

There was a common sense that 'money worries' were widely felt. The survey was distributed to a general audience but 27% still worried about money most or every day and a further 42% worried about money occasionally. Although not representative, this sample gives an indication that financial concerns are not only felt by marginalised groups. Support providers said that increasing numbers of families who were previously financially independent were now needing assistance and this was projected to increase with ‘the cost of living going up’.

Some parents have bills paid but little money left over, creating an underlying emotional pressure. For example, parents described working long hours but not having money for clothes, a haircut, or to complete home renovations which led to feelings of frustration, despondency, and worry, which in turn, exerts negative influence over mental health and wellbeing. Restricted budgets impacted what could be spent on children. Providers helped parents with low-cost ideas for home activities made from items found in kitchen cupboards because ‘people don’t have the money’ to buy toys. Another provider spoke about encouraging parents towards home-brand products, whilst others considered access to second-hand goods:

> I mean things like… nearly new sales… And you know, it's not just because people like a shopping opportunity, I think it's because the rising cost of living means that actually people are, you know, really conscious of what they're spending (Toni, support provider).

However, Terry raised an interesting point about second hand goods, referring to it as ‘quite a middle-class option’, making a distinction between those for whom second hand purchased goods are a choice, ‘I can choose to buy second hand clothes and be green’, and parents living in a financial situation in which there are no choices. As explored above, parents want to do their best for children. Therefore, we consider the emotional experience of financially providing for children and whilst many will be happy with second hand goods, home-brand products, and home-made toys, some parents can feel a sense of profound disappointment from not having the choice.

It is said that comparison is the thief of joy and certainly ‘just about coping’ parents could find it challenging to witness other families having greater financial freedom. For example, one working parent said they did not like ‘having children's friends over when we couldn't afford the things they have'. Providers too, spoke about the despondency that can come from being unable to afford the things that you see others enjoy:

> I think that everybody wants to have something new or something like a holiday by, sort of like we want this, want that … to live like that, you need to have a good income and I think a lot of them feel quite low that they haven't got that income (Mic, support provider).

We see therefore, that having 'just enough' can be demoralising and stressful for parents not typically eligible for welfare support, but not earning enough to comfortably meet family needs either. It also means that there is little capacity for financial shocks. These 'shocks' had two forms. Firstly, families faced problems when confronted with an expected expense:

> There's no safety net. So these families are desperately trying… they might have a washing machine or something, if that breaks down there is no safety net (Terry, support provider).

The other reason a family may be tipped into a more vulnerable financial position, is loss of income, either through redundancy or from being unable to work due to the parents' own health or caring responsibilities. For example, when Sam was asked about pressures facing parents the response was:

> I think it's, it's financial would be the biggest one at the minute. There's one or two been made redundant (Sam, support provider).

For some parents, both shocks could happen simultaneously. For example, there are many expenses when having a baby and a job loss at this time can be especially worrying:

> We might have some families that have bought a pram, perhaps and haven't got the rest of it, but their partners lost their job, so they would never normally come to a [charity]. So situations have changed quite drastically. So we're seeing a lot of that (Terry, support provider).

Parenthood can also limit potential earnings. A mother posting in the social media analysis faced financial problems but her working hours were limited by her child's anxiety which meant that she 'never coped with after school' care. A support provider, who worked with parents of children with additional needs, talked about parents having to 'reduce their hours considerably' and also said that 'parents have lost their jobs due to the additional care needs of a child.' The support provider described the fear that parents feel when the phone rings, in case it is the school telling them to come and collect their child, which for a working parent (particularly a socially isolated single parent), is problematic. Once again, parents facing one type of challenge therefore become more vulnerable to additional stressors.

4.5.3 Struggling to Parent Amid Precarious Household Finances

Parents can face significant financial challenges, such as debt and insufficient means to access basic needs for the home and household. Some families have experienced longstanding financial precarity, such as those living in homes where there has been intergenerational worklessness. Others are in working-families not typically regarded as 'vulnerable' families but now face serious financial hardship. For any parent living with high levels of financial insecurity, there are risks to mental health and wellbeing:

> I know you're sort of specifically in mental health, but I think poverty and that goes hand in hand, doesn't it (Terry, support provider).

This section draws primarily on interview data from providers, with supporting data from the social media analysis. The level of severe financial difficulty discussed here was not disclosed by surveyed parents.

Part of the mental strain that comes from financial insecurity is the 'worry work' (section 2.2) of managing everyday tasks without adequate means. As Alex explains, this generates pressure on mental health:

> Because all those [financial pressures] link into heightening mental health and anxiety and 'how, how am I gonna get through tomorrow? How am I gonna feed the children tomorrow? How am I gonna?' It's like that. 'How? How? How? How? How am I going to do this?' (Alex, support provider).

When exploring 'how' parents do respond, these scenarios are not phrased as 'options' or 'choices' because, as Terry stated, 'poverty is not a choice'. What follows then, are presentations of actions described within the data.

Support from welfare payments can help but is not always available. For example, some immigrants have no access to the welfare support:

> There's no recourse to funds. I know what that means. It means there is no money. So they have to have everything [from a charity]. … nothing means nothing (Terry, support provider).

Providers spoke about parents struggling to understand the benefits system and not receiving their entitlements, whilst parents in the social media described barriers to claiming. One parent said her former partner had spent her Universal Credit and now she was left with nothing, demonstrating that even when payments are made, parents can be vulnerable.

One pathway when faced with financial pressure, is debt. Parents buy what is needed on credit or 'on HP [hire purchase] … which usually … you know, high payback'. Many service providers described significant concern about the level of debt that parents are living in:

> People have gotten more into debt and we are seeing some of the women, they do disclose that they say they're in like £10, £15, £20,000 worth of debt. That's what they're disclosing so you can probably add a bit more on that (Terry, support provider).

In the social media analysis, there were a number of postings about debt, from parents who were distressed and sometimes suicidal. Service providers, too, described direct relationships between debt and poor mental health:

> There's a massive thing, with debt at the moment we seem to be as a team, and definitely with me, I've got a couple of families that have got huge debts… there's almost like a direct line between their debt and the parental mental health (Niya, support provider).

In order to manage debt and survive on inadequate means, parents deployed various strategies. One strategy was to sell or pawn possessions:

> We would meet people, mums particularly, that were on their way to pawn their jewellery so they could feed their kids for the summer (Terry, support provider).

However, this strategy is limited. Once there is nothing else to sell or pawn, what then? Buying second-hand could work well, but could also leave parents vulnerable:

> Some of the families will get something on freecycle or they buy something on [Facebook] marketplace and it's broken … So there's that other part where people are trying but actually you know, they're getting ripped off left right and centre because they're vulnerable and, and that adds to their mistrust and to their, you know, the spiralling debts (Terry, support provider).

If an item cannot be purchased or acquired for free, there is the option to 'make do or mend', but this can be unsatisfactory. In two further examples from Terry, one mother attempts to 'make do' and another attempts to 'mend':

Make Do:

> And I said, 'is there anything else that you know, what is there, anything that's challenging at the moment'? [Parent replied] 'Oh I suppose I could do with a new oven, but it's fine, it works. It's just [got] no door on it' (Terry, support provider).

Mend:

> The mum's bed had broken, so she'd gone to the bins and got some cardboard, like large cardboard boxes, put that underneath her mattress …. But that all got damp and mouldy, in her bed was mouldy. She was pregnant, and she had a 2-year-old sleeping in the bed with her (Terry, support provider).

These scenarios are unsafe. We see therefore, that parents and children are at risk as well from lack of financial resources.

Finally, financial concerns can reach a point at which housing is at risk and parents do become homeless. Indeed, there were social media posts from parents describing homelessness and risk of homelessness. These scenarios generated high levels of stress on parents and also profound sadness, at not being able to provide a safe and stable home for their children. This is a sad but important point on which to conclude this chapter. Having a 'home' is not a given for all families, access to this space can be under threat. In the social media analysis and particularly from the provider interviews, it was evident that many families are facing dire financial circumstances exacting immense pressure on mental health.

4.6 Conclusion

Data for the 'Home and Household' chapter was complimentary (see Chapter 3). It was not convergent as the data sets revealed different insights. For example, suicidal ideation and parenthood was raised only in social media analysis. It was also the case that different data sets contributed different amounts of data, such as the enjoyment of parenthood was expressed most clearly in the survey, and provider interviews gave greatest insight into parents living in poverty. However, all data sets spoke of the importance of the home space and household relationships on parent mental health and wellbeing, concurring with established literature (section 2.2) and extending insights, for example in how parents exchange peer support for mental health issues online (including but also beyond the perinatal period) and experiences of home during the pandemic (discussed further in Chapter 7). All data identified issues about pressures on parent time and lack of opportunities for time to be spent on self-care, and all data sets highlighted the widespread nature of financial concern within households and the risks generated by lack of adequate access to monetary resources (see also, sections 1.2.2, 2.2). Finally, all data sets showed that experience of these issues are felt unequally with certain demographics at greater risk than others, particularly parents in the perinatal period, single parents, parents with mental health problems, and parents of children with additional needs, considered alongside literature in Chapter 7. It is vital to recognise and respond to these varying contexts of home-life in order to promote parent health and wellbeing beyond the COVID-19 pandemic and into new ways of living, working, and caring at home.

Chapter 5 Communities of Support

5.1 Introduction

This research draws on the proverb ‘it takes a village to raise a child’ (section 1.3), critically exploring the people and places of the ‘village’, access, and inequalities to support and impacts upon parent mental health and wellbeing from different elements of the theoretical village’s support. The previous chapter explored how the environment of home, the relationships and activities that are enacted there, and the emotional experiences of these influences, impact upon parent mental health. Attention now moves beyond the home, to consider informal extended-family and friendship relationships and (physical and online) spaces of ‘community’. In this chapter, the interest in time and money flow through the themes rather than providing demarcations but were still key in building a picture of community engagement, the influences on mental health and wellbeing, and various layers of inequality (section 3.6.2). Resources of space and relationship were developed more overtly but overlap significantly in the enmeshed connection of people and their environment. This chapter does not focus on facilitated groups or organisations, such as stay-and-play groups, support groups, or healthcare services, as these are considered in Chapter 6. Instead, attention is directed towards informal and unstructured community engagement, differences in access perceived and experienced by different demographic groups, and the potential impacts on parent mental health and wellbeing from interacting with and in, ‘community’. Themes from this chapter will be revisited in Chapter 7 (the Discussion) where they shall be integrated with wider literature and themes identified in other findings chapters. Data is drawn from the social media analysis, parent survey, and provider interviews.

5.2 People and Places Creating Positive Communities

5.2.1 Parent Perceptions of Community Support

Across the data sets, parents and support providers sometimes expressed the viewpoint that ‘the village’ has dispersed and parents lack social support. That can be the case, as explored later (section 5.4.1.2). However, many parents do receive informal social support. In the survey 66% of parents agreed or strongly agreed that they were happy with their social support, and 71% agreed or strongly agreed that they had made good friends with other parents (Appendix C). These were surprisingly high figures in the context of widespread difficulties with social support detailed later (section 5.4) but show that there are people well supported socially. In the social media analysis, some posters described support from parents, grandparents, siblings, and in-laws. Indicative examples from the parent survey and support provider interviews, are shared below:

> We’ve had some minimal support from my parents, and (after [COVID-19] vaccination) lots from wife’s parents. We’ve been in a support bubble with them (P70, male, 30-39yrs).

> There's one family and there’s Great Granny, Granny, Daughter and, and two children. There's 4, 4 generations come and they often all come together (Sam, support provider).

Support from grandparents was emotional and practical (‘they are often the childcare‘) with potential to support parent mental health and wellbeing by reducing financial burdens of childcare and (where the relationship is supportive) giving parents confidence their child is under the care of a loving relative. One provider spoke about a grandmother who had moved in to support her daughter who was a new parent and had an alcohol addiction, whilst another said that teenage mums were often accompanied by their own mum. In addition, many survey participants said they would speak to family if they needed mental health support.

There is an expression that ‘friends are the family we choose for ourselves’ and in some situations, respondents ‘built’ a new village of support with a partner and/ or friendships. For example, one interviewee commented ‘they [my friends] are my family’, a Mumsnet poster described relying ‘heavily on friends’ as family were not close-by, and a surveyed parent wrote ‘I have a fantastic husband. Shit family but great friends!’. Indeed, when asked about seeking mental health support, many survey respondents said they would speak to friends or colleagues and many described time with friends as a favourite aspect of parenthood. The quote below encapsulates some of the temporal changes and different places of parent-friendships which offer support and as such, can positively influence mental health and wellbeing:

> When my children were small, meeting in small groups with other parents and their similarly aged children in people's homes, community centres or parks. My children are older teenagers so now I value online forums and my real-life friends as sources of support and advice (P123, female, 40-49yrs).

In the social media analysis, responding posters frequently encouraged the (distressed) original poster to speak to 'real-life' friends and during interviews, many support providers described a key goal of their offering as being to help parents build friendships and a sense of community, as described below:

> We're trying to build community so that they've got peer support so that they don't always need to rely on someone like us or a, a professional, they can support each other (Eden, support provider).

The work of services to facilitate peer support is returned to and explored in Chapter 6. The focus here remains on informal relationships and, as considered next, the elements that contribute towards these relationships being a supportive resource for parent mental health and wellbeing.

A key attribute of valued relationships was when a parent could be emotionally 'honest'. In the previous chapter, parents hiding emotional distress was discussed but it was considered a special relationship where parents could be open with others:

> I feel best when I spend time with friends with similar parenting stresses/same juggles in life and those who are honest about their experiences. When I am with 'my tribe' of parents it's acceptable for us to admit life is tough, being a parent is a struggle sometimes and just that in itself helps you realise you're not alone in this. And that makes me feel normal! (P141, female, 30-39yrs).

Many parents spoke about how hard it can be to share emotional distress but sometimes, the risk is rewarded by increased support and a realisation that other parents are having similar experiences. For example, a surveyed parent described how they ‘reached out’ to friends to say they were struggling to cope during the pandemic and their friends told them that they had experienced ‘similar crisis points’. In the social media analysis, some told their friends about a diagnosis of depression and were surprised to discover that others had also had mental health issues. In these situations, parents are emotionally vulnerable as they make disclosures about mental health issues and, as we explore next, are not always met with support. However, where they are heard, validated, and realise that others face similar challenges, it can provide reassurance and comradery.

5.2.2 Valued Community Spaces

In the previous chapter, some parents stayed home because it was preferable to going out (section 4.3.2), but sometimes the reverse was true, and parents wanted to be ‘out’ to avoid being at home. One surveyed parent noted, ‘once we are out the house it's always better’ and another talked about going out to ‘avoid tantrums at home’. Enjoyment in community spaces was described positively for parent wellbeing and in the social media analysis several posts promoted the benefits of ‘getting out’ for parents experiencing mental health problems. Data for this section was drawn largely (although not exclusively) from the survey as this was the method that captured the most ‘positive’ responses from parents’ own accounts.

What parents look for in a community space changes over time. For example, some mothers of infants want a space to breastfeed comfortably. One of the support providers spoke about an initiative where local business displayed signs to indicate that they were ‘breastfeeding friendly’, which was described as well received. Parents of young children want safe places for children to play, such as ‘soft-plays’, ‘play-centres’, and ‘farm-zoos’. This was both to share enjoyment with children but also to meet with other parent-friends in an environment perceived to be safe:

> When children were younger meeting with friends with kids at soft play centres. Bit of time to self knowing kids were safe (P31, female, 40-49yrs).

Parks and playgrounds were popular with parents and younger children. For example, one survey-parent said, 'I've loved going to the playground and park with the kids as it makes us all happy!'. However, spaces did not need to be designed primarily for children to be valued. In the wider natural environment parents spoke of 'puddle splashing', finding fossils and sharing 'love of the outside world' with younger children. Parents could also enjoy general hospitality spaces such as coffee shops with friends and small children, provided the venue was 'kid-friendly'. Although the term was not well defined in the survey data in which it appeared, I explore 'unfriendly' spaces later and from that deduce, a preference for spaces where the noise and activity typical of children was accommodated without perceptions of critical social judgement.

As children grew, there was less focus on dedicated child-spaces and more interest in generic venues. Many parents commented on places that they would go with children 'now they are older', enjoying shopping, eating out, and a variety of cultural and tourism sites with their children:

> Now they are older coffee shops are good and places to visit like National Trust parks for a day out or the zoo. They also love a day at IKEA! (P272, female, 40-49yrs).

The natural environment retained importance but activities, such as walking, running, or cycling. Parents felt getting out into these spaces helped strengthen family relationships:

> Being in the outdoors with my children. It's where we are most relaxed. I feel we can talk better in the outdoors (P32, female, 30-39yrs).

During the pandemic access to green space was especially important. Parents who had accessible green space spoke about how 'having countryside and open spaces on our doorstep has been helpful' and the value of being able to go 'out walking in nature, acting as a release from being confined to the house'. Whether alone or as a family, utilising natural spaces was often described positively for wellbeing.

In order to enjoy these spaces, parents need to be able to physically access them. It was widely reported that when travelling with young children, shorter journey times are welcome. Parents appreciated spaces that were a ‘short drive’, an ‘easy walk’, or even just ‘behind the house’. In the survey data, a majority of parents described good access to community spaces prior to COVID-19. Less than 10% said that it was difficult for them to access places like shops or the GP, and 81% agreed or strongly agreed that they had easy access to natural spaces and felt safe accessing them. Not all parents enjoyed good access, but those barriers are explored later.

Many activities identified above incur financial cost, particularly hospitality and tourism venues. Green space may be accessed for ‘free’ if local enough and families have the personal capacity to reach it, and also enjoy it without additional expenditure. However, greater financial freedom allows choice in access to community spaces, reminiscent of links between choice and financial (in)security presented previously (section 4.5.2), as in this example:

> We're quite an affluent area generally … Sometimes people just think well, I don't need to go there [an organised group] for a coffee or whatever, I think I'll go to the garden centre (Ellis, support provider).

Financial means is not the only factor to enable good community access, but it helps.

The technological environment is significant site of community for many parents. Connecting via technology can allow flexible social contact:

> Online. That's where my friends are. We all work and have children. It's the one place we can share and talk (P289, female, 40-49yrs).

Parents used a variety of means to maintain and develop social connections, including phone calls, video calls, online groups, messaging, and social media. For example, in the short quote below a parent describes three different mediums:

> A small private group on Facebook that includes mums with babies born at the same time as my daughter. Text conversations with friends who are also mothers. Face time with family members (P25, female, 30-39yrs).

There are layers of privacy and openness in virtual communication. A text conversation may only involve two people but a private Facebook group, WhatsApp group, or similar, can accommodate more. However, these platforms still have a degree of privacy. By contrast, the site of the social media analysis, Mumsnet, hosts a forum that can be viewed by anyone with an internet connection (although you do need to be a member to post). Technology allows parents to build community with others anywhere in the world, anonymously if they chose, and perhaps based around a common need or interest. One surveyed parent said they valued an 'online support forum for my autistic daughter' and another said, 'online support has been a lifesaver, single parent groups where people share similar experiences'. Once again, we see the value placed on social relationships with other parents who understand and are supportive.

An advantage of online forums is that they encourage the formation of anonymous communities which allow for a different type of communication. In this study, original posters sought support and advice about their mental health, to ask what was 'normal', how others coped and what to do about parenting, partners, medication, therapy, work, money, and discussing mental illness with children. Many commented that they could only ask these questions in the forum because of the anonymity and could not speak to anyone in 'real life', either through fear of judgement or because they had no one to talk to (both explored in more depth later in the chapter). In the majority of threads parents received one or more sympathetic reply, demonstrating the site regularly provided an avenue of support. Sometimes, the original poster returned to thank responders for their advice, and even share examples of actions that they had taken in response to the suggestions, such as making an appointment to see the GP. Therefore, although the support was 'virtual', the impacts could be real. This was particularly important during the pandemic, when physical sites of connection were closed but for those with access, virtual spaces of community remained accessible.

5.3 Interrupted Community

There were situations in which access to community spaces and connection with social supports suffered temporary interruption. For example, (see 4.3.2) the variable weather of the UK could interrupt access to parks, playgrounds, and natural spaces in winter or with rainy days. Hospitality and tourism venues have hours of opening and closure, not necessarily aligned with times when a parent most needs to ‘get out’, and online social interaction is inherently reliant on technology which can fail. Social supports can be temporarily disrupted with holidays, illness, or absence from work during parental leave, examples of which were shared across methods. However, the lifestyle restrictions and closures of the COVID-19 pandemic interrupted community to extents that could barely have been imagined previously and as such, provide the most striking representation of temporary losses in access to community spaces and relationships. This unique period, and what it revealed about longer-term considerations, is explored below.

During COVID-19, the temporary closures of community spaces and lockdown restrictions severely limited access to physical environments beyond the home. For context, 71% of surveyed parents agreed or strongly agreed that the pandemic disrupted places that they would usually go for support and in a separate question, 39% found it hard to cope with the changes brought about by COVID-19 most or every day and a further 50% did so occasionally (Appendix C). Parents frequently spoke of missing hospitality, sporting, and leisure venues for time by themselves (for example, the gym), with friends (for example, coffee shops) or with children (for example, soft-play centres). Even access to outdoor spaces was restricted. As one parent noted ‘during covid: playgrounds [are difficult to access]- most of the equipment has been removed!’. When travelling beyond a certain distance from one’s home was prohibited, those without local access to green were no longer able to enjoy being in nature. Given the importance placed on such access we see another unequal impact of the pandemic experience. Parents described negative impact on their mental health and wellbeing from the ‘loss of being out coping mechanism’ and lost access to these important spaces, as exemplified in a typical response below:

> Very limited as to where we could go. We are a very active family and take our son out as much as possible. So COVID affected us quite a lot (P59, female, 40-49yrs).

During the pandemic the flexibility to shop strategically was limited by closures of some shops and travel restrictions, which as noted below, was particularly difficult for low-income families:

> I think there certainly seems to be the impact of the pandemic, for sure, because especially all the shops were closed and when you've got not much money…. That was, you know, so the lower cost items in shops that were closed. So the families that probably were almost coping and where able to do things, that was nigh on impossible (Terry, service provider).

Added financial strain from temporary closures could therefore, add pressure on the mental health and wellbeing of families struggling financially (section 4.5). Some community places could still be accessed during lockdowns, and at times, these were welcomed:

> Boring places like supermarkets and the Post Office which have seemed like an anchor to normality (P78, male, 40-49yrs).

Many parents did not feel safe to go into the community though, because of 'fear about going out /seeing people, constant worry about catching or passing on COVID'. On public transport people were exposed to greater risk of contracting COVID-19 than they would be in a private vehicle which created an additional concern for those without a car. For example, a surveyed parent described 'extra stress about going out and travelling on public transport' during COVID-19 and so she and her child stayed at home even more. Furthermore, there were new challenges to accessing these remaining spaces. A single mother in the social media analysis described disapproval from fellow shoppers for her young child accompanying her when people were told to shop alone, but she did not have anyone to leave the child with. This example brings us to the issue of interrupted social support.

The social media analysis (partly capturing UK 'lockdown one') and the survey data ('lockdown three') included many accounts of interruptions in social support related to the pandemic, with parents' accounts of people they would 'usually' be seeing. There were multiple comments such as this:

> [Lockdown] increased my stress slightly as I normally would have more me time - the children used to spend a long weekend or school holidays with their grandparents (P58, female, 40-49yrs).

Parents found this disconnection from social support networks highly problematic and it was frequently described as one of the worst aspects of lockdown. It was particularly hard for new parents who often described loneliness and isolation (longer term experiences of loneliness and isolation explored later in the chapter). As one parent wrote 'not being able to see family and friends has impacted on my wellbeing as a new parent', and on Mumsnet, a new mother posted that whilst she had expected maternity leave to be somewhat lonely, she thought she would have family support but was denied by COVID-19. Below, a provider talks about the isolation and loneliness of parents with 'lockdown babies' (babies born during the COVID-19 restrictions):

> People were in isolation. Lockdown babies were being born, and no interaction. Parents were very isolated and a lot of mental health [problems] (Mic, support provider).

Single parents and parents raising children with additional needs were also vulnerable to the loss of extended support during the pandemic and some found this intensely lonely. Once again, COVID-19 lockdowns exacerbated pre-existing vulnerabilities, demonstrating unequal impacts of the pandemic, with the temporary interruptions felt particularly keenly by certain groups.

In the examples above, we see distressing interruptions to how people 'usually' accessed the community and social relationships. These interruptions took a toll on parents and many accounts, particularly in the social media analysis, described high levels of distress. However, for some parents a return to previous levels of community support and access would have brought a reduction in pressure on mental health and wellbeing. The ongoing value from these insights though, was the way in which such experiences highlight the importance placed on usually being able to access safe and welcoming community places and relationships. The importance of everyday experiences like getting out, meeting friends, and visiting places in the community may appear so mundane that the relevance in supporting good mental health and wellbeing could be overlooked. However, the temporary absence of these resources made their significance more visible, which in turn, raises concern for those facing longer-term barriers. Therefore, greater attention is now focused on long-standing issues of community engagement and as such, chronic stress on mental health and wellbeing.

5.4 Hostile Environments

5.4.1 Challenges in Community Relationships

5.4.1.1 Negative Support

The concept of 'negative support' was introduced in section 2.3.2.1 and refers to social contacts which rather than supporting mental health and wellbeing, become a stressor. For example, in the quote below, a support provider gives an example of the sorts of situations that they hear parents describe:

> 'My neighbour, I tell her stuff and then she tells everybody, and then I go to the school playground and people are like calling me names saying, you know, they know my business and so and so will have a to go at me' (Sasha, support provider).

A Mumsnet poster described 'pushy' in-laws, and another said a former friend only made 'negative' comments about her children, whilst a surveyed parent 'didn't appreciate unsolicited advice' from others when trying to address her child's behavioural issue. Providers noted that sometimes parents had involvement from friends or extended family that was 'not positive' for the parent's wellbeing. In the social media analysis, one parent described being told to 'pull yourself together' by a family member when they asked for emotional support. It can be seen therefore, that many parents were disappointed in the quality of their social support.

An example of this negative ‘support’ that was mentioned often, was for parents with children who had additional needs. In one example, a distressed mother was told by another Mumsnet poster that she should have predicted the response of her (possibly) autistic son to a crowded environment and not taken him there. In an interview, a support provider working with families where children have additional needs gave this appraisal of the criticism that many parents experience from their own parents:

> The older generation don't seem to understand [neurodiverse] children. Or they don't want to know. They just want those nice quiet diddy ones that do as they’re told (Robin, support provider).

In these situations, the ‘support’ may be well intentioned, but not well received. Furthermore, as well as feeling judged for difficulties, parents felt unrecognised for efforts made by themselves and their children, to help things get better. One provider commented that parents of children with additional needs ‘don't get enough praise’ and a Mumsnet poster was sad that improvements made by her son were not acknowledged, and others only ‘chose to see’ his difficulties. Lack of understanding was common.

5.4.1.2 Experiences of Loneliness and Social Isolation

In the survey, 25% of surveyed parents felt lonely most or every day and another 44% were lonely occasionally (Appendix C). These figures are alarming *but* the survey was launched during a national lockdown. What is not known is how many parents were feeling lonely because of the lockdown and how many experienced chronic loneliness. The qualitative data from across methods is useful to explore this. As noted already, many did comment about loneliness in relation to the pandemic (section 5.3) but others stated that the pandemic exacerbated an issue rather than created it. For example, a parent wrote ‘I feel even more isolated, lonely and helpless than I did pre covid’ and another said that although lockdown was hard, at least they no longer felt like ‘the only person without a social network’. The social media analysis had multiple posts from parents expressing chronic loneliness. Parents frequently said that they were posting because they had ‘no one to turn to’, no one else ‘to say it to’ and ‘no friends at all’. Although there was comfort from online support, it did not remove the loneliness many felt from a lack of in-person social contact, which was described as 'the worst feeling in the world'. Ongoing concerns about parent loneliness and isolation were also raised during interviews. It is evident therefore, that loneliness and social isolation amongst parents were not restricted to the pandemic and as such, longer-term issues contributing towards these issues are explored next.

A person can feel subjectively lonely even when with other people (section 2.3.2.2). This is often associated with feeling like they 'don't fit in' and heightened by a perception that other people are more socially comfortable and have more friends that they do:

> Yes, I think loneliness can happen whenever, whatever's going on in life, you can have, you know, people all around you, and you can still feel lonely... But yeah, a lot of people are lonely (Mic, support provider).

Parents described feeling lonely with other people in places like the school-gate, soft-play centre, and at parent groups, where the presence of other people but absence of a connection, created a sense of loneliness.

For many parents though, there were problems of social isolation. One risk for isolation, is that of parents who move to a new area in which they don't know anyone. Changing societal norms mean many parents 'tend to … live far from family' and friends too, may be 'country-wide' and not local. Parents are then vulnerable to isolation, and in turn, loneliness:

> Some of these women are isolated, they have nobody, you know, like I think the whole ethos of the family has changed … you know the extended family that used to be around years ago and you know aunty lived next door, nan was across the road, that's all changed… some of the families have got nobody, got no one around, they're isolated (Terry, support provider).

In the survey, 60% of parents were not living in the area where they themselves had grown up (section 3.5.2.3). Some 'everyday' reasons to move were shared in the social media analysis, such as moving to a new area for a partner, or job, or their partners' job. Providers also spoke about the frequent moves made by military families. However, other reasons for moving were also addressed. The breakdown in a relationship with a partner was a common reason to move, sometimes in the context of domestic violence. When a parent leaves a domestically abusive relationship, they may flee to a different area but although this moves them from the abuser it can also remove them from any pre-existing supportive relationships:

> We've got [refuge] here. It's our emergency housing unit …. And we have parents in there that were just popped into [location] away from their abuser. Don't know anybody (Riley, support provider).

Other providers spoke about the needs of refugees and asylum seekers, away from their country of origin and previous supports, leaving them vulnerable to isolation and loneliness. Although emotional support could be given via technology and this was appreciated, a lack of in-person contact was still problematic, as evidenced during the pandemic when almost all social contacts were virtual and people still felt lonely (section 5.3). Whether by choice or necessity, parents felt that their social connections were often geographically 'scattered' and the lack of local support left them feeling lonely.

Moving to a new area does not necessarily result in isolation if the place that is being moved to provides connection with a new community. However, parents and providers were concerned about a lack of community cohesion, as described below:

> We don't have community anymore. Because it doesn't exist anymore. Yeah. And in the socially deprived areas, years ago, you used to have the older women used to look after the younger women and if someone didn't have sugar, someone else gave sugar. It's not like that anymore. There is no, NO sense of community whatsoever. If people go in, they shut their door. They don't think about it. They don't talk about anything. But there's no community sort of spirit (Alex, support provider).

In many neighbourhoods, people do not know each other, so although they live in the same vicinity, do not form a social community or metaphorical 'village', restricting the availability of local support for parents. One provider commented ‘although I lived in [location] for a number of years, … I didn't know many people in the area’ and another noted ‘we probably don't really talk to our neighbours very much, do we?’. Lack of social connection in ones’ area can be a problem for anyone, but for parents there is also the loss of emotional and practical support with child rearing. In keeping with the framework of this research, one surveyed parent noted ‘society doesn’t have the same ‘raised by the village’ ethos anymore’ and so as well as feeling lonely socially, parents can feel alone with the responsibility of caring for children.

There were some circumstances in which the risks of loneliness and social isolation were heightened and one of those, was the perinatal period even outside of the pandemic. Some surveyed parents reflected back about ‘isolation in the early years’, remembering the perinatal period as an ‘exhausting and lonely time’. There were similar comments from the social media analysis. One mum in the perinatal period said that she ‘had never been so lonely’. It is a time in which parents may find it harder to meet with established social contacts such as friends and colleagues but, can also feel insecure about establishing new relationships. Becoming a parent is a huge transition and as explored previously, many parents can feel anxious about how they are managing (sections 2.3.2.3 and 4.2.2.1). Making new friends at this time of vulnerability can be hard. The separation from previous contacts and hesitation to build new friendships, compounds the risk of loneliness.

Single parents often described loneliness and isolation. For example, one said that the hardest aspect of parenthood was ‘isolation (am a single parent)’ and another said ‘being a single parent with limited support’ was difficult. Issues included lack of childcare and money, impeding them from seeing social contacts. In the social media analysis, a single parent described feeling particularly lonely in the evenings after children were in bed, without someone at home to ‘snuggle up with’ and without the opportunity to go out and see friends.

Another group of parents where loneliness and isolation were regularly discussed was parents raising children with additional needs. There were social media posts in which parents expressed the loneliness of caring for a child with additional needs, described as 'hard and lonely place'. The issue was also picked up in the survey. For example, one parent commented what was hard about parenthood was 'isolation, not enough… places to go for children with ASD [autistic spectrum disorder]' and another said that they felt 'isolated and trapped' by a lack of support for their autistic child. It was a topic discussed by a number of providers in interview as well. One described it as 'a lonely world' for parents of children with additional needs and another said parents were 'lost and alone' until they find peer support.

For parents with a mental health condition there was a cyclical nature to experiences of loneliness, social isolation, and their mental distress. As noted above, many parents posting in the social media analysis described intense feelings of loneliness. Some commented that their friends were too busy to support them or they did not want to 'lumber' friends with their concerns. Others said that they did not have friends and were isolated but lacked confidence to pursue social relationships because of their poor mental state. Parents were fearful that others would judge them harshly and therefore, avoided social contact but this increased loneliness and social isolation which again, compounded the negative impacts on their mental health and wellbeing.

5.4.2 Unsafe and Inaccessible Spaces

5.4.2.1 Challenges to Accessing Physical Community Spaces

One of the issues exaggerating loneliness and social isolation was a fear of going out. On occasions, parents felt fearful for themselves and/ or their children in public areas, such as in this quote:

> Parks - before and during Covid not felt safe (either because of strangers or risk of contracting virus during pandemic) (P233, female, 40-49yrs).

Another parent spoke of concern about being able to 'protect my son' at the playground and in the social media analysis, a parent had someone attempt to steal their bag in a park. Natural spaces could feel unsafe but so too, could urban spaces. In the social media analysis, there were references to being robbed and service providers talked about risks to parents and children living in areas of high deprivation with high criminality. In the survey 92% felt safe in the area where they lived, but qualitative data from across the methods gave examples of feeling unsafe which adds an important caveat to this statistic. When parents feel physically unsafe accessing community spaces, they are less likely to do so, adding to risks of isolation and further pressure on mental health.

A barrier to accessing physical community spaces is lack of transport. One surveyed parent noted it was difficult to get to 'anything that you have to drive to and I live in an area where you have to drive everywhere' whilst another said that they felt guilty that their children had 'missed out' because they did not have a car and it was 'impossible' to take them to activities. Providers too, were that it was advantageous for parents to be able to access supports within walking distance, or with good public transport links. Lack of access to transport is not necessarily associated with lack of financial means, but it can be. As well as not being able to afford a car, managing petrol costs were a concern. However, sometimes it is the families struggling financially, that require a higher level of community mobility, to enable them to shop strategically for lower-cost items:

> And then you go in and out and then you're going from Tesco's to Aldi's to Lidl's, 'cause you're trying to find the cheapest option (Alex, support provider).

Engagement in community when money is tight is driven more by necessity than choice, taking time, mental effort, and potentially more financial outlay, to navigate.

Access to community spaces could be difficult because of disability, neurodivergence, physical health, or mental health condition. This could be because of the needs of a parent. For example, in the social media analysis parents talked about community spaces, such as supermarkets, as stimulating anxiety for them. It could also be that the needs of the child influenced access, as in this quote:

> My son has ASD [Autistic Spectrum Disorders] so there are many public places that are less accessible. Busy shops etc. (P29, female, 40-49yrs).

The majority of comments about accessing the community with additional needs though, related to feeling unwelcome in that space, rather than not being able to access it because of the physical environment. Consideration moves on therefore, to consider social barriers to accessing physical spaces.

The activities and behaviours typical of childcare were not always socially sanctioned in public, creating problems for parents. For example, in the quote below, a provider explains how new mums describe breastfeeding away from home:

> In the community they're a little bit less confident or they have people judging them. I've had experiences where I've had parents say to me or 'we don't feel like we can do that [breastfeed] because we feel like we're being watched…' (Lesley, support provider).

Hospitality venues were frequently referenced as places where parents experienced social discomfort. One surveyed parent wrote they did not like 'some… cafes due to being made to feel unwelcome by other customers' and another said, 'in a pub/restaurant that maybe isn't child friendly.' Shopping was mentioned frequently, whether for specific tasks, like 'shopping for clothes/ shoes', or commonly, supermarkets. Children being noisy, boisterous, or (most feared of all) having a tantrum, could lead to parents feeling embarrassed and judged in public places. Even babies crying, which all babies do, caused parents to worry about what other people would think of them as a parent. Indeed, challenges with babies and toddlers led some parents to move to online shopping (identified in social media analysis) and therefore, avoid going into supermarkets. Although in one regard this addressed the issue, it did so only by removing access to a community venue.

The worry that parents felt about how they would be judged in public was significant. In the survey 19% of parents agreed or strongly agreed that they avoided or dreaded going to places due to worry about what people would think about them or their children which, although a minority, is still nearly 1 in 5 from a convenience sample of n=259. Furthermore, qualitative comments from across all methods identified a concern about feeling unwelcome in community spaces. Frequently, this related to fears of being judged. In the survey parents described 'fear of being judged by other people about parenting', 'judgement from others regarding my parental choices', and dealing with 'others judgements'. In the social media analysis, parents described feeling judged by extended family, friends, strangers, service providers (explored more in Chapter 6) and even other Mumsnet posters (expanded in section 5.4.2.2). The providers also noted that, 'parents feel a lot like they are being judged for how they parent' and carry a 'worry of being judged' when in public. Judgement was a dominant concern which influenced not only how parents felt, but the ways in which they accessed (or avoided) community spaces.

When children had additional needs, parents often described feeling judged in public, particularly hospitality and retail venues. For example, in the social media analysis, a mother described a difficult visit to a coffee shop with her child with additional needs. She believed other customers were looking at them with disgust as the child had a 'meltdown', and so she went home in distress. A number of surveyed parents had similar comments, with one indicative account shared below:

> Shopping with autistic daughter - I cannot control what she may say and clearly I am judged by others if she has an abusive outburst, there is a lack of understanding (P82, female, 40-49rs).

One of the providers had worked with children with special educational needs over many decades and remembered being denied entry into community venues with the children in the past, with people saying, 'you can't come in here with THEM'. This provider said the situation had improved somewhat, in that explicit stigma is rare now, but more subtle forms of stigma still exist. Members of the public think, and perhaps say, 'can't you control that child' and other parents 'cuddle their [own] children away'. Indeed, another provider said 'having a child with autism you're always parenting on show. People are always watching'. In the social media, survey, and interview data there were examples in which parents of children with additional needs stopped aspects of community access because of feeling judged in public. There can therefore be a dual impact on parent mental health and wellbeing from the emotional distress at feeling judged and the increased isolation resulting from an avoidance of community spaces and social contacts.

Parents with a mental health condition were another group of parents highly concerned about being judged. Stigma towards parents with mental illness was widely discussed in the social media analysis and also mentioned in the survey, with parents concerned about negative comments from extended family and wider society. However, the greatest concern from parents with a mental health condition related to judgement from professionals and support services. Therefore, this issue is explored in depth in the subsequent chapter.

5.4.2.2 Virtual Spaces and Social Messaging

Finances can create barriers for technology-mediated engagement. Sam described trying to keep in touch with a father whose phone service was frequently cut off from unpaid bills. In the quote below, a support provider describes parents' avoiding forms of communication through which creditors may make contact:

> And it's been really difficult to engage, to get them [parents] to answer their emails, get them to answer their mobiles, because they are being chased by bailiffs and everything (Terry, support provider).

We see therefore, that financial pressure can inhibit access to technology mediated spaces but in addition to financial constraints, there can be other barriers too. Although in the survey, the majority reported good access to the internet (99%), the survey was distributed online and of course, the social media analysis also captured data from people with internet access. Provider interviews could give more background into why some parents lacked digital access, as below:

> One mum came in. She's like 'I don't know how to use it [social media]'… But some don't want it…. some people aren't on Facebook, cause maybe they had a previous awful relationship and don't wanna be on there. Some .. maybe on child protection procedures, you know, and can't have. You know, there's lots of reasons (Riley, support provider).

Some parents may not lack digital access generally but excluded from certain virtual sites. For example, groups may limit access to members, such as closed Facebook site for parents of children with additional needs or a WhatsApp group for dads only. Setting limits on membership could help members to feel safer and build community, which is positive, but it is also acknowledged as creating a barrier for others. There can be many barriers to digital access, literacy, and/ or, acceptance.

A difficult barrier to mitigate in online support, are the negative experiences of critical interactions that are virtual in nature but real in impact upon mental health and wellbeing. In the survey a parent commented 'social networking sites like Facebook can be stressful with polarised opinions and name calling'. In the social media analysis, where we remember that people posted anonymously on Mumsnet, there were also critical responses. Furthermore, criticism was not just directed towards the original poster (OP) but between respondents, with comments such as 'do you honestly think [that was helpful]' or 'I hate responses like this', to express displeasure at the comments of others. Interestingly, when a poster described themselves as female and having problems with her own mental health, there was typically sympathy expressed towards her, reassurance that the children would not be adversely impacted, and sometimes anger at perceptions of inadequate support from a male partner. However, when female OPs posted about a male partners' mental health problems, there were angry comments about how he was treating her and the children, and the OP was advised it was harmful for their children to stay. On occasions, these posts were very critical of the original poster. There were exceptions to this dichotomy, but it was a pattern repeated often, with the potential for such responses to damage trust in the forum as a source of support and even deter future help-seeking from the site. Of further interest, when a person posting identified as male themselves, they were typically met with support. It was posts *about* men, rather than *from* men, that were met with such criticism.

Previously, the value of sharing honest accounts of struggles in parenthood was introduced but parents and support providers described dominant narratives of an ‘idealised’ vision of parenthood, child development and child behaviour, which created stress and dissatisfaction for parents compared to their own reality. As will be demonstrated, whilst ‘there’s always been a lot of comparison’, the rise of social media has played a significant role. In the survey, 28% reported using social media every or most days and another 42% used social media occasionally (Appendix C). Before considering this matter though, it is important to reiterate that this study is not exploring situations in which children are at serious risk of harm but rather, everyday situations where parents are providing reasonable care but left feeling inadequate by social pressure and negative comparison.

Across the datasets were comments that comparison, and dissatisfaction with self and self as a parent, had intensified with social media. Parents can feel pressured by the images of parenthood that they encounter online, even though it was widely acknowledged that such images are often unrealistic. Within the social media analysis some posters commented about idyllic images of parenthood portrayed by some other Mumsnet contributors, saying that there was pressure to ‘pretend that [parenthood’s] easy’ when it is not. Surveyed parents did not like how ‘people put posts of their perfect families’ on social media, ‘depicting a ‘flawless life’ with children’ and said that posts are written through ‘rose-tinted lenses’. Reviewing such posts led parents to feel pressured to do more as a parent and question their own situation or choices. In the quote below, a provider describes the impact of viewing such content on parents and their sense of confidence:

> I think there is a huge pressure in in how they see, of what their children should and shouldn't be doing and how they view themselves as a parent, particularly with all this social media and celebrity nonsense. I think some parents fall into that because let's face it, adults are just as much on TikTok and Instagram as their children are. And I think they set themselves up to fail because they see this stylised vision of what parents should be and they failed abysmally because that's not the real world (Niya, support provider).

Some surveyed parents said that they avoided social media for these reasons and on Mumsnet, posters encouraged a distressed parent to stay away from the internet as a strategy to lessen anxiety. Similarly, a provider relayed this conversation with a mother worried about her baby's sleep patterns, in which the mother had said:

> 'Oh, it's terrible, I'm all on Instagram, there's so much online, it tells you about what they should be doing' (Ellis, support provider).

Social media and other internet sources provide huge volumes of parenting commentary. However, it was not just from social media that parents were accessing information and such other influences also need acknowledgement. Indeed, mainstream media and dedicated publications are also prolific avenues of advice for parents, as expressed in the quote below:

> When I was a new parent, there were a lot of books and materials I read which reinforced a feeling that I was getting things wrong or not good enough, examples might be meal planners or Gina Ford style parenting which are useful for many but not for me as they didn't feel achievable (P245, female, 30-39yrs).

This sentiment was echoed by a provider who commented about 'all these books and everything that says you should do this or they should be developing by that,' which in turn, led parents to doubt themselves and their own judgement. Another support provider shared this metaphor:

> I remember listening to a radio programme about the difference in child rearing now compared to 40 odd years ago, and it being of that of a gardener or a carpenter, and now parents are expected to be carpenters, where they're expected to actively construct and make and shape the children... as opposed to being a gardener, where you might just plant some and seeds and just let them grow… And I, and I think that's it's really helped me because it's really helped me then reflect on the pressure of, on parents to be carpenters (Toni, support provider).

The point to make here is that what could be a resource (whether from an online source or in-print) to help parents had become counter-productive for some, in that resources intended to support parents, became part of the problem and rather than enhancing parenthood skills, damaged confidence and wellbeing. The information was too much, sometimes contradictory, and set parent expectations for themselves and their child that were not being met and therefore created distress. One support provider commented that when parents felt their child was developing or behaving differently to what was written, it was as a consequence of their parenting which created high levels of anxiety and whilst sometimes there may be an additional need requiring support, often the anxiety was driven by unrealistic comparison.

5.5 Conclusion

In this chapter the relationships and spaces of 'community' have been explored, alongside consideration of factors which impact equity of access. Data regarding enjoyment of community spaces and engagement in supportive relationships was mostly drawn from the survey, with complimentary data from other methods. There was a high degree of convergence between methods for 'problem' themes. For example, data from all methods spoke of the impact on parent mental health and wellbeing from interrupted access to community spaces and informal relationships beyond the household, during the pandemic, concurring with other studies (see section 2.3) and returned to in Chapter 7. All methods revealed ongoing barriers to engagement in community spaces and the pervasive fear of judgement that deters parents from utilising such spaces, including the potential and perils of online communities which can challenge or intensify, such perceptions. Of particular note (and importance given the dearth of research in the area) are the concerns about loneliness and isolation for parents that were identified frequently across methods (section 2.3.2.2). In particular, concerns were raised for single parents, parents (especially mothers) in the perinatal period, low-income parents, parents with mental health problems, and amongst parents of children with additional needs. Where access to supportive community spaces and relationships is present, parents can enjoy positive benefits towards mental health and wellbeing. However, there are many issues and inequalities. Therefore, we need to consider formal spaces of support available to parents and so in the next chapter, we turn to the service landscape.

Chapter 6 The Service Landscape

6.1 Introduction

Home and informal community spaces have been explored but within the 'village' are also organised or formal support spaces (section 2.4). The services providing these offerings can support parent mental health and wellbeing with appropriate responses to need or inadvertently widen inequalities with barriers to access and options that do not address the challenges and circumstances of would-be service users. The first section (6.2) serves as a device to 'set the scene' of the service landscape, by providing a brief introduction to the types of services and offerings referred to throughout this chapter and subsequent chapters. Some services were identified whilst developing the asset map and others were detailed in parent and support provider accounts. Many services are primarily concerned with child outcomes but are included because of their relevance to parent mental health and wellbeing, even though rarely dedicated to that purpose. The chapter will then explore facilitators and barriers to service access before concluding with aspirations for change.

6.2 Service Landscape

6.2.1 Family Support Offerings

Universal parent groups include new parent groups and stay-and-play toddler sessions held at churches, libraries, community centres, and open-air venues (such as facilitated gatherings to meet at a park and walk together). These groups are not as one support provider phrased it 'a support group with a capital 'S'' but can be supportive of mental health and wellbeing by connecting parents with friendship, advice, structure to time and a place of belonging. Many groups are run by volunteers, charities, and churches. Some groups are offered in the public sector (libraries and remaining Children's Centres) and some operate in partnership between the public and voluntary sectors. Universal access parent groups were the single biggest type of parent support offering identified when creating the asset map, generally focused on parents with infants and pre-school age children.

Universal access parent offerings were also offered by health services. New-parent checks offered by the GP and contact with a health visitor are typical examples. Whilst not captured on the asset map, engagement with these services was raised in other methods. These professional services are also referred to below as avenues of mental health care.

Some family-focused offerings were selective by need or circumstance. For example, groups for families with multiple-births, mothers with postnatal depression, young parents, or families who have children with additional needs. Such groups were offered mostly, although not exclusively, by charities or in partnership between charity and state services. In addition, there were 'support groups' focused on bringing parents together with others 'who are feeling the same' and to 'share experiences' for peer support and learnings. Most parent support groups identified in the asset map were for parents of children with additional needs, particularly neurodivergence such as autism, and organised by charities.

Another type of parenting offering were parenting courses (section 2.4.1.2). Facilitators of parenting courses (including Eden and Sasha) spoke about benefits of participation for the mental health and wellbeing of parents and so parenting courses are deemed relevant.

Finally, families in complex circumstances may require support specific to their situation. For example, services supported families with the consequences of financial insecurity, such as advice about debt and welfare eligibility, and assistance with access to food, clothing, and essential items such as white goods. Furthermore, families can be supported with individual, usually in-home, support, ranging from peer support visits from a volunteer, through to the family work of Children's Services. Families are usually referred by another agency, such as the health visitor or school, generally because of concerns for the child. In most situations, parents choose whether to engage but if a child is at risk of significant harm, intervention is mandated.

6.2.2 Mental Health Care

When someone experiences mental illness, they may seek the support of health services. Mental health care typically begins, and for many people is managed exclusively (section 2.4.2.1), in primary health care services, such as the GP and health visitor. When parents were asked in the survey, where they would seek mental health support if needed, many wrote GP (or doctor) and/ or health visitor and these forms of support were also raised in the social media analysis and interviews. However, sometimes specialist adult mental health services are indicated. The types of dedicated mental health services referred to in this study include IAPT (Improved Access to Psychological Therapy) services (section 2.4.2.1), community adult mental health teams and in-patient mental health services. Occasionally, dedicated perinatal mental health services (community and in-patient) were mentioned. In addition, professional mental health care was sought from occupational health, specialist mental health charities, and the private mental health care and therapy sector. Finally, the findings demonstrated that the challenges of accessing child and adolescent mental health was impactful upon parent mental health and wellbeing. Consequently, I deemed it relevant to incorporate interaction with CAMHS (child and adolescent mental health services).

6.3 Benefits and Facilitators of Service Access and Delivery

6.3.1 Services, Relationship Support, and Supportive Relationships

6.3.1.1 Improving Household Relationships

Some offerings sought to promote positive household relationships, particularly between parents and children. Given the importance of the parent-child relationship (section 4.2.1), support to foster stronger parent-child relationships can positively contribute towards parent mental health and wellbeing. There were ‘incidental’ ways in which providers supported the parent-child relationship, such as 'tips' for creating low-cost toys or using household items in play. Tips could also be shared to help parents manage difficulties, as exemplified here:

> I suggest, I don't tell people to do it. No, not my place. But, it's such a simple little thing [advise about supporting a distressed child] and it helped (Nic, support provider).

These 'tips' were informally shared in a normalised manner from experienced workers or volunteers, to assist the parent. Parents were discreetly supported to build confidence, potentially reduce difficulties at home, and improve household relationships, before a situation worsened.

Some interviewed support providers delivered structured advice about parent-child relationships through parenting courses, and were positive about impacts for families:

> We do get some positive results... parents will say, 'I've realized that sometimes it's my issue, it's my reaction to the child's behaviour that's making it worse, so I've learned to kind of not shout so much and speak calmly, to take a moment before I react'. So that's really positive. And that's nice to hear (Eden, support provider).

There could also be more direct benefits for parents, for example through exploring parent needs and opportunities, as introduced below:

> We look at relationships and we look at you know that we need a supportive network… and who who's in your network, you know and they draw it out their little circles, 'I'm [the parent] in the middle and who's good for me, and who's bad' and what they can do, the self-care, you know, the diet (Sasha, Support Provider).

Although parenting courses were rarely mentioned in the social media analysis or survey, there were examples of parents reporting benefits from facilitated support. For example, a mother with postnatal described how the perinatal mental health team 'sent' someone to help her build confidence in her relationship with her baby and how valuable this had been. It can be seen from these accounts, that parents can benefit from sensitive support to develop the parent-child relationship that also, aims to support parent mental health and wellbeing.

6.3.1.2 The Value of Peer Support

In Chapter 5, informal friendships were explored. In this section, facilitated offerings dedicated to fostering peer support are considered. The cyclical relationship between pre-existing social relationships and participation in organised offerings was identified. Socially well-connected parents benefitted from 'word-of-mouth' information about services and also, the social support to attend (where appropriate) with someone known to them. This phenomenon was noted by support providers who described friends attending groups 'on mass', and how they knew that 'if one person's come… they'll come and they'll come'. It was by this process that groups would grow:

> I would tell them [parents] about [the group] and now they come to [the group, and] they bring their friends to [the group] who then will bring their friends sort of thing. So, I think that's how it builds up (Lesley, support provider).

Whilst this phenomenon was commonly described for women (many subsequent quotes refer to 'mums'), it could also encourage male attendance:

> [A father] heard about a, another dad focused activity called [Dad group] at a local church. So he went along to that with some other, not with some other guys, but he knew some of the other chaps from this [organisation]…. So I think he then felt enabled to go himself because he would know, he knew there would be some sort of names or at least faces that he had met once before (Toni, support provider).

Parents who are socially well-supported therefore, learn about offerings from friends and have peer support to encourage participation, creating positive cycles of engagement.

Many survey responses extolled the value of participation in universal parent groups for building peer support. For example, parents valued ‘library meetings with other mums’ and stay-and-play groups, as typified below:

> The baby groups held at churches and community centres helped a lot when my children were younger. The social side was great for my children and for me, I met other mum's who ultimately became friends (P90, female, 40-49yrs).

Parents in the social media analysis described the importance for mental health and wellbeing of attending universal groups, to get out of the house, and meet other people. Furthermore, support providers described benefits for parents:

> I have had a lot of parents say to me actually ‘it's [the group] really helped our mental health because we haven't felt under pressure and we've been able to talk to other parents and we formed our WhatsApp group and now we will go for coffee’ and that was what we wanted (Lesley, support provider).

Parents can build confidence and learn from peers in these groups. A support provider said parents ‘boost each other up’ and another said parents, ‘started forming that bond and kind of informing each other’ about different parenting matters.

During the pandemic some groups met under a support group rule, but most universal group offerings temporarily closed. Parents talked about being ‘isolated not being able to go to groups’ and one parent said that closures impacted their mental health and wellbeing ‘massively’. These experiences are shared in this ‘Facilitators’ section because they make visible the value of these spaces usually for those that can ordinarily access them (section 5.3). For example, Facebook posts noted whilst compiling the asset map, asked when offerings would resume and providers had similar feedback:

> When we were forced to close by COVID, if ever I bumped into a mum in town or walking around the town, it was always talking about [the group] and ‘when are we gonna reopen’ sort of thing? There was a desire to come back (Sam, support provider).

By combining comments about the value of attending universal access groups with experiences related to the impact of their temporary closure, such spaces are demonstrated as a mainstay of the parent support landscape for parents of younger children. Such spaces may not typically be integrated into a consideration of parent mental health care but when viewed from this preventative framework, are identified as understated sites for promoting parent wellbeing.

Peer support was fostered through engagement with groups targeted by need, such as support groups. Parents could find hope in the experiences of others who 'have been through it and come out the other side' and were 'still standing' despite the complexity of their situation, reinforcing the importance of a supportive 'village' (section, 5.2.2). There was a sense of strength and solidarity in support groups, described here:

> And you know all of us together, to these other parents, we're an army of support and that's what it's all about (Robin, support provider).

These groups were also sites of knowledge-sharing between parents. One support group facilitator noted, if someone in the group has a question, 'one of the parents knows, we all learn from each other'. Parents connected to this 'army' could find reassurance and acceptance which in turn, could combat loneliness (section 5.4.1.2). Peer support is important for mental health and wellbeing, particularly in the context of the isolation and distress that parents in difficult circumstances may be experiencing. In the quote below, a support provider describes a common reaction to a new parent meeting other parents who understand their challenges:

> Quite often when somebody new turns up [to the group], they'll be in tears by the end of the session and crying on the shoulders of the other mums and saying, 'I didn't feel, I felt so alone and now I know I've got people that I can come and talk to'. it's that loneliness, losing that loneliness (Nic, support provider).

The relationship between social isolation, loneliness and mental health has been explored (sections 2.3.2.2 and 5.4.1.2) and will be returned to in Chapter 7. What can be seen from these accounts, is that facilitated offerings which bring parents together was an important option to promote mental health and wellbeing where circumstances may impede parents' access to other forms of social support and/ or, where it is advantageous to foster relationships with others who have specialist understanding of their needs.

6.3.1.3 Support-Provider Relationships: with Colleagues, Role, and Families

Attention shifts now, to the relationships of support-providers. Turning first to relationships with colleagues, it was evident that peer support mattered to support providers. Where colleague relationships were strong, it was an asset as exemplified with comments such as 'we're not on our own, so we're part of the team…it's not all on your shoulders', and 'I think that's a team, isn't it… you pull together'. Services are created by people and those people needed support and community too. Relationships with a manager were important and could create a positive workplace environment. Many support providers spoke warmly about their managers with comments such as 'we have a team manager who I think is just really, really good', and identified this as a crucial component in enabling them to perform their own role.

The next consideration is a support provider relationship with their role. The support providers had differing reasons to motivate their actions. Some were driven by wanting to 'give back' having benefitted from an offering, some recognised that they had a 'skill set' that was needed, and some were motivated by faith ('lots of community work is close to the church's heart'). Uniting all accounts was that their work with families (whether paid or voluntary) mattered to them and they cared about the families. Support providers gave comments such as 'we know our families really well' and another said their organisation focused on, 'building relationships with the families'. Support providers took pride in helping parent:

> You don't know the difference of sort of the service that you offer, what, what impact that that really is having on someone. I mean it, potentially [it's] life changing for them (Lesley, support provider).

When interventions were successful, support providers described feeling 'so rewarded'. It should be acknowledged that many support providers were in roles focused on enhancing child outcomes but there was a widely held desire to support parents too.

Switching now to the parent perspective of parent and service provider relationships, some parents spoke highly about support received. In the survey, 31% of parents agreed or strongly agreed that they were happy with the parent-related support they received from health professionals (Appendix C) whilst qualitative survey comments included, 'my first health visitor was an absolute godsend' and 'I have seen a psychologist a few times and it's been enormously helpful'. A mother on Mumsnet described feeling more confident about having another child because of support from her GP for postnatal depression, whilst another mother described being well cared for on a Mother and Baby Unit following a diagnosis of severe postnatal depression. In addition to benefits from the initial relationship, parents could also derive benefit from subsequent referrals, as in this example:

> I have accessed help [with mental health] in the past by first speaking to my health visitor who suggested talking to my GP. I then spoke to the GP and over the last 5 years I have used anxiety medication and accessed CBT therapy on the telephone and app based (P35, female, 30-39yrs).

A positive experience previously could encourage future help-seeking. For example, one parent in the survey commented, 'I have previously used a CBT [cognitive behavioural therapy] therapist so would consider recontacting her'.

When parents are in challenging circumstances, they may be fearful to engage with services, but encouragement from a trusted support provider can build confidence, as in this example::

> So we've been able to build up relationships with some of the families to get them to have the confidence to go to other agencies. So we've referred them on to things like [IAPT] (Terry, support provider).

In this next example, a support provider established a relationship with a parent by responding to practical needs. From that point, it was possible to consider further referrals:

> Mum's got five kids and she's got no washing machine and you go out of your way… [and] when you get it, 'Yes, I've managed to get this washing [machine]', and you're so pleased and see their face when you arranged this. It's amazing. And when you get to that point, they then really start to open up about what life been like for them. Then you can start to actually look at the parenting programmes, look at what's best gonna fit them (Alex, support provider).

When parents were particularly hesitant to engage, the process could be facilitated by a personal connection between support providers. In the quote below a support provider encouraged parents to engage with other services, through personal recommendations:

> So we're like, 'ohh, can I just do a referral? Get my friend [name] come round and she can go through it all'. And she's great, … have you got a health visitor? And then they'll be like 'no they don't bother coming in' and you're like 'I've got a friend in the health visiting team, she can do…' (Sasha, support provider).

It may also be that support providers would meet with a parent individually, prior to them engaging with a group or other service, as explained here:

> But first thing is literally, let's meet up for coffee somewhere, nice coffee shop somewhere, you know, public… And yeah, to break the barriers and just hope to support them. And then if they, if they met you once, usually they'll come to a group (Robin, support provider).

In this way then, it can be seen that positive relationships with support providers can lead to positive cycles of engagement, with participation in one offering leading to engagement with others.

6.3.2 Accessing Spaces of Support

The physical location of venues was important. Some offerings, such as those run by libraries, health services, and larger funded charities, were centrally planned and distributed somewhat evenly, to ensure parents had a local resource. Charitable organisations develop in a more ‘ad hoc’ fashion (section 6.4.2.2) but some tried to improve accessibility, for example by running groups on different ‘side[s] of the city’ to reach more parents. Sometimes services co-located with, or ‘hosted’, other services, so that a parent accessing one resource would have ease of access to other opportunities. Examples include Health Visitor appointments in a library, and CAMHS clinicians connecting with parents through a support group. There were also offerings, particularly parenting courses, that moved through schools, community centres, libraries, and church halls. These roaming offerings had the advantage of reaching into communities before moving on to take the support elsewhere.

The physical attributes of the venue mattered too. For example, it helped to have ‘a lovely hall’ with no or minimal stairs, so that parents can, ‘just wheel [the] push chair in’ and venues needed to have convenient parking and public transport. During the pandemic, size of the space and ventilation became important, and services were able to return sooner or accommodate more parents if they had larger spaces and windows for fresh air. For some families, specific features of the environment have ongoing relevance, such as families with neurodivergent children who can find certain stimuli overwhelming. One support provider described changes that could be made to an environment:

> I can control that little bit of the world for them. That's all I can do but like, I can make it dark. I can make it quiet (Nic, support provider).

It can be seen therefore, that features in an environment can make spaces more accessible and as such, facilitate engagement. However, some parents (and other community members) were looking for venues that simply offered safety and warmth:

> So it's a warm place to go and we're finding that more and more now. So because some stay for quite, you know, that's the idea, you can spend the day

> at our place….. And yeah, it's a warm place, dry and yeah (Mic, support provider).

Such venues were not purposed with addressing parent mental health but by responding to a need, provided places to help to mitigate stressors and gave examples of services creating safe spaces within a framework of 'village' support.

Finally, parents and support providers described accessibility benefits from online information and offerings. Support providers commented, 'I think social media now is a really important part of how we reach parents', and 'people find us on the internet' when looking for support. Moreover, groups and services can be delivered 'virtually'. One support provider said of online delivery, 'I love it, I think it's really good, I really do, the flexibility' and parents too, described benefits:

> [Parent group] is where I have found mums I am most similar to and have offered continued support from when my baby was a few weeks old into toddler years. I couldn't get to these meetings when I went back to work as they were face to face on a day I had to be in the office but since they have moved online I have been able to access them again which has been hugely beneficial (P264, female, 30-39yrs).

Online and in-person offerings were not a binary choice. Examples were given of 'people who've met on Facebook and then come physically to meet' at a parent support venue and similarly, parents who meet in person and then connect online. One provider described a closed Facebook group for support group members and said, 'I've never known a group so supportive on social media'.

6.3.3 'The Right Time' for Services and Parents

The timing of an offering was associated with how accessible it was, with comments from parents and support providers expressing advantages of 'drop-in' services, as in this quote:

> It's a drop-in service... and that has been really successful actually… that has really really taken off and we've had loads of really positive feedback from

> parents just saying how brilliant it is and they really like that it's just a drop in and they don't feel under pressure (Lesley, support provider).

A key consideration regarding time, was how long a parent could access a service for. Some offerings were provided in an on-going manner, such as weekly stay-and-play groups or monthly support group meetings. Other services, particularly those targeted by a 'problem', were time limited. However, it is recognised that to establish relationships takes time. Indeed, support providers talked about families being guarded about challenges initially but when you have 'built a relationship' they share more. One provider described working with parents on a separate issue first and then 'further down the line, I would say 9 times out of 10 there are elements of parental mental [ill-] health going on there'. One service that worked with families that did not limit the length of intervention described this as 'one of the biggest differences and … a strength' of the offering, as expanded below:

> Unlike other organizations, we don't have set times. So we don't say we can only have six weeks and then we're off, we tend to stick with them until we feel that they're ready to, you know, we're, either they've got sorted the issue out or they've got to a point where they're able to do the rest without our input (Eden, support provider).

It is noteworthy that the support provider refers to families no longer requiring support and this was also addressed in other interviews. Support providers were looking for *enough* time to build a relationship and address issues with the family but not to stay involved so long that it fostered dependency:

> Trying [to do] the least that we can, you know, because that's the idea, isn't it? … because it's it's not good for their confidence if you're involved for a long time, it's like they need somebody. They don't need somebody (Sasha, support provider).

Many support providers described wanting to empower parents to develop 'tools' to care for their children and their own mental health and wellbeing more effectively and helping families develop social supports to reduce the need for service-intervention in future. It can be seen that there was a delicate balance regarding the length of time that a service engaged with a parent for targeted support.

6.3.4 Financial Support for Services and Families

6.3.4.1 Service Funding Assets

Funding for services is a crucial facilitator of provision. However, as most comments related to barriers (section 6.4), this section is brief. There were some positives though. Offerings based in churches and community centres were supported by that larger organisation which reduced their overheads (for example, a stay-and-play group or community support group). Furthermore, charities were proud of the skills within their organisation to secure and manage funding:

> It's just one of those, you know, financial things. You just have to keep very clear records of the hours they work, the projects they're working on and make sure that your report back accordingly. So, we are very good at doing it. We've done it for a long time (Eden, support provider).

Similarly, another support provider mentioned a ‘lovely lady’ who was ‘brilliant at fundraising’, another commented ‘we've got money for the next few years’ and another talked about their CEO being very good at securing donations from business.

6.3.4.2 Responding to Families in Financial Precarity

It appears counter-intuitive to address financial precarity in a theme focused on ‘positives’ but the responsiveness of services to family needs recognition. Debates surrounding the role of services in mitigating consequences of oppressive public policy will be considered in Chapter 7, but here the focus is on the efforts of those supporting families in difficult circumstances. In the social media analysis, parents were helped by services for debt advice, support with welfare entitlements, and there were occasional references to food banks, providing at least some relief in a challenging time. In support provider interviews, there were frequent references to helping families in precarious financial situations. One of the support providers described a ‘natural order of what needs to happen first’, to ensure upstream determinants were addressed as a priority:

> Need to get the money in, you know and then secure housing. Sometimes they get made homeless or whatever. Trying to secure the housing straight away (Sasha, support provider).

With housing secure, support providers wanted to ensure the family had suitable access to other essentials:

> So we were able to get her a chest freezer so that she could batch cook and buy things in the sales, because she said she would only buy meat if it was in the sale. And we also got them like uniforms from the uniform bank, and we got them lots of gas and electricity vouchers (Terry, support provider).

Providers spoke of increasing demand for food aid from families and particularly noted the increased demand from 'working families that are on low wages'. Indeed, demand from parents was so strong that providers said that they would 'put on some activities for children' during school holidays, whilst parents collected their food. Other providers, even in roles not typically associated with food support, talked about 'help[ing] with food donations' and 'offering food tokens', as well as providing clothing and other goods:

> There was fleeces and jackets or body warmers. There was a fleece blanket… There was gloves, there was a bag of food. … And people were very grateful for that. And some families with, like one family came in and had two children were so thankful for the bags of food that came with it as well. But they didn't care about the jacket was too big or the, it was red and not blue, they were so thankful that they had something (Mic, support provider).

Support providers who provided material support emphasised that, 'it's not about just giving out free stuff'. Support was intended to address an immediate need (and potential crisis) but also, establish a relationship and explore longer-term changes. Such interventions were not targeted to mental health but could benefit parent mental health and wellbeing by addressing a source of stress and a conduit to engaging with other support, including mental health care (section 6.3.1.3). Once again, it is evident that in a village model, support for mental health and wellbeing comes from many sources and that action on social determinants of health offer indirect but important components in mental health promotion at a community level.

6.4 Barriers to Accessing and Delivering Parent Support Offerings

6.4.1 Difficult Relationships Impeding Support Service Engagement

6.4.1.1 Unsupportive Peers

Not all parents enjoy contact with other parents in facilitated offerings. When asked about difficult places in the survey, responses included, 'baby/toddler groups. I find other parents annoying' and 'when you are forced to be with other parents due to your child and their activities'. These opinions are acknowledged and respected. However, given the value that many parents did describe from engagement in parent-support spaces, barriers from engaging in peer support offerings are considered next.

In section 6.3.1, it was shown how social support can help parents to engage with support services but for parents without those connections, it can be intimidating to approach a new service. One support provider said, 'the scariest thing is walking through those doors, not knowing somebody' and another talked about how hard it can be to get the 'confidence to… overstep that threshold'. This can create a negative spiral of disconnection from services which in turn, creates fewer opportunities for parents to make friends and build social support. The anxiety that some parents expressed about attending unfamiliar groups, provide important contextualisation to offerings identified in the creation of the asset map. For example, whilst many stay-and-play groups and support groups were located in the case study area, a socially isolated parent may find it harder to learn about these offerings (returned to later) and be more fearful of attending.

When parents attend groups, there could be social challenges to navigate. A commonly mentioned issue was the embarrassment of crying babies, toddler tantrums, or behavioural disturbance (section 5.4.2.1). Support providers expressed regret that parents would often leave a support venue in these situations. Sometimes it may be a rare interruption, but other parents consistently avoid places due to child behaviour which then separated them from support, as in this quote:

> My son went through a phase when he didn't want to share and would lash out at other kids. I avoided baby groups then as hideously embarrassed. Found this quite isolating (P28, female, 40-49yrs).

For parents who have children with additional needs it can be difficult to attend groups because, as presented in the previous Chapter (section 5.4.2.1) there can be fear of judgment about child behaviour or parenting capacity. It is unfortunate that some parents potentially most in need of support, feel most hesitant to engage in offerings designed for families because of perceived lack of understanding and judgement related to the needs of their child.

Some parents found parent-groups challenging when they were experiencing mental health problems. One respondent struggled with 'cliquey local baby and toddler support groups…due to extreme anxiety postpartum' and another gave this response:

> I found the [parent group] experience -before and after birth- to be a negative one. Competitive and I became very depressed as I struggled to breastfeed... Most paid-for baby 'classes' were exclusive rather than welcoming (P115, female, 40-49yrs).

In the social media analysis, parents experiencing mental health problems described difficulties attending organised offerings, referring to the pressure to 'act normal', not wanting to 'break down' in front of others and needing to take anxiety medication prior to meeting other parents. Offerings dedicated for parents with mental illness were identified whilst developing the asset map, but rarely.

Finally, potential problems from facilitated peer support are recognised. Some support providers noted that whilst being with others in similar circumstances was 'mostly a positive thing' for parents, it could also 'bring challenges', through disagreements, shared negativity, and difficulties arising from 'vulnerable people supporting each other'. Primarily, these experiences related to in-person contact through organised groups, but it could also relate to facilitated online support offerings as well. For example, one support provider spoke about screenshots being taken from a closed online support group discussion and shared with people from outside of the group. Although many services were keen to foster peer support, relationships between parents participating in organised offerings may not always be as supportive as intended.

6.4.1.2 Challenges in the Parent – Provider Relationship

Relationships between parents and support providers could become strained. Sometimes support providers felt frustrated with parents (one said, 'I'm a little bit, your children need you, sort your shit out') and a service could be withdrawn if the parent did not act upon recommendations ('you can't keep going over and over and over the same things'). Sometimes support providers were concerned that parents 'try to put a label on their children straight away' rather than acknowledge ways in which the home situation contributed towards problems. Occasionally, providers (from statutory and charitable services) were troubled that different social 'norms', led a minority of parents to manage household budgets in a manner detrimental to children, such as spending limited finances on smoking or recreational drug use. Furthermore, if a child was identified as being at risk, the provider had safeguarding responsibilities to the child (see 4.2 and discussed later in Chapter 7). However, challenges were contextualised within a larger picture of wanting to support families.

In parent accounts from the survey and social media analysis there were frequent complaints about service providers. For context, 23% of parents in the survey disagreed or strongly disagreed, that they were happy with the parent-related support received from health professionals (Appendix C), and whilst that number was the minority, it was still concerning. Many parents were hesitant to engage with services, particularly about mental health. In the survey, when asked if they would be concerned to ask for mental health support, comments included, 'I would probably put it off until I felt really bad', and 'would leave until I had no choice'. There were many reasons contributing towards this hesitation, but an influential component related to past experience of help-seeking, as elaborated below:

> I had post-natal depression many years ago, and when I finally plucked up the courage to ask the GP, it was dismissed as 'everyone feels sad from time to time'! (P91, female, 40-49yrs).

In the social media analysis parents referred to health service providers that ‘did not help… at all’. In one example, a parent described being ‘cut off’ by the GP and told to ‘go away and look…. on the internet’. These experiences are worrying because help that was needed was not received and parents were deterred from trying again:

> I tend not to [ask for mental health support], times when I have opened up I have been told ‘chin up’ or ‘we’ve all been there’. This has made me less likely to discuss true feelings with anyone (P68, female, 40-49yrs).

Other comments included ‘[asking for mental health care] gets me nowhere has been my past experience’, ‘I tried going through the NHS once after a miscarriage and was declined ‘, ‘I would not bother going to my GP’ after a previously disappointing encounter, ‘[I] had poor experience when seeking support previously so would likely not contact anyone’ and, ‘when I have asked [for mental health care] it's been pushed to one side or just offered a pill’.

Concern was frequently expressed about difficulties accessing professional help for children, considered here because of the strain on parents. One support provider said that when parents ask for help with their child, they are ‘popped on another parenting course’ rather than concerns being investigated. Military terms such as ‘fight’ and ‘battle’ were often used to describe attempts to access support for children, which can take a toll on parents:

> You tend to be able to recognize a parent with a special needs child because they turn into little tigers. I think there's a surface strength that they develop. And they learn if they don't scream and shout, they're not gonna get any help. So there's this surface crispness, or sharpness, and protectiveness, but inside they're probably all melting (Nic, Support provider).

A difficult situation for parents raising children with additional needs was made harder by complications in accessing professional care.

Perhaps the greatest barrier though, was fear of judgement. Even interventions designed to support parenting issues were beset with stigma. For example, when invited to a parenting course, parents might think, 'you're basically telling me I'm not a good parent'. For parents needing mental health care, the fear of how they would be perceived as a parent could be overwhelming. When asked about accessing mental health care in the survey, comments included, '[the] children may be looked at as being unsafe' and, 'as a parent you would be judged as not coping'. In the quote below, a parent expands on this theme:

> I was very down after having the children, I was frightened to see a GP. I was genuinely worried that social services would be sent out or my children would be on some sort of register (P115, female, 40-49yrs).

In the social media analysis parents often spoke about fear of mental health services, using terms such as 'worried', 'scared' and 'literally terrified' that social services may 'take' the children. Indeed, some parents were so concerned that they avoided professional help. Parents talked about the loneliness of not feeling safe to disclose difficulties and a wish to talk to a professional without being 'reported'. When parents care for children with additional needs, there can be particular concern about disclosing mental health issues. One parent commented '[I] wouldn't want people to think I couldn't cope. 3 of my children have ASD [autism spectrum disorders], and other issues' and another parent worried about 'being seen as the crazy parent especially as I have to keep pushing to get my daughter help'.

Although rare, it cannot be ignored that there are situations in which child protection processes are pursued. A few support providers had worked with families with experience of child protection proceedings and noted that often, parents had long-term mental illness and trauma stemming from their own childhood. In the social media analysis too, although rare, were instances where custody had been withdrawn from a parent. Once child protection concerns were identified, parents may be required to engage in treatment programmes. However, once court processes are underway, a parent may have fairly short periods of time in which to show improvements and demonstrate that they can act in the best interests of the child. One of the support providers expressed concern that for parents with long-term issues and the stress of child protection proceedings, 'dealing with' mental health problems in the allocated time can be extremely challenging. Furthermore, parents who have had involvement with child protection proceedings may hold a ‘hate for the system’ that intensifies reluctance to engage with support services in future, in a worrying and damaging spiral of service avoidance and risk.

6.4.2 Barriers to the Spaces of Parent Support in the Service Landscape

6.4.2.1 Locating and Accessing Spaces of Support

A challenge identified not only from the accounts of parents and support providers but also emergent from my own attempts to develop the asset map, was that of the ‘invisible’ spaces of parent support. When internet searching for ‘parent support’ in Hampshire, I was directed to broken links, out of date listings of closed services, and 3rd party loops which linked to databases but never ‘at-source’ listings to verify information. Furthermore, the search provided only a selection of available offerings. For example, I emailed one support provider for information about their group and when they replied, they volunteered a screenshot from their local area (closed) Facebook site, with another 24 groups that had not appeared in my searches. In summary, I found it more complex to identify offerings than anticipated and I was unable to develop a comprehensive asset map of offerings from an online search. My experience echoed accounts from parents and providers. Parents described difficulties finding out about support and a provider commented that parents are ‘generally finding it hard to find out anything that's on’. When parents were asked in the survey if they would have difficulty accessing mental health care, comments included ‘I wouldn’t know who to ask’ and ‘wouldn’t know where to go’. Another remarked about not ‘knowing where to get support’ with breastfeeding. Many too, struggled with ‘how to access support’ for children with additional needs and one support provider described parents becoming ‘lost in the system’, particularly those with a first language other than English. The internet is useful (see section 6.3.2) but not a complete source of information. Furthermore, not all parents have access to the internet (section 5.4.2.2). Isolated parents may also find it harder to learn about support options and lack social support to attend because as identified previously (6.4.1) they lack the ‘word-of-mouth’ information.

Given the challenges that some parents, particularly those already facing disadvantage, experience in identifying spaces of support, it is important that service providers facilitate access to information about options. However, lack of signposting was identified as a concern. For example, one volunteer asked health visitors to tell new parents about their universal group but the request was declined saying, ‘we can't specifically do that because we, if we did that for one group, we'd have to do it for every group’. The quote below gives another example of a missed opportunity to signpost a parent to support:

> So [the mother] sat down with the form and suddenly she burst into tears and said, ‘how do you spell autism’ and see, it was dreadful, she’d basically been to the doctors, he told her, her child had autism and that, and had left her that word. And she had no idea what it meant, what the consequences were, nothing (Nic, support provider).

The lack of signposting by services can be detrimental for any parent but for those who are isolated, lack internet access, or have other health literacy needs or support considerations, the risk that they will remain unaware of support offerings is heightened in another negative cycle of non-engagement.

6.4.2.2 ‘Mind the Gaps’ in geographic access to support

Services need to set parameters around access to their offering. One typical criterion, is based on location, as below:

> We do try to stick our boundary to [location] that we're based in [location] as best we can. We try to keep it kind of quite tight, because otherwise you're travelling long distances and obviously we have a lot of people living in [location], so they need our support (Eden, support provider).

However, centrally planned public sector offerings have reduced. One support provider commented, ‘well you can't go to the Sure Start centre, ‘cause it's not there anymore’ and another talked about areas where, ‘they've lost the library and the Children’s Centre’. Funding cuts leading to such closure are explored later (section 6.4.4.2) but here, the focus is on the spatial inequities created by the loss of public sector provision. In the quote below, a service provider talks about how far parents were needing to travel for support in their area, following such closures:

> That's a long walk [to the nearest service]. If you're the pushchair and a young mum, or an old mum, whatever mum you are… it's accessibility, isn't it, you know, people, you know, not everyone drives. Fuel's ridiculous (Riley, support provider).

In place of public sector provision, there was increasing reliance on churches and charities. However, whereas public sector services have a level of strategic planning to manage geographic distribution (as one interviewee noted, 'they [Sure Start centres] were splattered about for a reason'), charitable offerings develop 'ad hoc', as this support provider explained:

> This isn't a central service for all people who can access, this is just 'ohh, they happen to be running a group there' … And so whilst you embrace people voluntarily doing lots of things, it creates postcode lottery and a reliance on those other people to do things, whereas it should be something that everyone should be able to access (Ellis, support provider).

The variation in geographic access to charitable support was highlighted whilst developing the asset map. I noted how one large parent support charity had volunteer-led activities in some parts of the county but not others, and some areas without local branches were in areas of higher deprivation such as Rushmoor and Havant. Furthermore, in the social media analysis, a mother described 'slim' access to support where she lived, noting that one of the largest new parent support bodies in the UK did not have a local group and the closest branch of another organisation, was over 30 miles away. It can be seen therefore, that geographical 'gaps' in provision occur often with charitable services. In this next quote the 'postcode lottery' is again demonstrated. Although it refers primarily to the needs of a child, the parent needed support too and a lack of help created by a lack of support coverage, added to the difficulty:

> When we needed help as my child was self-harming I found it very hard to find anyone who covered where I lived. I spent days ringing and pleading with various groups before I found one (P68, female, 40-49yrs).

Reliance on any form of charitable provision can be seen problematic but reliance on unpaid volunteers is particularly precarious as spaces of support are at risk of closure if volunteers are not available. When compiling the asset map I noted volunteer-led offerings temporarily closed due to illness (facilitator or child) or holiday, and it was also described in interview:

> It's been me [running the group]... and then one Friday, I was away… and just couldn't get anyone else. And the group just had to stop. So that really loses momentum (Ellis, support provider).

I also discovered listings from offerings that were permanently closed due to volunteers leaving with no-one to replace them and during interview, Nic described an offering that had 'unfortunately closed' because:

> Basically, there was only one lady doing it and she ran out of steam and she's got [a health condition], so she was running out of steam and just basically couldn't run it anymore. There wasn't anybody to take it over (Nic, support provider).

Offerings run on a voluntary basis make a significant contribution to the service landscape but rely on the time and goodwill of small groups of people (even individuals) and are vulnerable to interruptions in support or permanent closure. Such closures are difficult to trace and even though some were visible in online searches through out-of-date listings and Facebook messages, it is likely others closed without a digital record.

Sometimes, gaps in provision can be negotiated by parents who have the health literacy to investigate and identify services and the resources to travel. For example, a volunteer said that parents travelled '20 miles or so' to attend their group, because there was 'nothing else' closer to them. Another support provider said, 'if people want to come to a group and they're happy to travel, that's fine, they can come from wherever'. These situations reveal geographical gaps in service provision have greater impact for families with fewer resources.

One response to limited offerings in an area is for the offering to 'move'. As mentioned in section 6.3.2, this was a popular way of delivering parenting courses. However, there is inherent precarity to moving offerings and parents' access to such support is dependent on it arriving locally at a convenient time and place and the parent learning about it. Indeed, roaming offerings could not be recorded on the asset map as there was no permanent venue, adding to the sense of elusiveness.

Offerings could be delivered online, which disadvantages parents without digital access, but raises broader issues too. When delivering an offering online there could be issues of parents being focused on another task (particularly parents with children at home and particularly if children have additional needs), having a suitable and quiet environment in which to take part, and having the technical skills and reliable internet connection. Whilst online offerings may be more accessible, many struggle to engage online, with neither time nor space dedicated or well-suited to participation. The quote below was shared humorously but portrays limitations in online offerings:

> Well, we've been doing it [groups/ courses] virtually. I mean, one parent was painting a fence while taking part in a course. One parent was in a store cupboard… And another one for four weeks, we just saw their forehead… I have a lot of sitting in the cars (Niya, support provider).

Furthermore, some people do not like online engagement and prefer in-person contact. One surveyed parent commented, 'online is not for me. It bores me. Would hate online to replace real groups post covid' and a support provider said, 'I hate the online business. I hated it. It was hard'. Therefore, whilst online opportunities can supplement engagement, they are not always appropriate, accessible, and cannot wholly address issues of geographic gaps in service coverage.

6.4.2.3 Perceptions of (In)Accessibility and (Un)Acceptability

This next section explores who can access parent support services and equally as important, who feels comfortable to do so. Many parent support services focused on a period of child development, mostly for parents of babies and young children. For example, the health visitor system is focused on infancy and most groups were for parents of pre-school children (although some library activities extended to older age groups, showing the broader scope of some remaining public sector services). Demographic gaps in service-provision means that parents of older children, particularly those on low incomes, may find it harder to access professional and peer support.

When compiling the asset map, I encountered groups initially advertised for 'parents' but later referred to 'mums'. Conversely, there were listings which had 'mum' in the title but later said it was for parents. Some examples said that the offering was for mums but had '(dads)' bracketed afterwards. Few groups showed images with men pictured. The impression was that whilst offerings were available to either parent, there was a presumption that mothers would attend and the quote below would concur:

> I never accessed family groups because I didn't want to rather than that they were difficult. I don't like most of the people who go to them and that's rarely any male company (I'm a dad) (P7, male, 40-49yrs).

When men did attend, support providers said it was often with a female partner or at the encouragement of a female partner. For example, one provider said, 'it's only if they've been really, really encouraged and they're very confident dads generally'. However, some support providers described increasing numbers of dads attending groups, perhaps when taking parental leave, on non-work days (particularly shift workers), and stay at home fathers, such as described here:

> I… ran a baby group in the afternoon and I've got lots of dads there and I went round and saying, 'why can you come'? And they were all primary carers (Nic, support provider).

Some providers wanted to develop offerings that were more inclusive of fathers. One option was to have 'dad-only' sessions, and during the asset map development, I encountered such groups. However, offerings for fathers were at weekends, whilst offerings for mothers only, were during the week, a point returned to later. Concern was raised about lack of support for fathers in the perinatal period who, as one surveyed parent commented ‘often get forgotten’. This point was also addressed at interview:

> There isn't anything like [the health visitor check] for dads and I’m really conscious that that's dads are largely forgotten in this process, but yet they're crucial… Actually, it benefits the whole family if dad’s mental health is thought about (Toni, support provider).

Indeed, perinatal mental health services also focus on women’s health. There was concern that peer support opportunities and the mental health needs of fathers were not well addressed.

Most stay-and-play groups identified whilst compiling the asset map were run by churches. Some welcomed people of all faiths or none, some made no comment about faith, and some stated activities would include Bible stories, songs, and crafts. This does not necessarily exclude people of other faiths or none, and indeed one Christian provider described how a group of Muslim parents, ‘come to our messy church as well, they love it’. However, it is acknowledged that religious components may deter some:

> I mean, you can only go to a mother and toddler group sometimes, mainly in our area it’s done by the church. …. But then you're, if you're not religious, but you've gotta sit there cause the only child baby group is run by the church. … and If you don't agree with that, or you don't want that then, but what else have you got? (Alex, support provider).

Raising this concern is not a criticism of churches. Church run groups were described as ‘fantastic’ in the survey and if churches no longer offered groups, a huge portion of parent support would be gone. However, it is a concern if parents do not have *choice* and are reliant of volunteers with the time and space to provide support, which is increasingly the situation with reduced public sector offerings.

6.4.2.4 Challenges of Capacity and Demand

Despite limitations introduced above, universal groups are popular. For example, one provider said ‘pre COVID it was not unknown to have 100 kids, so that’s probably about 80 adults there, which was … too big in hindsight’ and another said that when they ran smaller groups in the pandemic they decided ‘this is really lovely, this works, let's keep it like we've got it now’. To achieve smaller groups, some operated a ‘first-come-first served’ system. Parents would come when they could and attend if there was space but could find the group full. Therefore, other sessions encouraged pre-booking, which meant, parents were confirmed a place but had ‘pressure’ to attend and also, parents could try to book but be too late. Furthermore, for parents struggling with their mental health, the complex needs of a child, and/ or, having to cope alone, remembering to pre-book and doing so early enough to secure a place, becomes yet another task on an already over-burdened parent (as introduced in 2.4.2.1 and returned to in Chapter 7), making engagement less likely. When asked about difficult to access places, one surveyed parent noted ‘needing to book activities and being quick enough to book way in advance!’. When demand outstrips capacity, there are parents looking for engagement but missing out.

There were situations when offerings switched from universal access to targeted support, as explained below:

> So it's looking at those families ...with all the things I've talked about, postpartum depression, isolation and low mood, new to the area, our [refugee] families. You know, there were, the list could go on. … so we then started a referral system for our [group] (Riley, support provider).

The tightening criteria to attend a stay-and-play group is a subtle but telling example of a wider move towards services being restricted as demand outstrips capacity. Raising thresholds for access to care more widely, are explored next.

The concern was consistently expressed by parents and providers that thresholds for care, at which point a parent becomes eligible for a service, are often set too high meaning that a person only becomes eligible once a situation has worsened. A surveyed parent commented ‘help often seems to be given when people are at rock bottom rather than before to help prevent that happening’ and a support provider talked about services only becoming involved once things had ‘spiralled so far out of control’. In the quote below, a support provider described concern about eligibility for perinatal mental health services:

> We all know that to access perinatal mental health services, you have to be really quite unwell. You know you have to have, the bar is set so high to be able to access those services (Toni, support provider).

There is concern that parents and/ or children that could have managed if offered a service sooner, deteriorate before becoming eligible. However, providing help in crisis and entrenched situations is more costly and takes longer, which stretches resources further. One response is to the raise thresholds again, meaning that the situation has to deteriorate further before becoming eligible for support. Across adult and child services, concern was expressed that professional care was trapped in a cycle of crisis care. There was also concern that the processes involved in accessing support behind higher thresholds for care deterred engagement by those most in need of the service, as explained below:

> Even to attend a group a family or a parent has to be referred into the service. So it's not just that, ‘oh, pop along and see how this goes’. You actually have to give consent to come and yeah, so I think that's the barrier sometimes (Niya, support provider).

It was evident in the survey and social media analysis that parents can rule themselves out of targeted support, surmising that ‘there are so many people in worse situations than me’ and not wanting to feel like a ‘charity case’ as well as holding fears about negative judgement as introduced. Given that parents who are most in need of support can find it most difficult to ask for it, introducing restrictions on attendance risks damaging engagement and widening inequalities.

6.4.3 ‘Not the Right Time’ for Services and Parents

On a practical level, the issue of time impacted parent engagement with services, as ‘anything with a time commitment’ can be challenging. In the social media analysis, a parent delayed seeing the GP as they were reliant on ‘someone having the kids’. In the survey, when asked about concerns seeking mental health care, one parent said, ‘I might not have time!’ and another commented ‘time is a factor’. In the survey, 28% of parents had difficulty attending groups/ classes etc and whilst this could be for a number of reasons, time was one consideration. Furthermore, 62% of parents had delayed doing things for their own mental health since becoming a parent (Appendix C). Accessing ‘parenting groups during work hours’ and getting to ‘any clubs/groups during school time, which is most of them’ was regularly expressed as a problem for working mothers. It was also difficult for working mothers to access individual support:

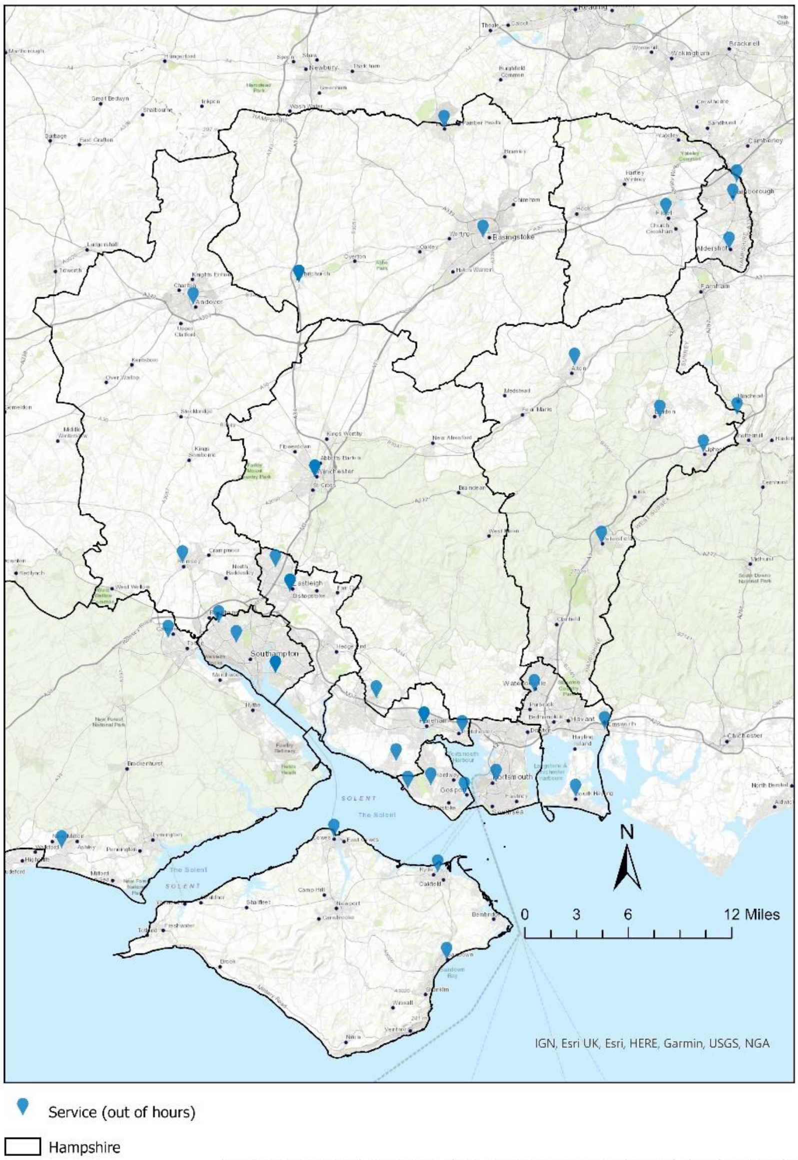
> Increased access to home visitors [is needed] -when I needed a health visitor for toileting issues for twins, it was a challenge getting to speak to someone. Also found it difficult to get help for multiple births via charities as I worked (P107, female, 40-49yrs).

Parents struggled with reduced offerings at certain times, particularly in school holidays. In the social media analysis parents felt overwhelmed with caring for children without these usual structured offerings. Some support providers too, recognised that breaks could be hard for parents:

> We started meeting in August because there was nowhere else … and that would be a difference we could offer, was being there a little, you know, few more weeks of the year. Because the toddlers don't go away suddenly in August [laughing] (Sam, support provider).

Sam laughed whilst making this point but it was a true word spoken in jest. Many offerings followed term-times but parenting is year-round. Parents relying on these offerings can find it hard to cope through scheduled breaks. The asset map image below, shows how little was found that offered ‘out-of-hours’ service offerings (36 services out of 288).

Figure 7 Out-of-hours Parent Support Offerings Identified in Hampshire



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The time required to build a strong relationship between a parent and support-provider was introduced above (section 6.3.3), with recognition that parents living in complex circumstances, may need more time to develop trust. When services were not afforded this time, it created tension between the needs of the service, for service-users to respond quickly and move on, and the needs of the parent. As one provider noted, ‘sticking [recommendations] on a plan and [saying] go and do that in six weeks’ was often ineffective with families in vulnerable situations. Parents also raised concerns about the limited number of mental health care sessions available from the NHS. This was widely discussed in the social media analysis amongst parents finding their allocated (typically six weeks) of sessions inadequate and was also raised in the survey with one parent commenting, ‘six weeks of talk therapy is crap’.

Many services face pressures on the time available to spend with parents but a common concern identified in this research and given closer attention, was contact with health visitors:

> Health visitor checks…. Between 12 weeks or whatever it is and 1 year is a big gap and then another gap until 2 and then you're on your own isn't good enough really (P290, female, 20-29yrs).

Many support providers expressed concern about health visitor contact and described a reduction from what had previously been available, as in this quote:

> The services are stretched a bit more and that. You might see health visitor once or twice. But I, you know, but when my two were younger, I would see them once a week (Mic, support provider).

In addition to limited scheduled appointments, there was concern about the loss of ‘weighing clinics’ where parents could previously access health visitor support and advice without the need for an appointment. In the quote below, a support provider reflected on these changes:

> You could ask them [health visitors] any question at a weighing clinic if, every week if you wanted to go. There are only bookable weighing clinics now. They don't have weighing clinics (Ellis, support provider).

Whilst these clinics were established for parents to weigh their babies, they were sites of broader reassurance, advice, and support and crucially, could be accessed flexibly, locally, and without the complications of a referral process and appointment time (adding to treatment burden, introduced in 2.4.2.1 and addressed further in Chapter 7) and without the need of pre-identified problems. The support provider went on to comment, ‘I can't imagine being a first-time mum… with no support like this’, demonstrating a perception of eroded support from public sector services, leaving new mothers more vulnerable to struggling with the challenges of new parenthood and subsequently, higher risks for mental health and wellbeing.

There was concern that limited access to health visitors increased the risk that mental health issues in new mothers may be missed (needs of fathers considered in section 6.4.2.3). For example, one mother described having post-natal depression and said that she ‘slip[ped] through the net’ as the health visitor was on sick leave and in the quote below another mother, who had a child with additional medical issues, described her own needs as undetected:

> There was not great follow up and the midwife/health visitor did not offer many appointments that enabled them to identify early signs that I was struggling and needed a lot more support (P98, female, 30-39yrs).

Some parents expressed concern that when mental health issues were disclosed, they were inadequately responded to. One new mother said the health visitor ‘shrugged it off’ when she described mental health concerns, and another said the health visitor had been ‘useless’ in responding to her mental health problems. Some support providers also expressed concern about increasingly distant levels of contact between mothers and health visitors with virtual appointments and parents being asked to ‘take a picture [and] show us’ if they had a concern about the baby, rather than mother and baby being seen in-person, which can make it harder to assess the welfare of both and again, reduces opportunities for incidental questions which many parents need as a foundational level of support and reassurance, particularly those who are struggling but scared to disclose their distress.

6.4.3.1 Waiting and working ‘in the meantime’

Waiting for mental health care was a common experience. In the social media analysis parents described waiting for assessments, appointments, responses from professionals, and even waiting (and giving up) for a helpline to answer the telephone. In the survey, one parent said, ‘I would have no problem asking [for mental health care], but difficulty accessing it because waiting lists are long’. Support providers too, talked about how ‘everything’s a waiting list’. Even the perception of waiting lists is a barrier and parents said it felt ‘futile asking’ for support. People are less likely to approach a service if they do not believe it has the capacity to help them.

Waiting times for professional support for children was a common concern. A support provider noted that ‘children get referred to SALT [speech and language therapist] or occupational therapists, … and then it’s sort of, 18 month waiting list’ and another said, ‘don’t ask me about CAMHS [waiting lists] though, because that’s massive’. This impacts parent mental health and wellbeing as parents ‘give up, they lose hope’. Another support provider noted ‘if a parent’s mental health isn't right, then it's never gonna’ be right for this child’ but similarly, if a child with additional needs does not have access to professional support, things will not be right for the parent (sections 2.2 and 4.2.2).

Whilst parents waited, there was frustration, sometimes anger, but waiting was not a quiet or still state. Parents and providers were highly active ‘in the meantime’. A common motivation for parents posting on Mumsnet was to seek advice ‘in the meantime’ whilst waiting for an assessment, service, medication, or in any other way waiting for ‘things to get better’. Responders also phrased recommendations as actions to take ‘in the meantime’ whilst waiting for professional care. In these discussions there was both sense of agency, that parents had power to make changes themselves, but also significant stress, that they were trying to ‘keep it together’ without the necessary support from professional services.

Support providers too, were busy helping families ‘in the meantime’, whilst they waited for another service. This could create inefficiency, as below:

> Quite often we have to do referrals to other agencies and like ourselves, we have waiting lists and they do too. So, if every service could start immediately, we could, you know, do the piece of work, close, on, but you're waiting for them (Sasha, support provider).

Another concern, was the work that community providers were being drawn into whilst a family waited for more specialist intervention:

> So, because things like CAMHS and others have such long waiting lists, we're finding that we're being asked to kind of bridge the gap and fill in while they're waiting (Eden, support provider).

In this scenario, support providers were concerned about being pulled away from their core business and into areas that they were not equipped to address. Comments included, ‘we’re not mental health professionals’, ‘I don't think I'm qualified to be the first point of call, but I am at the moment’, ‘we’re not therapists, … this is not therapy’, ‘I can't give advice… I'm not a health visitor’, and ‘we are only parent carers, we're not trained’. However, they felt compelled to do what they could, because they believed there was ‘no one else there who can, or is going to, …, step in… anytime soon’. Therefore, they offered what they could but kept ‘referring it on again’ in the hope that another service would be able to provide the level of care a family needed. This was not only unsatisfactory for families but also problematic for services and support providers, creating negative effects through the system of care provision.

6.4.4 Money Troubles

6.4.4.1 Issues of Affordability of Offerings

Parent engagement with universal access groups can be influenced by cost. In the survey, when asked about places that were difficult to access one parent wrote ‘ones I can’t afford to access’ and a support provider explained:

> There's not much free stuff in [location]. [Private] Sessions are £6.50 upwards… People, you know, affordability. [Location] is very deprived area…and to have services of £6.50 a morning and even those parents on good money, it’s often unaffordable. So, when we run free things, everyone flocks (Riley, Support Provider).

When compiling the asset map, I found some groups advertised themselves as free and others gave clear costings, but regularly such information was partially incomplete or even contradictory. Furthermore, different payment structures could be per parent, per child, or per family. Payment per child disadvantages families with multiple children. Many groups were advertised as free but with ‘donations welcome’. Support providers emphasised this was voluntary and if parents could not afford it, it was ‘not an issue’ or as another provider noted, ‘If it wasn't manageable, I wouldn't ask for it’. One of the support providers described a donations box being available on a table but parents were not specifically asked to put a donation in and many did not, which was one way of managing this situation. Such matters were intentionally managed discreetly, but few listings stated that inability to pay should not deter attendance. Although support providers were keen for groups to be accessed by need, the advertised request for 'donations' particularly where the amount was unspecified, had the potential to dissuade attendance from parents with financial concerns.

Access to mental health care was also influenced by cost. Sometimes, parents wanted (or felt they needed) to 'go private' rather than relying on NHS mental health care. For example, one parent said, 'I can't afford therapy and it's not readily available as far as I know' and another said, 'I speak to a private therapist fortnightly now… but this wasn't financially viable last year'. Another parent accessed support through their workplace but was 'out of free sessions' and did not know what to do now. Many that used private services were positive about the support but regretful that they had not been able to access it from the public system, as in this quote:

> It is a shame accessing some of the better therapists comes at such a high price. My experience of NHS referrals for therapy have all been terrible. Only the private sessions that I have funded myself have been beneficial and it has cost thousands (P56, female, 30-39yrs).

In the social media analysis, posters discussed how CBT (cognitive behavioural therapy) appeared to be the 'only' form of talking therapies available via the NHS (section 2.4.2.1). Whilst many found it useful, equally others had not but could not afford private sessions of another therapy. A surveyed parent made a similar point, commenting 'the only therapy available tends to be CBT which just isn't appropriate for everyone and doesn't always help'. This is another reminder, that financial security brings greater choice when accessing care and widens inequalities for those already disadvantaged.

6.4.4.2 Service Funding Cuts

In the public and charitable sectors, services risk closure through loss of money. In the quote below, Alex described concern about the impact of funding cuts on mental health:

> I mean, but it's always classed as funding cuts, funding cuts, but actually, those funding cuts have caused [pause] partly caused, I think, and this is just personal to me, I think that they've caused an increase in mental health [problems] with young mums that are suffering with depression and lonely and they've got, they can't just walk down the road and know that there's somewhere to go (Alex, support provider).

Funding cuts threatened both public and charity organisations but a unique precarity for the charitable sector, was the process of 'constantly having to chase for grants' to keep an operation going:

> I mean, you're fortunate if you get [funding] that's sort of two or three years, but that's less and less now. Mostly it's a year. So you might get funding for a year and then you have to reapply. Some funding you can only get once, some you can reapply every year (Eden, service provider).

Typically, funding was attached to a 'pot of money' for a specific project and rarely recurring. Indeed, some providers received COVID-19 grants but 'now that money has dried up'. An additional consequence of working under the threat of funding cuts was damage to collaboration between organisations. Whilst many support providers described working closely with other services, one provider expressed concern about charities 'all battling for funding'. When charities are insecure about funding, it can damage interagency relationships.

Some services (particularly in the public sector) were 'thinned' by reduced funding. For example, it was said that staff tried to do 'the same amount of work and maybe more in [reduced] hours' but often the scope of their offering had to be reduced, discreetly eroding available levels of support. Some public sector services were described as 'woefully undermanned', leaving existing staff with too much to do. Such subtle changes were not evident from developing the asset-map but more visible, were situations in which funding cuts led to service closure. An example of lost funding and service closure was Sure Start Children's Centres (section 2.4.1.1). When compiling the asset map, I was frequently directed from online searching, towards Sure Start Centres. In one part of the county, these services were operational but mostly, they were outdated listings leaving a digital footprint of lost services. Old links raised false hope and it was disheartening to discover advertised offerings were discontinued. In the survey, many parents commented favourably about Sure Start and some expressed regret about reduced services. For example, 'classes at the children's centre were brilliant but some of these had been withdrawn due to funding cuts before Covid'. Support providers too, spoke about the loss of Sure Start with comments such as 'we don't have Sure Start anymore, these families are in dire straits'.

One perceived impact of Sure Start closures, was reduced access to peer support. In the quote below a provider who had worked for Sure Start addressed this point:

> And I still see families now at the petrol station, 'Ohh, I remember you, I did this with you, I'm still really friends with those parents I met at so and so group' and it breaks my heart that families don't have that anymore, you know, that's not there anymore for them because they were so important (Riley, support provider).

Critics may argue there are other places for parents to socialise such as the stay-and-play groups explored previously. However, although Sure Start was universally available, staff could identify and support parents facing challenging situations. The loss of this was of profound concern:

> I think the worst thing they done … is [sighs] they got rid of the Sure Start centres, they got rid of those early help hubs where families felt that they could go and talk and that's when the first things used to be picked up and you could deal with it there and then (Alex, support provider).

The loss of Sure Start then, was a lost opportunity for early intervention with families experiencing difficulties. In the quote below, another support provider expresses regret at the closures:

> Children's centres… were very good at reaching out to families and particularly those more vulnerable who struggled to go along to groups or don't feel like they fit in or are quite anxious, you know, or shy. They were good at building relationships with them and so when they went, I guess they probably felt they had nowhere to go. … So those are probably the families that fall through the loop, fall through the gaps a little bit (Eden, support provider).

Sure Start Children's Centres were not perfect. One surveyed parent described asking a Children's Centre for mental health support but 'never hearing back'. However, there was a profound sense of loss from their closure and concern that families experiencing difficulties remained hidden until the child started school, by which time issues may be entrenched. The potential for the new 'Family Hubs' (section 2.4.1.1.) will be considered in Chapter 7.

6.5 Aspirations for Future Service Development

6.5.1 Easier Access to Better Information

There were calls for 'better promotion of what's out there' and 'easier pathways to finding the correct help' to address the issues that parents face locating support (section 6.4.2.1). The internet is recognised as part of this solution but also the need for improved signposting from in-person contacts:

> Training for the medical community and raising awareness among the wider population. Not just about common conditions (to inform and destigmatise) but also to better inform as to where you can seek help (P106, female, 30-39yrs).

Parents and support providers wanted information shared through multiple (online, in-print and in-person) pathways, a message reinforced by the difficulties that I too experienced, compiling the asset map.

There were frequent calls from parents and support providers, for ‘resources targeted locally based on local need’, with ‘local groups’, local ‘drop-in centres’ and support through local libraries, community centres, schools and churches. ‘Drop-in’ spaces were suggested, where people can access the support that they need without an appointment and there were also calls for ‘more facilities available for those parents who work school hours’. The quote below incorporates both of these points:

> You almost need a service that is outside of the normal working hours. And I don't know, in a family centre somewhere, … and they can turn up. They don't have to make an appointment. They can turn up... And have … a mental health worker there, someone from substance misuse there, someone from therapeutic services there, housing… benefits (Alex, support provider).

Similarly, there were calls for flexible timeframes for service interventions, responsive to parent needs rather than attempting to ‘fit’ parent needs into pre-determined allocated intervention schedules.

Parents wanted ‘more support groups or increasing availability of groups already there’, so that parents could join ‘free accessible parent meet-ups where you can go and talk to professionals/ others who are feeling the same as you’. This point is expanded below:

> Parent groups are desperately needed. Talking and listening to others has helped me feel that I’m not the only one feeling and going through problems. There are lots of mums out there who struggle with the simplest of tasks but find it a real struggle and feel alone. Talking is so important (P265, female, 40-49ys).

Often, such calls came from female respondents but ‘facilitating support groups for fathers’ was identified as a need too. There were also calls for better access to parenting ‘classes’ or ‘workshops’, as in the quote below:

> Better access to… family therapy and parenting workshops would be an enormous help. It would be great to have somewhere to get advice and mentoring, like I imagine you would have had from elders in the past (P115, female, 40-49yrs).

However, it is important that such courses consider the mental health and wellbeing of the parent and promote self-care, if courses are to be truly supportive. Stigma must also be dispelled to encourage engagement with re-framing as ‘we all have stuff to learn’ and ‘we all need a bit of help’.

Another option to improve flexibility of access, was development of online opportunities. Parents in the survey were keen for there to be more ‘online support groups’, ‘online videos calls to a professional’ and ‘online resources from trusted sources’, in addition to more ‘traditional’ ‘support calls’ and a ‘national helpline’. These perspectives show that there is an appetite amongst some parents for remote methods of support to form options in an overall package of support but as addressed previously, not to replace in-person support opportunities.

6.5.2 Opening the Door to Universal Spaces of Support

Many parents and providers wanted improved access to universal care. Indeed, one support provider wanted ‘early intervention’ to be so early, that children in schools were taught about developing warm parent-child relationships, long before they even became a parent. For many parents and providers, improved universal access support for parent mental health and wellbeing began with ‘more ability to talk to GP’ and improved contact with health visitors, with those visits also be more focused on mental health. Indicative quotes are shared below from both perspectives:

> More of a focus [on mental health] for health visitors/ midwives. I think mum’s mental health should be as important as baby (P56, female, 30-39yrs).
>
> Why aren't health visitors trained more in mental health to be able to have more in depth conversations about, you know, basic interventions in mental health first aid, for example, would be amazing. I think they they're such a valuable resource (Toni, Support Provider).

Furthermore, there was interest in having ‘check in for dads mental health’ with a health visitor, and a return to scheduled weighing clinics for babies, where parents could be assured of being able to see a health professional without an appointment.

Other suggestions regarding universal access services, included calls for 'reopening Children's Centres', which was echoed by this support provider:

> I would bring back Children's Centres. I really would. I would put it all back in place (Riley, support provider).

Once again there were calls for the service to not only be restored but expanded, this time for parents of older children:

> My dream is family centres where activity, play and social time happen beyond the early years (P66, female, 40-49yrs).

This recognises the need for ongoing access to universal spaces of parent support for parents of older children as well as returning to easier access to support for parents of pre-school children.

6.5.3 Supporting the Mental Health and Wellbeing of Parents who have children with additional needs

When asked what would help parent mental health and wellbeing, many comments related to the needs of children. In the survey, comments included 'more support services for new child diagnoses', 'schools could provide more support for a child's mental health and wellbeing', and 'The NHS needs to step up and get interventions in place for parents who can't cope with the behaviour of their children'. There were also calls for better respite. Similarly, support providers recognised that parents would benefit from improved professional support for children when needed:

> I think it's probably maybe just got to be more support quicker… support for children who are really, really struggling needs to come sooner because I think that is so much of the pain and the challenges that we're helping parents to manage (Eden, support provider).

Furthermore, there were calls for specialist supports for parents *focused on the needs of the parent*. Options include support groups as outlined previously, but also dedicated resources and spaces. The 'dream' of one support provider is shared below:

> I want a safe house for them [parents of children with additional needs] to come to, to have treatments, talk, a lovely garden where they can sit and just relax. Somewhere we can take their kids off to, so they know their kids have been looked after…. But just a safe place for them. A haven (Robin, support provider).

There is a delicate balance in supporting parents of children with additional needs to create easier and more supportive pathways to care for the child as a critical first step, but also to recognise and respond to the needs of the parent too.

6.5.4 Improved Mental Health Care for Parents

Desired improvements to mental health care for parents were expressed, beginning with mental health promotion that did not require a 'mental illness' for engagement:

> I probably had increased anxiety as a new mum but didn't want a 'diagnosis' or to indicate to some people that I sometimes found it hard to cope. Maybe some casual mental health support groups that are available to everyone, without having to have a diagnosis (P245, female, 30-39yrs).

As another parent noted, 'sometimes all people need is an understanding listening ear, no advice or judgement'. There was also interest in improved structures to identify mental health problems, as this parent envisioned:

> It would be good if mental health checks were a regular thing like dentist appointments (for everyone, not just parents), so making mental health a regular appointment service rather than something you turn to only if you really need it (P290, female, 20-29yrs).

Such routine consideration of mental health could help provide 'reassurance that it's ok to ask for help' and enable parents to engage with services when ready, not require them to make disclosures at a (service-led) pre-determined opportunity:

> Continuing to ask a mother about their mental health and wellbeing. At 6week GP check I was asked about my mh [mental health] but I was not ready to talk at that point. I was still overwhelmed post birth and dealing with a new born (P25, female, 30-39yrs).

When parents do access mental health care, there were calls for this process to be easier and sooner:

> A lot more support will be required for mental health for parents and families and it shouldn't need to take months and years to provide it (P160, female, 40-49yrs).

Support providers made comments such as, 'no one should jump through hoops to get an appointment to see someone if their mental health is that significantly poor' and what is needed is 'a much more accessible, bureaucracy free, way in which parents can access mental health support' (section 6.5.1). Indeed, recognition for the specific needs of parents who access mental health services was an area for attention. In the quote below, a support provider describes a desire to see mental health services that are more accommodating specifically, of parents in the perinatal period:

> Whether that is counselling, whether that is advice on, on self, you know self-care advice, whether that's mindfulness classes, what you know, whatever that is, but that it's tailored to new parents, so that actually they can go with their baby or, you know, it's a time that suits them (Toni, service provider).

More generally, there were calls for 'better investment in mental health services' to enable 'shorter waiting lists' so that 'staff can do something rather than just put people on waiting lists', or as another parent phrased it, 'better funding for mental health services. Less lip service and more action'.

6.6 Conclusion

This Chapter has explored parents' interactions with the service landscape, ranging from small voluntary led groups to specialist state-provided services. There have been elements of good practice and reasons for hope, often linked to the hard-work and dedication of the people that are passionate about supporting parents and families and use resources that are available to creatively respond to the needs that they see. However, it has also demonstrated that access to formal spaces of support in the 'village' is not equal and many parents face significant to engagement, associated (as in earlier chapters) with resources of relationships, space, time, and money, creating unequal experiences of treatment burden and help-seeking opportunities. Furthermore, there has been significant erosion of services, particularly public-sector services in recent years, as reported in prior literature (section 2.4) but also, more subtle erosions that are less well recognised in media or academic publications. Overall, what remains are often diminished services with limited capacity to meet demand. This can leave parents and families without access to necessary resources and create further strain on service providers.

Findings were mostly convergent or complementary, with parents and support providers expressing similar concerns and interestingly, similar aspirations for change and future practice, which again, often aligned with previous research (section 2.4). These concerns are developed alongside the literature in Chapter 7, whilst aspirations for change, form the focus of Chapter 8. Some points of potential dissonance have been explored between parent and support-provider perspectives, but still these points were largely framed around a common concern for the family wellbeing. Parents were frustrated with services at times, but often such frustrations were shared by support-providers working or volunteering in a system that they wanted to see offering better (and sooner) support.

This has been the final findings chapter. Data about parent access to support at home, in the community, and from services has been explored. In Chapters 7 and 8, findings from this study are integrated with extant research, to develop a detailed picture of inequalities in access to support for parent mental health and wellbeing in the modern ‘village’ of UK parenthood and extend the debate in key areas identified through this research.

Chapter 7 Discussion: Parent Mental Health and Inequality

7.1 Introduction

This discussion draws together findings alongside wider literature, for an over-arching exploration of parent mental health and wellbeing and inequality, relating to research questions 1 – 3:

Q1: If ‘it takes a village to raise a child’, how is the modern day ‘village’ constructed for and by UK parents?

Q2: What resources are required to access the support of the village, and what inequalities exist in parent access to these resources?

Q3: What are the impacts on parent mental health and wellbeing from unequal access to support?

Findings related to research question 4, which was informed/synthesized by the answers to the first three research questions, are presented in Chapter 8.

By taking a broad perspective, connections between social changes and service-losses become apparent and effects that have arisen from supports being chipped away, become visible in a way that would not have been possible from a narrower scope of enquiry. This Chapter is organised by the familiar resources of relationships, space, time, and money.

7.2 Relationships: the fabric of the ‘village’

At the heart of this study is the importance of relationships that parents’ experience. With the guiding principle of the ‘village’ approach informing the analysis, the accounts of parents’ experiences were underpinned by a relational story about ‘linked lives’ (Hall, 2019a). Relationships can support parent mental health and wellbeing, cause stress, or more typically in the messy nature of human interaction, do both

(Falkov, 2015). Relationships will be considered, guided by the environments of home, community, and the service landscape, that framed the findings chapters.

7.2.1 Household Relationships

Households can be composed in many ways but in this discussion, the focus will be on the parent-partner and then parent-child relationship. Not all partner relationships discussed in this research related to heterosexual relationships but the majority did and so in keeping with this data, the focus is primarily on heterosexual relationships. For literature pertaining to LGBTQ parenthood, see Acosta (2020), Darwin and Greenfield (2019) and Luzia (2010). In this research though, it was the gender dynamics in heterosexual relationships that were evident, particularly in the social media analysis, with female posters expressing dissatisfaction about male partners (section 4.2.2.2). The gendered nature of managing household tasks and care relationships, and the tensions that this can create, are well documented (section 3.3). In this study (section 4.2 and 4.4.2), as in previous work (O'Reilly and Green, 2021, Franklin, 2019, McAuliffe et al., 2019) many women described disproportionate burden of domestic and care duties, leading to frustration and relationship disharmony. That is not to say all women felt this way, others spoke positively about their male partners. However, there were multiple examples where the distribution of care and domestic work led to resentment, which could negatively impact the relationship and mental health and wellbeing. Furthermore, when the partner-relationship was strained it not only created a pressure on mental health and wellbeing but damaged a potential support. This was particularly relevant where a parent had problems with their mental health and in some cases, a diagnosed mental illness. Whilst some parents described emotional support from partners, many others felt unsupported and rather than providing a source of support, the partner relationship was a cause of additional stress (Gabb and Singh, 2015). However, services supporting the partner relationship have previously described as 'a patchwork of largely uncoordinated provision… inconsistent in level and availability', with high levels of need but particularly poor levels of access, amongst couples living in poverty (Callanan et al., 2017, p. 5). Problems in the partner relationship were reported across multiple methods but pathways to support were not clear.

An avenue of peer support captured in the social media analysis, was to post for relationship advice in an anonymous online forum. In this study, threads seeking relationship advice appeared (although this could not be verified) to have been written by women mostly (but not exclusively) in heterosexual relationships. These threads were still posted in the 'mental health' forum but related to partner-relationships. The women who wrote the original posts were largely met with supportive comments from the online community but respondents were often critical of the male partners described in these posts, even (or perhaps especially) when the man had mental health issues (section 5.4.2.2). Indeed, some posts were highly critical of the woman who stayed in a relationship with a man who had problems with his mental health. There were connections with wider narratives about male (in)competency in parenthood (Bourantani, 2018), stigma against male mental illness (Latalova et al., 2014), and the different reception sometimes afforded to and about men in online spaces (Pederson, 2015). The forum was of course, a site of peer support, and whilst moderated could not be expected to provide advice akin to professional counsel. Nevertheless, the critical nature of so many comments about male partners adds a note of caution that the 'support' was contextualised and could further distress.

Partners may separate and construct new family formations. In this research (section 4.2.2.2), there were descriptions of single parents having strained contact with a former partner and challenges negotiating step-family relations, creating strain on mental health and wellbeing (Walker, 2022 and Tarrant, 2020). The challenges experienced by single parents were identified at multiple points during this study (for example, sections 4.4 and 5.4.1.2), highlighting the need to consider the impact of single parenthood on mental health, wellbeing and access to support, as also recognised in previous research (such as Attree 2005, and Longhurst et al., 2012). Multiple comments in this research though, indicated that single parents often felt that their circumstances were poorly accommodated.

Domestic abuse was a serious issue raised in the social media analysis and provider interviews, (section 4.2.2.3), connecting with wider research about the prevalence of domestic abuse. The Office for National Statistics estimates that 1.7million women and 699,000 men in England and Wales, experienced domestic abuse in the year ending March 2022 (Elkin, 2022). Although not extensively addressed within this research, references to domestic abuse were a reminder that the partner relationship could be a source of serious harm on physical safety as well as stress on mental health and wellbeing.

Moving on now, I consider the parent-child relationship. The love parents felt for their children was expressed regularly, even in challenging circumstances, such as expressed in the social media analysis (see 4.2.1). In keeping with previous research, in this study it was found that time with children was highly valued (Kehil and Thomsan, 2011), could bring 'joy and satisfaction' (Park and Lee, 2022, p. 1) and was widely regarded as a highly meaningful occupation (Llewellyn, 2010). Parents described children as a motivation for many positive actions, even a reason to live (4.2.1, see also van der Ende, 2016). However, difficulties were also raised. The significant and long-lasting harmful effects of a poor parent-child relationship on the child are well documented (Reupert et al, 2022). Parents too, can experience negative impacts on their mental health and wellbeing from parent-child relationship issues (Falkov, 2015). This discussion will focus on two areas where concerns were commonly identified in the parent-child relationship; when the child had additional needs and/ or, the parent was experiencing problems with their own mental health (section 4.2).

In qualitative methods there were descriptions of difficulties in the parent-child relationship when the child had additional needs (section 4.2.2.1 and McAuliffe et al., 2019). During the pandemic parents with child(ren) with special education needs and/or neurodevelopmental differences were one of the groups identified as having a heightened risk of depression (Shum et al., 2021) but high levels of parent stress and depression have also been identified as long-term concerns (Park and Lee, 2022), a conclusion echoed by this research. In this study there were also accounts of parents being physically attacked by their children (see also, Holt 2011). Poor relationship between parents and children when children have additional needs can be damaging to both and requires empathetic support but as was identified in section 6.4, and will be returned to later in this discussion, such support is often lacking which leaves parents attempting to cope with high levels of need at home. A significant concern was identified though this research about unmet needs in households where children have additional needs.

The parent-child relationship can face particular pressures when a parent experiences mental illness. In this research, parents found it hard to engage with children whilst depressed, found worries about children became a focus of anxious thoughts, and children could be unwittingly placed at risk of harm during a parent's manic episode (section 4.2.2.3). These results are reflected in the wider literature (Creswell et al., 2015; Gladstone et al., 2015b). Parents described strategies to mitigate adverse impacts on children from their mental illness and worked hard to preserve the relationship even when suffering significant distress (section 4.2.2.3). However, they expressed feelings of inadequacy and fears that their children would be adversely impacted by their mental health (4.2.2.3 and see van der Ende, 2016). It is human nature to want to do well at things that are valued and it 'is a source of considerable pain' to feel less capable than others or than one once was, to perform activities of high personal meaning (Kielhofner, 2008, p.37). Living with a sense of 'failing' one's children can create a sense of anguish between ideals of parenthood and reality of the lived experience (Pedersen, 2016) which was expressed directly by parents, particularly in the social media analysis. Of particular concern in the social media analysis, was that some posters wondered if their children would be 'better off' if they completed suicide (section 4.2.2.3). This relates to the concept of 'perceived burdensomeness' explained in the 'interpersonal theory of suicide' as one of the conditions typically present in those who attempt suicide (Van Ordern, 2020). To summarise this principal, people who act on suicidal thoughts typically believe that they are a burden to those that they care about and that it would better for those loved ones if they were to die (ibid). Such feelings can be difficult to discuss and were only identified in this research in the social media analysis where parents spoke anonymously. However, they raise an important area of concern. Suicide is the leading cause of death amongst men aged 15-49yrs and the second leading cause of maternal death in the UK (Mental Health Taskforce, 2016). Exploring the impacts of the parent-child relationship is a critical part of mental health care for parents and whilst the parent-child relationship can be a protective factor to deter suicidal planning, it can, as demonstrated, also feature as a component of concern.

7.2.2 Informal Communities of Support and Impacts on Parental Mental Health and Wellbeing

Parent and support provider accounts in this research revealed that when parents felt well supported by friends and family it could provide emotional support and practical relief (section 5.2). Such sentiments have been echoed in previous studies (Mikucka and Rizzi, 2016) and addressed in wider literature, exploring geographies of caring relationships more broadly (Bowlby, 2011). As also explored in previous studies, these relationships were enacted in local public spaces (section 5.2 and Cattell et al., 2007), home (section 4.2.1 and Kehily and Thomson, 2011), and online spaces (section 5.2 and Brady and Guerin, 2010). Being able to honestly share parenting struggles with a 'tribe' of supportive other parents was described as beneficial for mental health and wellbeing in this study and past research (Reupert et al., 2022). Many parents said that they would, or had previously, spoken to family and friends about their own mental health or to seek support with the needs of the child (section 5.2), which relates to informal help-seeking behaviours also described elsewhere (Newlove-Delgado et al., 2022). Social support has been found to have a 'buffering effect' against the risk of depression in mothers who have children with additional needs (Park and Lee, 2022), and 'sandwich generation' women (caring for children and older relatives) described being about to 'keep going' with social support (Evans et al., 2016), demonstrating the value of social support with parents in challenging circumstances. Although the pandemic interrupted access to social support, the reliance that so many parents 'usually' had on friends and family testify that the village has not entirely 'gone' for many parents (section 5.3). Indeed, the disruption experienced during the pandemic served to highlight the significance of such informal social support that is often enacted so discreetly as to be almost overlooked. When parents who were used to being socially well supported were separated from that support, it generated significant distress and practical implications (i.e., managing childcare). Such difficulties draw attention to the needs of parents who chronically lack social support networks, shining new light and perhaps broader empathy, for the situation of parenting without strong informal networks of care. The benefit from strong social support evident in this research adds to calls from previous studies, that facilitating social connection and peer support between parents is not a 'luxury' but needs to at the core of promoting parent mental health and wellbeing (Jupp, 2022). Some of the barriers to enjoying supportive social relationships are explored next.

Within this research, as in wider research, issues were expressed about community 'support' perceived to be judgmental or unhelpful (section 5.4 and Attree, 2005, Pedersen, 2013, Middleton and Samanani, 2020, Damaske, 2013). Parents with a mental illness (Reupert et al., 2022), single parents (Dermott and Pomati, 2016), and parents caring for children with additional needs (in the case of Kelada et al., 2019, parents of children with cancer) could be particularly vulnerable to critical social comments that lacked understanding of the family challenges. Contradictory and unrealistic 'advice' from traditional media and social media sources, added to a lack of confidence, confusion, and stress, (section 6.4.1.2, and Ekinsmyth et al, 2004). Sometimes parents felt they did not belong in spaces of parenthood and felt alone, even in company, reflected in online data and the survey (section 5.4 and Bourantani, 2018, Jones 2014). Sometimes parents encountered unkind social connections, enacted in physical locations such as the school gate, as well as the virtual spaces of social media (Archer and Kao, 2018). Such encounters could leave parents distressed and avoidant of these places in future, therefore separating them from supportive relationships that could have been fostered in those spaces (Bunting, 2017).

Pre-pandemic (2016-2017), 5% of UK adults (not only parents) reported feeling lonely (ONS, 2018). The findings in this survey (although not representative) were significantly higher (section 5.4). However, the survey was distributed during a pandemic lockdown (February – May 2021) which would have influenced results. Indeed, the figures were more closely aligned with a survey conducted during the first lockdown, in which 24% of respondents felt lonely (Mental Health Foundation, 2020). Still, qualitative accounts frequently described loneliness and isolation as long-term concerns linked to changing social practices (section 5.4.1.2). This connects with wider literature as exemplified in the quote below that also draws on the village metaphor:

> The village, in many countries today, is dissipated and fragmented and individuals are increasingly isolated and are not eager to ask for, or provide help to, others (Reupert et al, 2022, p2).

The fragmentation referred to above links to many factors evident in this study (section 5.4), such as migration within or between countries (see also, Eastwood et al., 2014), more women in the workplace and working until later in life (section 4.4.2 and McKie et al., 2002), family dissolution (section 4.2.2.2 and Walker, 2022), and funding cuts leading to reduced communal spaces to bring parents together (6.4.4.2 and Jupp, 2022a). The internet can offer new ways of forming connections and social capital can be built online but is considered more as a supplement rather than alternative to in-person connections (section 6.4.2.2 and Drentea and Moron-Cross, 2005). Many posters in this social media analysis, although grateful for the support, expressed regret that they were sharing concerns with online 'strangers' as a consequence of inadequate 'real life' support and limitations to online support were also identified in the survey and during interviews (section 5.4).

This research demonstrated that many parents experience loneliness and whilst the pandemic made the situation worse, did not create it. Data concurred with previous studies about risk of loneliness and isolation for parents in the perinatal period, parents from ethnic and language minority groups including refugees, parents with mental health issues, who have children with additional needs and single parents (Jaworska, 2018, Bunting et al., 2017, Eastwood, et al., 2013, Uwamaliya, 2015 Nowland et al., 2019, van der Ende, 2016, Attree, 2005, Quelta et al., 2020). Furthermore, whilst loneliness and isolation can be experienced by anyone, there are high levels of intersectionality between these domains and socioeconomic deprivation, in another example of social determinants of health impacting upon mental health and wellbeing (Shim and Compton, 2020). Indeed, a large quantitative study found that mothers already privileged by education and income were more likely to be socially well-supported than women facing disadvantage, leading to the conclusion that, 'relationships with relatives should not be considered to be coping strategies of disadvantaged women, but rather additional dimensions of social privilege' (Mikucka and Rizzi, 2016, p969). Loneliness and isolation, particularly when combined with socioeconomic disadvantage, have been shown to have negative impacts on physical and mental health (Leigh-Hunt et al., 2017, Nowland et al., 2019) and leave people more vulnerable to adverse impacts as the state withdraws (Power et al., 2021) as they do not have access to wider resources of support and as such, are impacted more severely by adverse events (Bowlby and McKie, 2018, Bunting et al., 2017). Findings from this research concurred with these earlier studies and reaffirms loneliness and isolation amongst parents as a pressing public health issue, particularly amongst those facing financial stress and as such, adding to concerns about health inequalities for these parents. However, as identified previously (section 2.3.2.2) studies dedicated to exploring loneliness and social isolation amongst parents are rare (Bessaha et al., 2020, Mund et al., 2020, Qualter et al., 2023). This study therefore, contributes towards this sparse literature and also highlights an important area on which to focus further research.

7.2.3 Parent Relationships with Services and Service Providers

The next layer of support in the village, is that of organised offerings. Whether volunteer led, charitable organisations, or statutory provided services, all offerings were at their core, about relationships (section 6.3.1). Sometimes, parents and support-providers do not have a warm relationship. Examples were given from parents feeling frustrated, even angry, with service providers and as in past research, this was often connected to not feeling listened to or responded to appropriately (section 6.4.1.2 and Baenziger et al., 2020; Hansen et al., 2021). The sheer number of negative comments about attempts to engage with health services expressed in the survey, social media analysis, and interviews, was troubling.

A specific area identified in this study, were the high levels of concern that parents had about engaging with support services through fear of how their parenting would be judged. This could deter parents from engaging in parent-specific offerings. For example, some interviewed support providers facilitated parenting skills groups, with the intention of supporting parents to foster warmer relationships with their children and sometimes, to manage child behavioural difficulties. These groups were described as beneficial for parent and child wellbeing (section 6.2.1), connecting with past research about the potential merits of such programs (McDaid and Park, 2022).

It should also be acknowledged that such programmes have also been critiqued (section 2.4.1.2) and within this study, there were concerns that sometimes parenting courses were recommended without an appreciation of the family circumstances or sufficient individual attention on the needs of the child. However, recognising the potential benefits of engagement in parenting courses, the stigma that can surround participation (section 6.4.1.2) is a concern and barrier (Holloway and Pimlott-Wilson, 2014; Pote et al., 2019). Parenting courses provide an example of the need to normalise support within a village model so that parents can engage in support without feeling such engagement implies negative connotations about their parenting.

The fear of judgement from services was especially pronounced amongst parents struggling with their mental health. Whilst parent-child relationship could encourage parents to seek treatment for mental illness, as parents wanted to improve their mental state for the sake of their children (section 4.2.1) many avoided contacting mental health services through fear of child (section 6.4.1.2). This is a unique challenge of engaging parents in mental health services and demonstrates again, the need for sensitivity to the emotional as well as practical implications of parenthood on mental health care help-seeking that needs to be considered by service providers (Reupert et al., 2022; Reupert and Maybery, 2016; Solantaus et al., 2015, returned to later in Chapter 8).

The support providers interviewed in this study generally described warm relationships with parents (expanded below) but where there were points of difference, it was about concern of parents pathologizing their children and seeking medicalised interventions, rather than acknowledging impacts of their behaviour on the child and also, unrealistic expectations of what a service could offer (section 6.4.1.2). These situations, suggest unintended effects of wider system issues, as providers may not have the time to invest in understanding the needs of the family, parents have not had early intervention to address emerging issues, and services that they interact with may not be the service that is really needed, but another organisation doing what they can ‘in the meantime’ whilst waiting for a higher level of support (section 6.4.3.1). In all of these ways, wider inadequacies in the system can damage parent-provider relationships and when parents have a bad experience with a provider, they are deterred from seeking help again (6.4.2.2 and Hansen et al., 2021), which increases the risk that parents will seek help late or not at all, both of which can create adverse impacts for themselves and their children.

The support providers interviewed in this study were united in wanting to help parents and where they were resourced to do so, found their work rewarding (see 6.3.1.3). People can derive great satisfaction from volunteering and working in caring roles and when that passion is nurtured (rather than drained) they provide the greatest resource of all. This passion was appreciated by parents (section 6.3.1.3). In wider literature, authors have spoken about how the transformative impact of relationships where parents feel that workers genuinely care about them (Darra, et al, 2020, Jupp, 2022). A great asset of many services was the commitment, professionalism, and experience of their (paid and unpaid) workforce and the relationships built with service-users (Power et al., 2021, Moffatt, 2018, Salyers et al., 2015) which was reaffirmed from multiple perspectives in this research. Alongside this passion though, was frustration and occasionally anger, that the resources did not exist for them to provide the level of support that they desired and arguably, that was needed to protect and promote parent mental health and wellbeing, particularly when they were being drawn into work that they did not feel qualified to perform as a knock-on effect from diminished resources elsewhere (section 6.4.3.1).

Finally, attention is given to peer support relationships fostered within facilitated groups. Attendance at groups is not just determined by practical constraints but also a sense of belonging, in which parents feel more comfortable where they share likeness with others (Townley, 2022). Parents experiencing mental health issues can find it hard to engage with a group, as presented in section 6.4.2.3 and also identified in prior research (Coates et al., 2017; Jones et al., 2014) but there were many other factors as well. Support providers interviewed in this research described varying levels of engagement from people from different ethnic minority backgrounds and also, a range of financial circumstances (sections 6.3.4.2 and 6.4.4.1). In each of these situations, the support providers commented on the importance (as Townley described above) of seeing others in the group with shared characteristics to promote a sense of belonging. Another consideration is that most stay-and-play offerings identified in the asset map were run by churches and the level of religious messaging varied. It was beyond the remit of this research to explore demographics who felt included or not in church groups but see Acosta (2020) for a discussion of inclusion in religious spaces for LGBTQ-parent families. Sharing and expressing faith is a key reason that people volunteer (Denning, 2021) but it is important that families have choice in where to attend. Some support-providers described regular engagement from fathers in their groups but all described working more often with mothers (section 6.4.2.3). Men have described feeling invisible in parenting spaces (Doucet, 2011) and (as was found when compiling the asset map) are often absent or minimally represented in the language and imagery used to advertise groups (see also, Brooks and Hodkinson, 2020). There were groups specifically for fathers, held at weekends. However, this reaffirms presumptions about fathers at work mid-week. In previous research, stay-at-home fathers have described feeling 'out-of-place' in these groups as well, conscious they are targeted towards 'breadwinner' fathers (Brooks and Hodkinson, 2019). Similarly, working mothers cannot access mid-week offerings, which many commented about in the survey, nor can they access father-only sessions at weekends, highlighting a need to promote access to supportive spaces that respond to modern parenthood so that more parents can benefit from access to facilitated peer support.

7.3 Spaces of Potential Support for Parent Mental Health and Wellbeing

7.3.1 Mental Health Begins at Home

This research reaffirmed the importance of home spaces for mental health and wellbeing (Blunt and Dowling, 2006; Jupp et al., 2019) but as introduced earlier, part of the home environment's emotional impact relates to experiences of leaving it. 'Getting out of the house' was a coping strategy described often in this research but restricted in the pandemic, not only by government laws (Appendix H) but also fears of contracting COVID-19 (section 5.3 and Thompson et al., 2022). Many parents described missing the release of ‘getting out’ and being able to ‘get away’ during lockdowns with negative impact on mental and physical health, and relationships (sections 4.3.2 and 5.3). People with clinical vulnerability were advised to ‘shield’ and spent even longer at home (section 4.3.2 and see Williams et al., 2021) but restrictions on getting out for people with different health conditions and abilities is not new. Indeed, ‘getting out’ with a baby or child can be a challenge, even without a specific health, (dis)ability, or social need (Boyer and Spinney, 2016; Ekinsmyth et al., 2004; Luzia, 2010; Middleton and Samanani, 2021). For people with mobility access challenges (Corran et al., 2018), mental health problems (Davidson, 2001), and social barriers such as stigma (Feeney, 2019), getting out can be even harder. In this research, many parents experiencing poor mental health described heightened anxiety about leaving home, sometimes even answering the door, which can create a longer-term sense of confinement damaging to mental health (section 4.3.2). Parents of children with additional needs were frequently identified as facing ongoing barriers to leaving home from physical challenges and a lack of social support. The national ‘lockdowns’ are over, but some parents continue to feel confined at home.

The unusual experience of being in home environments during the pandemic, does require closer attention, particularly in relation to what those experiences teach about longer-term trends. Some parents positively described time at home in lockdown and referred to favourable aspects of their home environment as having helped (see 4.3.1 and also, Marsh et al., 2021). However, many found lockdowns a challenging period in spaces ill-suited to the extra activities conducted at home, which resulted in increased stress and household tensions. This finding was similar to other studies (Aznar et al., 2021; Blundell et al., 2020; O’Reilly and Green, 2021). For example, some parents felt constrained without a garden. In the UK, one in eight households do not have a garden and Black people are almost four times as likely to not have a garden as White people (Dutton and Engledew, 2020), demonstrating who is more likely to experience this negative structural impact in the wider population.

The juxtaposition to the above situation, were parents who could not stay home. During the pandemic, keyworkers typically maintained employment outside of the home. Within this research were those who welcomed the opportunity and those that did not, upset about not caring for their children and often, fearful of contracting and/ or passing on COVID-19 (section 4.4.2). Such fears were well founded, with keyworkers over-represented amongst those who died from Covid infections (Blundell et al., 2020). Since the pandemic, more people work at home (Office for National Statistics, 2022), advantages of which were extolled by survey recipients in this research (section 4.4.2). However, home working is typically less viable for keyworkers, particularly sectors such as care and retail, dominated by women and people from ethnic minorities in often low-paid positions (Blundell et al., 2020). Indeed, low-income earners are less likely to have work from home options (Office for National Statistics, 2022). More broadly, problems of work/ life balance were raised often by parents in this research, as in other studies (Ekinsmyth et al., 2004; McKie et al., 2002). Inflexible work practices, unaffordable and inaccessible childcare, and poor social support, were all described as adding stress to the work/life interface for parents, in particular, women, single parents, and parents of children with additional needs (section 4.4.2). Questions of who can, must, and cannot, go out of home for employment are complex and whilst lockdown restrictions brought renewed interest to the subject, there are ongoing challenges. There are risks of wider inequalities in mental health where not all sectors have opportunities for hybrid or flexible working and parents have different needs according to the circumstances of their family.

There was concern during the pandemic that family issues were ’hidden’ because the family did not go ‘out’ and many services (often cancelled or moved to online delivery) did not go ‘in’ (Institute of Health Visitors, 2021). Once again though, COVID-19 shone a light on a longer-term trend. Across the methods, but particularly in support provider interviews, were concerns that social and professional contacts between parents and supportive others were eroding even prior to the pandemic with for example, more migration across and between countries leading to less contact with family (see section 5.4 and Qualter et al., 2023), reduction in health visitor contact (section 6.4.3) and closure of Sure Start Children’s Centres (section

6.4.4.2 and G. Smith et al., 2018). The possible impact of limited contact with services risks damage to health outcomes over time for parents and for their children (Institute of Health Visitors, 2021). This is another way in which inequalities persist or widen for some communities who cannot access support.

Finally, whilst distressing lockdown experiences at home were widely reported (section 4.3.2) for many, the home may have been sufficient again when restrictions on movement were removed as the pandemic situation improved, for example, children returned to school (see Appendix H). However, some parents face ongoing challenges with home environments which may be generally unsatisfactory or even unsafe. In this study, examples included a mother sleeping on a mouldy mattress or cooking in an oven with no door (see 4.5.3 and also, Serjeant et al., 2021; Thompson et al., 2017 for further discussion about unsafe living environments). Housing insecurity and homelessness were identified in support provider interviews and some social media accounts, creating strain on mental health and wellbeing, as also described in prior studies (Bassuk and Beardslee, 2014; Keeshin et al., 2015; Rybski and Israel, 2017; Thompson et al., 2017). In this research, as in prior research, housing insecurity was associated with families living in poverty (Hall, 2019; Wilkinson and Ortega-AlcÁzar, 2017) and escaping domestic violence (Keeshin et al., 2015). Within the case study area of this research, government reports indicate that The Test Valley, Rushmoor, Southampton, and Portsmouth have higher rates of homelessness per 1000 households, than the average for the rest of England excluding London (Department for Levelling Up, 2022). Thousands of UK parents experience homelessness (ibid), with many more living in unsafe and/ or insecure housing, creating considerable pressure on mental health and wellbeing. The research presented here shows the relevance of housing in this study, as with previous research on mental health and inequalities, underscoring the importance of structural social determinants of mental health (Compton and Shim, 2020).

7.3.2 Access and Barriers to Community Spaces of (possible) Support

When parents exit their home, they enter into neighbourhood spaces. Some of those described within this research included retail, hospitality, and leisure/ recreation, including ‘natural’ places, such as woods and beaches, and ‘built’ venues, such as soft-play centres and historic houses. The importance of access to ‘green’ and ‘blue’ space was described often (section 5.2.2) and many people found solace in nature during the pandemic (see also Pouso et al., 2021), with the ongoing positive benefits on mental health and wellbeing of engagement with nature reported elsewhere (Liu et al., 2020). Less attention typically focuses on the impact to wellbeing of ‘ordinary spaces’ which was a key component of this study, such as retail and hospitality venues (Cattell et al., 2008) and the characteristics that make spaces accessible (or not) to parents (Eastwood et al., 2014; Ekinsmyth et al., 2004). The importance of community access to these ordinary spaces for parent mental health and wellbeing was expressed in this research and once again, disruptions to accessing usual places of support increased the focus on generally under-recognised spaces. During the pandemic, access to community venues was heavily restricted and parents described negative impacts on their mental health and wellbeing from exclusion to these meaningful places (section 5.3), sharpening attention on those facing long-term, structural barriers. One such barrier identified in this and previous studies (Boyer and Spinney, 2016; Dowling, 2000) was lack of access to a car, which was described as placing limitations on community access for parents, their children, and their access to healthcare services as a result (section 5.4). The concern was intensified during the pandemic with fears of travelling on public transport (Thompson et al, 2022) but was also reported as an issue independent of pandemic experiences. Another barrier for some parents, is from poor accessibility to environments that fail to accommodate a physical disability such as, limited wheelchair accessibility (Corran et al., 2018). However, in this research, social barriers to accessing community locations were described more commonly than physical barriers, (section 5.4), whereby it was fear of judgement and stigma that deterred community access and as already discussed (7.2.2) could increase risks of social isolation and loneliness.

7.3.3 Exploring the Complex Landscape of Services Supporting (?) Parents

Findings about access to a broad range of services echo concerns in the literature about erosion of universal access and preventative offerings (Institute of Health Visitors, 2023; G. Smith et al., 2018), rising thresholds of care (Jupp, 2022a), long waiting lists (Kiely, 2021), lack of information about support options available (Hansen et al., 2021; HM Government, 2023) and inequality in service-access (Tudor Hart, 2000). Service-access issues shall be explored through the pertinent example of universal parent support offerings for parents of pre-school children. The discussion will then move to broader access to spaces offering organised support.

Stay-and-play groups were the single biggest type of (albeit rather indirect) parent support identified in the asset map and were mentioned often, by parents and support providers in qualitative data as places with potential to promote positive parent mental health and wellbeing. Therefore, access to, and impacts from closures of, stay-and-play style spaces are explored in relation to parent mental health and wellbeing. As noted in section 6.2.1, these groups are not intended as 'support groups with a capital 'S'' but this research, as in previous studies, revealed positive impacts on mental health and wellbeing for parents engaged in stay-and-play style groups, as exemplified in the quote below (the term 'playgroup' is used widely in Australia where the study was based):

> Bailey draws on a history of feedback from mothers about finding social support in playgroups, reporting that 'we still regularly get that feedback, … playgroup saved my life, playgroup helped me get out of the house, helped me stop feeling so lonely' (Townley, 2022, p. 747).

This quote is similar to comments made in this research, promoting the value of these groups for parent mental health and wellbeing through peer support, structure to the day, and advice (see also, McLean et al., 2020). Stay and play groups (section 6.2.1) form a significant part of the response to the government's localism agenda, towards 'a vision of communities, volunteers and local agencies stepping in to fill up the gaps' particularly since closures in public sectors (Jupp, 2022b, p. 26), such as Sure Start Centres (G. Smith et al., 2018) and libraries (McCahill et al., 2020). However, differences between stay-and-play groups offered by trained staff and those convened by volunteers were raised in interviews and considered next.

A difference between professionally run and volunteer led groups was the ways in which group facilitators would be expected to respond to complex situations of those attending (section 6.4.3.1). These accounts resonate with an example shared by Jupp (2022a, p71), of a mother who was supported to leave a domestically violent relationship by Sure Start staff who were trained to identify ‘those signs’ which may have been missed by volunteers at a ‘toddler group’. The issue is not raised to diminish the significant levels of support offered by volunteers in stay-and-play groups but recognises that volunteers cannot be *expected* to address complex support needs of families, although they may try. Examples shared by volunteers interviewed in this study included support for complex social situations, parents with mental health issues, drug and alcohol addiction, and families where children have additional needs. Volunteers tried to ‘fill the gap’ but were aware of their limitations and wanted families to connect with professional support, although knew such help was limited. If parents have options for accessing professional care, volunteer groups compliment professional offerings and provide another layer of peer support within the village model (see also, Reupert et al., 2022). However, when other forms of support are diminished, volunteers confront higher levels of need than they may be equipped to manage. Volunteers remain integral to government policy plans for family support (HM Government, 2023) and so caring for volunteers and ensuring they are not given inappropriate levels of responsibility is an important ongoing area for attention.

Another issue arising from increasing reliance on the charitable sector to provide universal levels of early years parent support, relates to geographic distribution of offerings. Public sector services and large charities have a responsibility and expertise to consider the equity of their offering and a plan strategically when distributing resources (section 6.3.2). For example, Sure Start centres were located so that most parents had one in ‘pram pushing distance’ (G. Smith et al., 2018). However, supports offered by individual churches or community centres, whilst commended for their efforts, are reliant on the time, skills, interests, and funding of individuals and groups, leading to postcode lottery (section 6.4.2.2 and McDonnell et al., 2020) and that was evident in this research. Although church-run stay-and-play style offerings were identified on the asset map in areas of high deprivation (see Cloke et al., 2012 regarding the work of faith-based-organisations in areas of high poverty), there were also organisations with 'gaps' in areas of high deprivation (section 6.4.2.2). An over-reliance on volunteers to provide foundational levels of parent support is likely to incur gaps and as also noted in other research, those gaps are more likely in deprived areas where capacity to volunteer can be lower (McDonnell et al., 2020; Townley, 2022).

Strategic planning (or lack thereof) is also apparent with service closures. Whilst developing the asset map many outdated listings revealed closed volunteer-led stay-and-play groups (section 6.4.2.2), and it is likely that others were 'literally falling off the map becoming the… disappearing spaces of care' (Power et al., 2021, p. 93) as they closed without trace. Venues are being lost, for example through the loss of churches (Roberts and Francis, 2006) but so too are individual groups. These closures are discreet but diminish the support landscape. It was not possible to estimate how many groups had closed but after-effects of closures (from voluntary and public sector offerings) were visible in those that remained, particularly in the level of demand created. In interviews, only groups targeted by restricted age-range or need described lower attendance numbers. The universal free or low-cost stay-and-play groups for pre-school children were often oversubscribed and had to limit numbers. These limits were necessary to keep the offering operational but inevitably excluded some parents. Some groups operated a booking system and others had a 'first-come-first-served' model, but both favour well-resourced parents and disadvantage those in complex situations (section 6.4.2.4). 'Drop in' spaces were described as preferable where possible (section 6.5.3 and Jupp, 2022a) but when demand exceeds capacity, alternative arrangements are needed that create additional barriers for participation. Parents unable to access the support of an over-subscribed stay-and-play group is a key example of a subtle, barely visible, but yet potentially damaging consequence of erosions in parent-support spaces identified through this research, that cumulatively build risk for parent mental health and wellbeing in an overall diminished landscape of support.

Policy and practice landscapes are constantly evolving and through the course of this research, a government ‘Best Start for Life Vision’ (2023) has begun to introduce Family Hubs, focused on the first 1,001 days of a child’s life (from conception to age 2years) but accessible to parents until the child reaches 19years, or 25 years if the child has special educational needs and disability (HM Government, 2023). Whilst the primary focus is to improve outcomes for children, there is also a stated aim of supporting parents. The initiative is committed to a ‘Universal offer for every family and a Universal+ offer to meet the needs of their specific local communities’ (HM Government, 2023, p32) to be offered through ‘welcoming hubs’ that have both a physical and online presence. The quote below lists some of the ‘joined-up’ services that are to be made available:

> Local family hub networks should offer Start for Life services, including midwifery, health visiting, parent-infant mental health support, parenting courses and infant feeding advice. Family hubs also provide support for families with children of all ages, helping them to access a range of services from housing advice to youth clubs and from mental health support to drug and alcohol services (HM Government, 2023, p.37).

There is reason for optimism with this initiative but also notes of caution. The focus in the quote above is on ‘interventions’ and there is no reference to lower levels of support such as stay-and-play groups that have been discussed here as a relatively safe, unintimidating and accessible pathway into parent support, formerly offered by Sure Start (Jupp, 2013). Furthermore, significant pressures confronting health visiting services will be returned to later in this Chapter. The descriptions of support for perinatal mental health, whilst welcome, focus on ‘women with moderate to severe or complex’ mental health needs (HM Government, 2023, p23), without describing support for prevention and early intervention. This moves the discussion to consider levels of restriction increasingly placed on support services, not only in the family-support sector but also evident in mental health care, with the move away from universal levels of support to resources targeted towards those ‘most in need’.

The policy of focusing resources on those deemed to have the highest level of need has previously been termed the ‘vulnerability narrative’ (Townley, 2021) or ‘high-risk approach’ (Rose, 2001) and is a dominant policy approach (Jupp, 2022, Callaghan et al., 2017). Indeed, this was an argument for the closure of Sure Start centres (Coe et al., 2008, Smith et al., 2018) and move to the ‘hubs’ for referral only family support services (Jupp, 2022a) as identified in the creation of the asset map. The rationale that resources should target those who need them the most, rather than provide more for the already privileged, is initially appealing but carries flaws. Reduced universal care can inadvertently make access harder for the prioritised population. Accessing a service via forms and referral processes add to the workload and burden of treatment (explained in 2.4.1.2) and can be off-putting, particularly for parents in complex situations, as was presented in section 6.4.2.4 and addressed elsewhere (Jupp, 2022a). In addition to bureaucratic barriers, there can be fear and stigma associated with a model that frames accessing support as reserved for ‘failed care’ (Emejulu and Bassel, 2018), rather than a normalised experience of support within a ‘village’ context (Reupert et al.,2022). This was evidenced in parent accounts from both the survey and social media, in which high levels of worry about engaging with support services were expressed, through fear of parenting capacity being judged negatively, sometimes leading to a complete avoidance of health and social care services (section 6.4.1.2 and see Jaworska, 2018). It is a stated government ambition that, ‘every parent and carer needs to know it’s perfectly normal to need help’ (HM Government, 2023, p39) but the loss of spaces where parenthood challenges can be normalised and parents feel safe to explore and share their feelings without the perquisite of a ‘problem’ (see 6.5.4), risks deepening self-stigma and increasing avoidance of services (Holloway and Pimlott-Wilson, 2014, Hansen et al., 2021).

Reserving support only for those families deemed ‘most in need’ reduces resources for early intervention/prevention, intended to stop problems developing and prevent families *becoming* those most in need. For example, one support provider interviewed in this research described how their organisation was being pulled away from early intervention support for families, to respond to families in crisis who were waiting (often a long time) for statutory services, particularly for children to be seen by CAMHS (section 6.4.3). In a connection with wider literature, 64% of surveyed health visitors reported that their work with vulnerable families and safeguarding concerns allowed 'little or no time for prevention/ early intervention work' (Institute of Health Visitors, 2023, p.5). Families are excluded from services for not being 'ill enough' (Reupert et al., 2022) or for child safeguarding concerns not serious enough (Institute of Health Visitors, 2023) and so by removing these lower levels of support, more people are 'pushed' into higher levels of need as they cannot access support in a timely manner for issues that otherwise may not have escalated so far (section 6.4.2.4). What is alarming is the cyclical nature of this process, by which ever increasing levels of need fuel a reduction in provision for lower levels of need as funding is siphoned to address the immediate crisis. More people then, are driven to crisis before qualifying for help and so the spiral continues. This places more children at risk of poor outcomes and creates untenable pressure on inadequately supported parents who are blamed for 'failed care' (Emejulu and Bassel, 2018) and the child's difficulties (Callaghan et al., 2017) without recognition of the greater 'failure' of village support (Reupert et al., 2022). Universal access services are the base of the health services pyramid (section 6.2) and eroding universal support, damages the foundation of health provision. Pitching the needs of those 'most in need' against 'everyone else' is a dangerous over-simplification that masks a system not resourced to meet the needs of the 'village' as a whole. It is like a (rather depressing) game of 'musical chairs', whereby the number of chairs is reduced and the numbers of those wanting a chair and clambering for what is left, increases. Deciding who 'should' get the remaining chair, does not resolve the true issue, which is that more chairs are needed and ideally, people should not be forced to fight each other to get one.

7.4 Time to Care

7.4.1 Parent Experiences of Time.

In this research, as in other studies, it was not purely how busy a parent was that mattered, it was the emotional experience attached to their sense of time (section 4.4 and Evans et al., 2017). For example, working parents were busy but time at work could also be enjoyed as respite from the challenges of parenting, or resented as taking the parent away from children. Parents were sometimes busy but bored, reflecting that time spent on activities not of one's choosing or not rewarding can feel burdensome (Kielhofner, 2006). Frequently, parents wanted 'more time' to spend on pleasurable activities, sometimes alone but often with family, friends, a partner, and their children. It was though, a common experience for parents to lack time for their own needs and across methods, parents were frequently 'time-poor' (section 4.4). In this study, as in previous research, time was stretched by activities, such as work (McKie et al., 2002), and managing wider care relationships (Evans et al., 2017). Furthermore, in this study, as in previous research, single parents, working parents, parents caring for children with additional needs and parents with other caring responsibilities identified feeling particularly time-poor (Dermott and Pomati, 2016; Evans et al., 2017; Hall, 2019; McAuliffe et al., 2019). As already addressed, some women referred to disproportionate responsibilities for mothers (sections 4.2.2.2 and 4.4.2) which connects with wider literature (McKie et al., 2002, Blunt and Dowling, 2006), exacerbated during the pandemic, particularly in relation to home schooling (O'Reilly and Green, 2021) and particularly for parents of children with additional needs (Shum et al., 2021; Thompson et al., 2022). However, fathers in this study described being time-poor as well (section 4.4). Concern for long-standing disproportionate impact of caring tasks on women does not preclude concern about fathers as well. Many parents described little time for their own self-care and subsequent negative impacts on their mental health and wellbeing. This included lack of time for restful periods during the day and disturbed sleep at night. Parents and support providers were concerned about the impacts of sleep deprivation on mental health and wellbeing (section 4.2.2.1, 4.4.1) and wider literature also discusses the difficulties of sleep deprivation for parents (Bowlby, 2012; Lewis et al., 2018). It is important for mental health and wellbeing that parents have time for their own self-care and rest (McAuliffe et a., 2019) but as been shown in this research, that is often compromised.

One of the consequences of being time-poor was difficulty engaging with services. For example, working parents often commented that it was difficult to access services, rarely offered at weekends or evenings (see section 6.4.3). As an example, however, whilst most voluntary stay-and-play groups were offered mid-week and not accessible to parents working business hours (with an exception was groups for fathers offered at weekend, considered in 8.2.1 in a discussion of gender), libraries across Hampshire held groups at weekends that were gender neutral and even open to older children to be inclusive of more families. This highlights the importance of preserving public sector parent support offerings who take a strategic approach to providing a broad range of offerings (section 6.4.2.3). Timing of offerings is given further attention in chapter 8.

Shifting now from time as a resource, to consider the temporal 'journey' of parenthood. Many surveyed parents reflected on distinct moments in that journey that were significant in different ways (section 4.2.1). Sometimes, this was connected to the challenges of a particular period in the child's growth, such as crying babies, toddler tantrums or teenage conflict (section 4.2.2.1). Other times it was about celebrating 'milestones' and 'firsts', that create a temporal perspective of care much broader than is apparent from day-to-day tasks alone (section 4.2.1). However, this depicts time in a linear sense of children (and parents) getting older. Experiences of time though, are more complex though, as described below:

> Time is not sequential but flows into everyday practice in the form of memories and aspirations (Hall 2019a, p. 66).

Memories and lived experience shaped how parents responded to current situations. Memories of past trauma could intrude into the present and adversely influence parenthood (section 4.2.2.3). Parents and providers talked about the impact of childhood trauma on subsequent parenting behaviours, recognising that it is often parents with their own trauma that are most likely to be involved in child protection proceedings (section 6.4.1.2). In Darra et al.'s (2020) study of young parents, 64% of the participants had experienced four or more adverse childhood events, compared to 14% of the general population. Exposure to adverse childhood events is associated with increased risk of mental illness in adulthood (Edwards et al., 2003). However, memories did not only impact the present but also expectations of the future, as poor past experience could damage hope and limit aspirations for change (Hall 2019a). Providers recognised this when they talked about 'norms' of families where there was intergenerational worklessness, high levels of mental health issues, and low confidence (section 6.4.1.2). Parents have a temporal context of past and imagined futures that influence their experience of parenthood, access of services, and mental health and wellbeing, in complex and often poorly understood ways. Services working with families need practitioners to have time to contextualise current difficulties as shaped by past and ongoing adversity (Bunting et al., 2017). However, services experience challenges of time as well and these are considered next.

7.4.2 Support Services 'Out of time'

Parents and providers described grief for lost services and a future that might have been but will now not transpire, because of cuts (section 6.4.4.2). The quote below demonstrates this point, referring to the lost 'alternative futures' of families that will not access a Sure Start Centre:

> 'It's not just what happened here before, it's what isn't going to happen in the future – the friendships that won't be formed and things like that' (Jupp, 2022a, p. 61).

This quote was remarkably similar in sentiment to a quote from a support provider previously shared in section 6.4.4.2. It was also a point made by those imagining how different lives could be if children and parents could access professional support sooner, rather than waiting as discussed, for crisis before care is offered. Feelings of loss therefore, were felt looking 'forwards' as well as 'backwards' in time. Mostly though, support providers were focused on everyday pressures of time in keeping offerings operational, and so this where most attention will be focused.

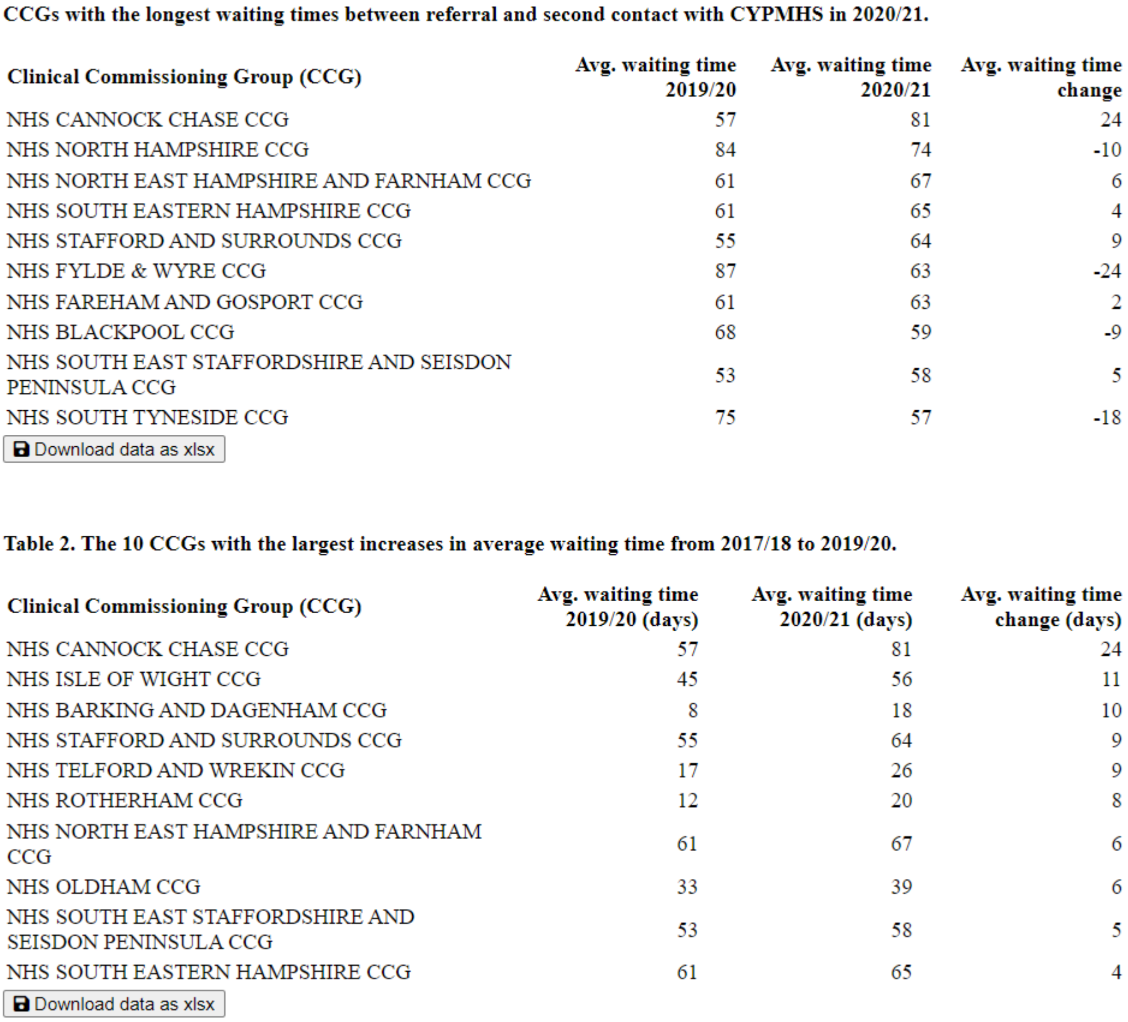
Support providers were busy. Many of those interviewed were busy in their paid or unpaid role and busy in other life roles as well. For example, some volunteers worked separately in paid jobs and had young children of their own (section 6.4.3). Many paid staff talked about large workloads, often made larger by reduced staffing hours and higher levels of need (section 6.4.3) which could limit time spent with families. Support providers did not want to offer limitless time with families. Many talked about helping the parent develop longer term social supports that would persist beyond access to their offering. However, they did want 'enough' time to be able to establish a relationship, understand the needs, and support changes. Some interviewees worked or volunteered in roles that afforded this time but cut-backs that restricted time to develop therapeutic relationships were raised too (section 6.4.3). This erosion of time resonates with other literature (see also, Jupp, 2022a). For example, GP consultations were notoriously short (Thompson et al., 2018) and in the disability care sector there is a 'constant pressure to cut hours' (Power et al, 2021, p92). It was also difficult to secure the time of volunteers, which is problematic given the reliance on volunteers as already addressed, for many foundational levels of parent support. In a separate research study, an interview participant said that 'the volunteering environment has really dried up' (Power et al., 2021, p.92) and many support providers interviewed in this research, also described a lack of volunteers to achieve the full ambitions of the support offering (section 6.4.3).

Of relevance to this research, and raised frequently in the study, was erosion of time with a health visitor (section 6.4.3). To help situate this finding of concern about health visitor contact within a wider context, additional materials were sought from beyond this research study. The Institute of Health Visiting (2023) surveyed over 1000 UK health visitors and found the majority described rising levels of need including perinatal mental illness, domestic abuse, and child safeguarding concerns. However, it also reported reduction in the workforce, claiming 40,000 fewer health visitors in England since 2015. As a result, only 6% of surveyed health visitors in England described working with the recommended caseload of 250 children per full time equivalent and 28% had a caseload of over 750 children, leaving insufficient time to perform key parts of their role. Even the five 'mandated' health visitor sessions do not always take place. Statistics for the case study county of Hampshire were explored to further contextualise the difficulties raised by participants in this research and the findings of the Institute of Health Visiting (2023) survey.

In the first quarter of the 2021/22 reporting period, 16.6% of births in the area of Portsmouth received a new birth visit within the intended 14 days, compared to 88.6% in Hampshire and 85.4% nationally in England (Office for Health Improvement and Disparities, 2022). It should be noted that in Portsmouth, 79.4% of births had a new birth visit after 14 days, so it did happen for most parents, but later than intended (ibid). However, only 9.9% of infants in Portsmouth had a twelve-month review conducted by the time they turned 12-months and this had only risen to 41.8% having this check by the time they turned 15-months, compared to 92.1% in the council area of Hampshire and 80.5% in England nationally (ibid). Portsmouth has areas of high deprivation (IMD, 2019) and appears to be the type of inconsistency that the Institute of Health Visitors was concerned about and that participants in this research, expressed such frequent concerns about (section 6.4.3). Health Visitors working without the time to fully engage with families is a risk for babies, parents, and the wellbeing of Health Visitors themselves (Institute of Health Visitors, 2023).

A result of reduced service capacity, is that parents need to wait to be seen. In the book 'The Places You'll Go' Dr Suess famously describes 'a most useless place' known as 'The Waiting Place' (Seuss, 1990) where people get 'stuck' waiting for events to occur. In this research, people were caught in 'the waiting place', waiting for support for themselves and/ or their child, particularly from child and adolescent mental health services (CAMHS). The impact on children and young people of waiting for care has been explored elsewhere (Bell and Pollard, 2022). In this research, the impacts on parents were the focus (section 6.4.3.1) and included having to reduce hours or leave work to care for a child, increased isolation from fear of going out, exhaustion from the worry and physical tasks of care, and feelings of blame and judgement for the child's difficulties. These issues have been identified by previous authors as well (Hansen et al., 2021). Government statistics about access to child and adolescent mental health services waiting times are presented to contextualise the issues described during this research.

Figure 7 Screenshot from Children's Commissioner Briefing on Children's Mental Health Services – 2020/2021



CCGs with the longest waiting times between referral and second contact with CYPMHS in 2020/21.

Clinical Commissioning Group (CCG)	Avg. waiting time 2019/20	Avg. waiting time 2020/21	Avg. waiting time change
NHS CANNOCK CHASE CCG	57	81	24
NHS NORTH HAMPSHIRE CCG	84	74	-10
NHS NORTH EAST HAMPSHIRE AND FARNHAM CCG	61	67	6
NHS SOUTH EASTERN HAMPSHIRE CCG	61	65	4
NHS STAFFORD AND SURROUNDS CCG	55	64	9
NHS FYLDE & WYRE CCG	87	63	-24
NHS FAREHAM AND GOSPORT CCG	61	63	2
NHS BLACKPOOL CCG	68	59	-9
NHS SOUTH EAST STAFFORDSHIRE AND SEISDON PENINSULA CCG	53	58	5
NHS SOUTH TYNESIDE CCG	75	57	-18

Table 2. The 10 CCGs with the largest increases in average waiting time from 2017/18 to 2019/20.

Clinical Commissioning Group (CCG)	Avg. waiting time 2019/20 (days)	Avg. waiting time 2020/21 (days)	Avg. waiting time change (days)
NHS CANNOCK CHASE CCG	57	81	24
NHS ISLE OF WIGHT CCG	45	56	11
NHS BARKING AND DAGENHAM CCG	8	18	10
NHS STAFFORD AND SURROUNDS CCG	55	64	9
NHS TELFORD AND WREKIN CCG	17	26	9
NHS ROTHERHAM CCG	12	20	8
NHS NORTH EAST HAMPSHIRE AND FARNHAM CCG	61	67	6
NHS OLDHAM CCG	33	39	6
NHS SOUTH EAST STAFFORDSHIRE AND SEISDON PENINSULA CCG	53	58	5
NHS SOUTH EASTERN HAMPSHIRE CCG	61	65	4

As can be seen from Figure 7 (Children's Commissioner, 2021), many children and young people in the UK are waiting months from referral for mental health care to second contact (which is taken as a proxy for treatment beginning, as the first contact is usually assessment). Hampshire (where support provider interviews took place) has 4 of the 10 CCGs with the longest waiting times in England (North Hampshire, North East Hampshire and Farnham, South Eastern Hampshire, and Fareham and Gosport) and 3 of the 10 CCGs with the biggest increase in waiting times (Isle of Wight, North East Hampshire and Farnham, and South Eastern Hampshire). However, within the support provider interviews, there were reports of much longer waits than the statistics in Figure 7 would suggest. The Hampshire CAMHS website displayed the following message on their website:

> We are experiencing increasing waiting times both for an initial assessment, and where appropriate ongoing treatment. Our average waiting time for initial assessments is 15 weeks and for treatment is 54 weeks. It is important to understand that some young people are seen much sooner, and unfortunately some will wait much longer (Hampshire Child and Adolescent Mental Health Service, 2023, correct as of 2nd March, 2023).

This message, that children and young people are on average waiting over a year to commence treatment and sometimes longer, was more in keeping with accounts from this research and verified those concerns. Although this thesis is centred on parents, the enmeshed nature of parent and child mental health and wellbeing has been highlighted frequently (Falkov, 2015). Whilst children wait, problems can become more entrenched, which also impacts those who care for them.

How parents respond to periods of waiting are explored next. Parents looked for self-help suggestions, peer support opportunities, alternative services, and tried to find ways to navigate waiting lists for an earlier appointment (section 6.4.3.1). Reminiscent of the descriptions and indeed images (by Theodor Geisel) of waiting captured in the story by Dr Suess (1990), Kiely (2021, p.781) describes 'feelings of slowness, stuckness, and stillness' for adults waiting for adult mental health services. However, in this research, parents waiting for an assessment for mental health services (for themselves or a child) were noted to be highly active as they tried to manage 'in the meantime'. These struggles were reminiscent of descriptions from service providers in interviews and literature (Cloke et al, 2017) about energy expended 'in the meantime', whilst striving for a more satisfactory response. In summary then, waiting was perceived as an active yet anxious state.

7.5 Money: Shaping Choices and Behaviours of Parents and Services

7.5.1 Financial Strain on Families

Within this research, some parents were financially ‘comfortable’ but many more could be described as ‘the squeezed middle’, families where one or more adults were working but there was financial concern (Stenning, 2020 and section 4.5.2). In the survey design, actual income was not gathered given that previous studies have shown that ‘subjective stress may have a greater association with risk of mental health problems than objective financial difficulty’ (Chakravorty, 2022, p. 2) and what can be purchased with a similar income varies in different parts of the country (D. Smith et al., 2018). Instead, participants in the survey were asked if, or how frequently, they had worried about money. From the convenience online sample, 27% worried about money most or every day and an additional 42% worried about money occasionally. When figures were combined with qualitative accounts it revealed frustration and weariness that despite working hard, parents could never get financially ‘ahead’, as described by Wilkinson and Ortega-Alcazar (2018).

The pandemic was particularly challenging for families on low incomes. For example, in section 5.3, service providers described the importance ‘usually’ of flexible shopping habits for low-income households ‘trying to find the cheapest option’ and, as also described by Thompson et al (2022, p.3), the inability to ‘shop around’ during lockdown restrictions made this more challenging. In this research (and Stenning, 2020), parents described foregoing everything except the ‘essentials’ of bills, food, and fuel (heating and car), and even then, often only by amassing debt (Hall, 2019). Debt has been associated with poor (mental and physical) health in multiple studies (Richardson et al., 2013). It has been estimated that approximately one quarter of people with a common mental disorder are under financial stress and that half of those with debt, have a common mental health disorder (Public Health England, 2018) which would fit with parent and support provider accounts in this research, linking debt with varying levels of mental distress (section 4.5.2) that risks being exacerbated by the rising cost of living since 2022 (Chakravorty, 2022).

Capacity to earn money is impacted by parenthood and within this research were multiple comments (Chapter 4) about challenges of juggling childcare and paid work and problems with the expense and availability of childcare (see also Boyer et al., 2013 for a discussion of the childcare environment). Once again, impacts are not felt equally and it is often those in lower-paid jobs and precarious positions that are most vulnerable to family-related interruptions to opportunities for work, exacerbated by further complications such as having a child with additional needs (section 4.5). For example, children missing school because of their additional needs was raised previously and has also been addressed in literature (in the example of Barnes et al., 2020, children with irritable bowel syndrome). When children are too young or too unwell to be at home unattended, this can impact a parent's capacity to work and subsequently, be paid. In another example from wider literature, a systematic review conducted by Roser and colleagues (2019) found that many parents of children with cancer suffered socioeconomic stress, with mothers particularly likely to experience job loss/ job quitting, and financial impacts to be more severe amongst parents from lower socioeconomic groups. In this research, many parents who described financial concern were working and several service providers described a changing demographic of those accessing charitable support to include more working families. Recent figures estimate that 61% of working age adults who are in poverty in the UK live in a household with at least one working adult (Joseph Rowntree Foundation, 2023). In their 2017 report, Loopstra and Lalor recorded 1 in 6 foodbank users as being from a working household but accounts in this research (section 6.3.4.2) as well as media reports (https://www.bbc.co.uk/news/uk-63303460) suggest a changing demographic for further research.

This research touched on financial precarity in households with intergenerational worklessness and high levels of mental illness. Interviewees reaffirmed points made in earlier studies that the impact of societal factors (Bunting et al., 2013) and trauma (Bassuk and Beardslee, 2014) need to be considered when working with families, and that 'top-down' prescriptions of behaviour change, that fail to understand the family context, are largely ineffective (Ghate and Hazel, 2002). However, whilst Greg (2010) reported on lack of access to mental health services for parents with mental illness, many support providers interviewed in this research said the issue was lack of hope that accessing services would be effective (section 6.4.1.2). Long-term poverty, worklessness, and mental illness can create situations in which such experiences are normalised and there is little energy or hope of change (Callaghan et al., 2017). These descriptions from support providers, of parents without sufficient confidence or belief to engage in mental health care, as well as practical constraints from time and lack of social support, offer context to the IAPT statistics shared in Chapter Two (section 2.4.2.1), that revealed people in the 10% most deprived areas have the highest rates of referral but lowest percentage of those completing treatment. Access to primary level adult mental health care has been made more accessible with IAPT (Delgadillo et al., 2016; NHS Digital and Thandi, 2022) but people in the most complex circumstances may still need support to engage with services. However, whilst this research has highlighted challenges for parents living in poverty with regards to engaging in mental health care (section 6.4.4), such challenges are not given routine consideration in many models of service delivery (Reupert and Maybery, 2016).

Overall, this research added to the perception that financial pressures on families in the UK are felt severely but also, widely (Stenning, 2020). Given the association between financial insecurity and mental health (Barr et al., 2015; Richardson et al., 2013)it is evident that many parents are at risk of adverse impacts in this latest financial crisis (Chakravorty, 2022). There are multiple impacts from these constraints on mental health and wellbeing, including access to community support offerings, which may incur a fee for attendance. It was identified whilst developing the asset map, that public sector offerings (such as from libraries, Health services and remaining Sure Start centre) were typically free or low-cost. However, smaller volunteer-led groups had significant variation in costings and many were excluded from the asset map for costing more than £2 for a parent and two children (see 3.5.3.3). With financial concerns referred to frequently by parents, support providers, and wider literature (for example, Chakravorty, 2022), the cost of an offering (even when described as a ‘donation’) is a critical part of accessibility. This research strengthens concerns that parents living in financial insecurity may find it harder to access groups and services with fewer public sector offerings and potentially unaffordable alternate options (section 6.4.4.1 and returned to in section 8.2.1).

7.5.2 Financial Strain and Services

Services have been impacted by austerity and changed models of health and social care delivery in various ways. An impact noted in this research were changes made in response to increasing financial needs in the community. At interview, several support providers provided or arranged access to assistance including food support (donations and/ or low-cost community 'larders' or 'pantries', see Thompson et al., 2018, Cloke et al., 2016, Loopstra and Lalor, 2017), material goods including essential clothing and household appliances, and vouchers for a complex array of government assistance, such as milk vouchers and gas/ electricity vouchers (section 6.3.4.2). These latter forms of assistance were less explored in academic literature than food support and would warrant further attention. Support providers commented, as above, that many families accessing support were not those who would traditionally be viewed as 'in-need' but it was also (relatively) new terrain for services. Many support providers worked or volunteered in offerings not primarily purposed with addressing poverty but the needs that they were seeing, drew them into this type of support. These changes to their practice represent another unintended effect of wider cuts and policy decisions. The interviewees were motivated by a desire to respond to the needs that they were seeing, but such responses have been critiqued elsewhere for perhaps inadvertently reinforcing oppressive structures by compensating for inequalities in neoliberal policy (Cloke et al., 2017). Acts to address an immediate crisis that do not tackle the cause of a social problem have been variously described as a 'sticking plaster' (Jupp, 2022c), 'panacea' (Power et al., 2021) or 'salve' (Cloke et al., 2017) as emergency provisions do not change root causes of poverty, which support providers were widely cognisant of (section 4.5.3). These responsive actions also consumed a significant proportion of the resources of agencies which, as mentioned previously, diverts such resources away from core offerings because as explored next, services experience financial strain too.

Interviewees from community centres and church-run stay-and-play groups described minimal need for fundraising, with the venue and sometimes refreshments and equipment provided by the church or community centre, and not infrequently supplemented by the volunteer(s). These spaces were funded by the larger organisation (church or community centre) and the volunteers had little visibility of funding at those higher levels. In these situations, funds made available to the group could be used for 'extras', such as to purchase equipment or pay for courses to enhance the offering (section 6.3.4.1). However, funding is only one type of precarity (Power et al., 2021) and as noted previously (section 7.4.2), securing the time of volunteers can be highly challenging. The relative of financial stability of these offerings therefore, should not be conflated with a lack of instability overall.

Charities with paid employees and multiple projects, described a constant precarity of 'chasing grants' which were usually short-term and generally tied to specific projects rather than sufficient to fund the whole operation (section 6.4.4.2 and Power et al., 2021). It took significant amounts of time and resources to secure, manage, and report on funding from multiple grants that needed to be pieced together to create a functioning service. Support providers spoke of the need to be creative in attracting and deploying funding but also the need to 'battle' for money, sometimes with other charitable bodies (section 6.4.4.2), again reminiscent of accounts described by Power et al (2021). Charities are limited in their capacity to plan for the longer-term by these piecemeal 'pots of money' and indeed, must dedicate resources to the administration of managing grants, which in itself is a further cost to the operation.

Public sector organisations do not 'chase grants' but face competing demands on limited resources. Overall concern throughout this research described a public sector funding landscape that was diminished to the point of not only inadequately meeting the needs of the population but creating more financial burden because early intervention services were reduced (section 6.4.4.2), leading to reliance on expensive late-stage interventions (Chowdry and Fitzsimons, 2016; McDaid and Park, 2022). Variations in spending, often termed 'postcode lottery', impact public sector services as well as charities, with examples including Sure Start (Smith et al., 2018), Health

Visitors (Institute of Health Visitors, 2022), and CAMHS (Rocks et al., 2019). Earlier in this discussion the Start for Life programme was introduced (HM Government, 2023). To date (2023) the Start for Life programme funds initiatives in 14 trailblazer sites and more recently, 87 additional Local Authorities. This funding so far includes Southampton, Portsmouth and The Isle of Wight, but did not include the Hampshire County Council area. The report states that all local authorities will benefit from funding allocated to the Supporting Families programme, but not specifically how that is allocated, and that 'areas not receiving additional funding will be supported to implement the Vision with nationally available guidance and support' (HM Government, 2023, p.22). With local authority budgets under considerable pressure (Marmot, 2020) it remains to be seen if guidance, support and a portion of the national funding will be sufficient to actualise the ambitions in areas not specifically funded.

Finally, the financial costs of the late-stage interventions described previously are briefly considered. Vast resources are spent on assessing people and moving them between services, to varyingly be told that they are too unwell/ not unwell enough, to qualify for that service as services try to limit access and manage resources. This situation creates an (expensive) 'illusion of helping' without actually meeting the need (Kiely, 2021) which is not only the antithesis of a 'no wrong door policy' (Bell and Pollard, 2022), but saps a great deal of resources. It also traps people on extensive and seemingly ever extending waiting times for support (section 6.4.3.1 and Kiely,2021).

7.6 Conclusion

This research has taken a broad perspective across the 'village' from multiple viewpoints, adding context to individual areas of concern and exploring relationships between them, as changes in one area create effects elsewhere. In conclusion, there are reasons for hope in the 'village', with examples of supportive relationships and dedicated support services. However, the research also developed a picture of a village in trouble, with unequal access to support and erosions in social and professional support spaces, summarised below.

This study has drawn on the disruption and distress of the pandemic to demonstrate the importance of social relationships, community spaces, and support services that many parents 'usually' value. This has served the dual purpose of highlighting support structures that are ordinarily so discreet as to be barely noticed or reported upon, but when such support was removed, the true relevance on mental health and wellbeing was made more visible. Secondly, the distress associated with the temporary disruption of the pandemic provides new empathy and understanding of situations in which parents face longer-term barriers to support. For example, many parents expressed loneliness during the pandemic but loneliness is an ongoing concern for many parents, particularly certain amongst demographics. Indeed, this was a key finding from this research and given the dearth of literature that considers loneliness and social isolation in mid-life, it was particularly important to explore this perspective. Parents could sometimes find support online, and this study has developed understanding of how parents exchange mental health peer support online, to consider the potential but also some of the pitfalls for this type of support. Furthermore, whilst the tensions experienced in household relationships were particularly testing for many in the pandemic, problems in family relationships are common but services to support such difficulties, are sparse. Finally, concerns about parents being 'time-poor' and financial strain were exacerbated in the pandemic (and attracted media and policy attention) but this research has shown that concerns of time and money are widely felt amongst parents, with the potential to harm mental health and wellbeing in an ongoing way, that should not be lost now that the specific challenges of 'lockdowns' have passed.

This research has reiterated that parenthood is a highly meaningful occupation with potential for profound impact on parent mental health and wellbeing. Love and pride in children can be uplifting and motivating but a sense of not meeting the needs of children as would be desired, can be distressing. This was particularly evident in the social media analysis amongst parents discussing suicidal thoughts, offering an insight into thoughts and feelings shared under anonymity. Indeed, fears about being judged as a parent were shown to be a significant barrier for parents seeking help from professional and social supports. Sadly, it was often parents in the most challenging circumstances who were most fearful of asking for help and were often most isolated. Throughout this thesis concern has been raised about inequality for different parent demographics, with a repeated focus on single parents, parents on low-incomes, parents raising children with additional needs, and parents with mental illness. Intersectionality between these domains, means that many parents face risks of inequality on multiple fronts.

From the perspective of services, it was shown that support providers brought passion, creativity and experience to the support landscape. However, many formal supports have been eroded and pressures on supports that remain, have increased. Parents experiencing pre-existing inequalities are vulnerable, not only to the individual impacts of losses in support, but to the cumulative effects of so many pressures combined, rising thresholds of engagement, and extended waits for support. Furthermore, support services are impacted by losses through changes to their practice (sometimes into areas they feel ill-equipped to manage), rising demand on services, and ongoing precarity of funding and staffing.

Responding to these challenges is complex. With the results summarised, there is the opportunity to consider the explicit contribution of this research to policy or practice, as well as the literature outlined above. The final Chapter sets out a series of recommendations while noting the strengths and limitations of the work presented, with the aim that some suggestions provide the basis for local-level change.

Chapter 8 Considerations for Future Practice, Policy, and Research

8.1 Introduction

Attention turns to focus on the fourth research question, which asked how access to support can be equitably developed to support parent mental health and wellbeing, given what was learnt from this study contextualised with wider literature. The chapter is structured in a 'quick wins, best buys, and game changers' framework, as used in the 'Research Roadmap for the COVID-19 Recovery' (United Nations, 2020) as it provides an accessible format to present and explore considerations concurrently for an academic and non-academic audience, given the potential interest to policy makers, practitioners, and community members of these discussion points. This format also reflects the interdisciplinary nature of the PhD, which draws upon multiple methods to pragmatically address applied public health concerns. As a parent with clinical experience and awareness of the need for evidence to inform public health action in this area, it was always core to the purposes of this PhD, that a section of the discussion would specifically address policy and practice implications.

8.2 Supporting Parent Mental Health and Wellbeing

8.2.1 Quick Wins

To explore 'quick-wins', the framework of 'who, where, why, what, when and how' is deployed as a well-recognised structure. Many of these 'quick wins' could be considered by those involved in delivering parent support offerings and are actionable at a local level.

Who: As presented in section 6.3.1.2, parents were more likely to engage in offerings where they perceive there will be others similar to them (see also, Townley, 2021). Therefore, representation in language and imagery matters (Brooks and Hodkinson, 2019) but it was noted in developing the asset map, that offerings were not always inclusive, particularly of men. If the offering is open to both parents, providers could use gender neutral language and include images (where appropriate) showing fathers in attendance as well as mothers. Parents were also more likely to return to an offering where they have felt welcomed and accepted (section 6.3.1.3). Ensuring new people are welcomed, spoken to, and included is straight-forward but impactful action, particularly for those who have been shown in this research and wider studies to feel excluded, such as fathers, parents of children who are distressed and/ or have additional needs, parents with a mental health problem, and parents from ethnic and or sexual minority groups (section 6.4.2.3 and for example, Acosta, 2020; Brooks and Hodkinson, 2020; Eastwood et al., 2014).

Where: there are three elements related to 'where' considered in turn below.

Spaces such as playgrounds, libraries, church halls, and community centres were shown to provide opportunities for parents to meet and build networks of friendship, support, and care, which in turn, hold positive potential for promoting mental health and wellbeing (see 5.2.1, 6.21 and also, Cattell et al., 2008; Feeney, 2019). Community spaces need to be protected and nurtured as the foundation of a village model for parent support, enabling access to free and low-cost opportunities to build peer support. It is perhaps misleading to describe maintenance of any space or service as a 'quick win' given the pressures enacted upon them but preserving the spaces that remain is described here because at least it does not require new initiative; but rather a focus on caring for the assets that exist. Such spaces are of huge but often understated importance for parent mental health and wellbeing. One need only look to the damaging experiences of temporary exclusion from such spaces in the pandemic to find evidence of their significance and the need maintain access (section 5.3).

It was found in this research, that open access online searches gave limited, sometimes frustrating, and often confusing results about parent support (section 6.4.2.1). Poor access to information about support available was also found in interviews (section 6.4.2.1) and in government consultation with parents (HM Government, 2023). Information listed (where appropriate) in open access online platforms is accessible to more people than that advertised only on 'closed' sites. However, as interviewees in this research noted, not all parents have digital access (Gann, 2020) and so physical posters and information dissemination (through direct referral or newsletters) from other support providers such as health visitors, GPs and schools, are important too. Critically, a ‘no wrong door’ policy (Bell and Pollard, 2022) would mean that wherever a parent asks for help, they would be guided to other services but as has been shown in this research, that is not always the case (section 6.4.2.1). Providers are encouraged to be mindful of opportunities to facilitate access to wider services and share resources with parents that signpost them to additional opportunities for support online, in printed form, and critically, in person. For some relatively small changes, impact can be achieved by sharing information more widely and openly with parents who may be unaware or support available to them.

The final ‘where’ considers service location. The physical location of a service is determined by many factors, and most of them not easy to amend. However, services could consider strategies such as rotating to different parts of the region where possible, by making use of schools, community centres and other public buildings (MacAlister, 2022). Co-locating services was also described as useful, so that parents can access support from different agencies in one place (HM Government, 2023). Having an option of virtual engagement was described positively in this research (section 6.3.2) as in other reports (HM Government, 2023) but as an *additional* option rather than replacement for face-to-face, with concerns about an over-reliance on virtual means also expressed (section 6.4.2.2).

Why: providers need to be clear about the purpose of the offering. For example, is the offering universal access or targeted by specific criteria, or if the service is run by a religious organisation, to be transparent about the role of religion and if people of all faiths or none are welcome to attend (which was found to not always be clear when developing the asset map, section 6.4.2.1). Providers may believe that such detail is implied but parents may not be confident enough to enquire if unsure.

What: it is helpful when an offering clearly explains attendance procedures. If booking is required, how to book, and if no booking is required, to state that too. Perhaps most critically, to be clear about costs and explicitly state that an offering is free where applicable (see section 6.4.4.1). If a donation is encouraged, providers could include a suggested amount but also a statement that non-payment should not deter attendance for families in financial difficulty (if appropriate). Services may also find parents appreciate practicalities advertised, such as the availability of parking, access, and bathroom facilities for people with a disability, and if free/low-cost refreshments will be available. Communicating details explicitly is a ‘quick win’ with potential to be of greatest value to parents who could be anxious about hidden costs and where they, or their child, have specific access needs.

When: many parents reflected on the difficulty that they experienced in accessing parent support options and indeed, appointments for their own health and wellbeing, because of time and associated treatment burden (section 6.4.3.1 and see Department of Health and Social Care, 2018). Working parents particularly talked about limited access to groups (section 6.4.3). This issue is not always easily resolved but is included after consideration as a ‘quick win’, as providers are encouraged to reflect on changing demographics including more working mothers and stay-at-home fathers (McKie, 2002, Tarrant, 2022) and consider if there are any, even discreet changes, that could be implemented to improve accessibility for these parents. Certainly, parents valued flexibility in timing to access services and providers are encouraged to think of opportunities to expand flexibility of timing where possible.

How: parents need to know how to find out more information if required. The rationale behind all these suggestions is for parents to be able to learn as much about the offering as possible, before needing to contact a service which some parents (particularly in challenging circumstances) may experience as a barrier (section 6.4.2.1). However, where appropriate, to include clear contact details (email, phone, online chat links) so that parents (or a support person) can contact if necessary.

8.2.2 Best Buys

8.2.2.1 Prevention, Promotion, and Early Intervention for the WHOLE Family

The conclusion of this study concurs with so many others, that prevention is better than cure and that investment in universal access supports, mental health promotion and early intervention when issues start to arise is desperately needed to help prevent situations deteriorating to the point of crisis (for example, Bee et al., 2014; Chowdry and Fitzsimons, 2016; Institute of Health Visitors, 2023; MacAlister, 2022; McDaid and Park, 2022; Reupert et al., 2022 to name but a few). These varying sources, including academic papers and professional reports, are united by a common concern also reflected in this research (section 6.4.2) that current policy and funding arrangements are so consumed by crisis-care that they are failing to provide preventative services at a universal level of entry. There is a fundamental difference between a commitment to *providing* support for those most in need, which is welcomed, and *reserving* support for those most in need, which has been shown to be unsuccessful as people are pushed into higher (and more costly) levels of need (section 6.4.2). Therefore, a 'best buy' is considered to be renewed funding and commitment to universal access services that support parents and promote mental health in the community. Furthermore, whilst prevention, promotion and early intervention for children is of course welcomed, these same principals must apply to meeting the needs of parents themselves, so that they can access support in a timely fashion proportionate to their needs. The latest government 'Start for Life' programme commits to developing an 'outcomes framework that has broad support' (HM Government, 2023, p60). It is vital that this framework incorporates measures of parent mental and physical health and wellbeing as well as satisfaction with their roles and supports, across the spectrum of needs and circumstances and considers universal levels of mental health promotion, not just 'interventions' after problems have emerged.

8.2.2.2 Holistic Care

It is in keeping with the 'no wrong door' principal, that advocates for health and social care systems that parents have their needs assessed and directed from first point of entry (Bell and Pollard, 2022). Before exploring these opportunities though, attention is drawn to the use of language about services being 'resourced' to provide the suggested support. Indeed, this discussion is described in the section of 'best buys' and should not be considered a 'quick win'. Recommendations for practice changes and developments sometimes fall to already over-burdened workers, creating yet more demands on their already limited time, without additional resourcing. For example, there is already concern about over-work and burnout for those working with parents, such as health visitors (Institute of Health Visitors, 2023) and those working in mental health services (O'Connor et al., 2018) which was mentioned by parents and support providers in this research (section 6.4.3). Considerations for practice and policy below are therefore made cautiously and with the caveat that they need to be resourced for implementation.

Parent mental health and wellbeing could be better supported if services primarily purposed with supporting parents, were resourced to routinely assess and provide a preliminary response to the mental health needs of parents. Perinatal mental health assessments conducted by health visitors with new mothers are an example of this (Institute of Health Visitors, 2023), but this service does not include fathers (who also have elevated rates of mental health issues after a baby is born, Wong, 2016) and is concentrated only on this period of parenthood. Therefore, it would be advantageous for more of those who routinely work with parents, including health visitors but also workers and volunteers in the types of services introduced in section 6.2, to be resourced with time, training, and supervision, to routinely discuss mental health with parents, offer a preliminary level of support, and facilitate engagement with mental health services if necessary. The term 'facilitate engagement' is used purposively rather than 'direct' or 'signpost' as it was shown that parents experiencing mental health problems may need the support of a trusted relationship to engage with mental health care rather than simply a referral or recommendation (section 6.3.1.3).

Parent mental health and wellbeing could be better supported if adult mental health services were resourced to routinely identify which service users had parental responsibilities and respond to the parenting needs of those seeking professional support. Such action is widely recommended in previous research (Solantaus et al., 2015, Reupert and Maybery, 2016) and was reiterated by support providers interviewed in this study (section 6.5.4), but is not systematically offered (Reupert et al., 2022). Given the enormous influence that parenthood has on parenting adults, it is critical that those working in adult mental health services are resourced with time, training, and supervision, to routinely discuss parenthood with those accessing mental health services who have parental responsibilities. The SCIE (2012) 'Think Family' resources and material from the Australian site www.copmi.net.au provide advice on implementing procedures that recognise and support the parenting role of mental health service users, in addition to academic references including Reupert and Maybery (2015), Falkov (2015), and Reupert et al., (2022).

Parent mental health and wellbeing could be better supported if services working primarily with children (such as CAMHS services), were resourced to routinely consider the support needs of parents and be able to facilitate engagement for parents with services that would respond to their own needs (Campbell et al., 2021). Furthermore, given the connected nature of parent and child mental health and wellbeing, a whole family approach when working with children and adolescents can be beneficial (Falkov, 2015) as well as close communication and interagency working between adult and child services (Reupert et al., 2022). In this research (5.4 and 6.4.2.2) and in other studies, parents have described feeling judged and blamed when their child is experiencing difficulties (Hansen et al., 2021). It is therefore, recommended that services focus on strengths-based approaches (Bassett et al., 2001, Bassuk and Beardslee, 2014) that recognise contextual factors of the family environment, explored next.

As has been described above, parents may come into contact with numerous statutory and/ or charitable, health and social care and community support organisations. Parent mental health and wellbeing could be better supported if whichever organisation a parent is in contact with, was resourced to assess and respond to needs connected to ‘upstream’ factors impacting mental health and wellbeing from a social determinants of health perspective, such as isolation and poverty (Solantaus et al., 2015). For example, guiding parents towards avenues of peer support and where appropriate, referral to social prescribing could help to reduce loneliness (Walker et al., 2019) which has been shown as a pervasive concern (section 5.4.1.2and Qualter et al., 2023). To support financial needs, support providers can direct service-users to financial support and advice (section 6.3.4.2 and Chakravorty, 2022). Parents living in complex situations may need support to address urgent matters such as food and housing security (Bassuk and Beardslee, 2014) before matters of mental health care and/ or support with challenges of parenthood can be addressed (section 6.3.4.2). Although these recommendations focus on information sharing, they are categorized separately to the ‘quick win’ of information sharing about other services detailed in section 8.2.1, because they have involve a fundamental shift towards exploring social determinants of health during contact with parents, which may not routinely occur (Shim and Compton, 2020). A recent report into support for families called for practical help, universally accessible, with targeted support and outreach as needed, based in familiar community spaces to which local parents already have a relationship and offered by practitioners who have a long-term caring relationship with the families (MacAlister report, 2022). This recommendation aligned with aspirations of parents and support providers in this research (section 6.5.2). Better still though, would be a course for action on the root causes of poverty and social isolation, explored next.

8.2.3 Game Changers

8.2.3.1 Action on Poverty

It is considered to be a 'game changer' to address poverty in a meaningful way. Mental health problems are experienced across the financial gradient and there is no suggestion that mental health problems would be eradicated with action on poverty. However, people living in poverty experience mental health problems in higher numbers and face greater barriers to accessing treatment (Delgadillo et al., 2016) and parents are no exception. Indeed, parents are one of the groups most impacted by austerity changes, the pandemic, and rising costs of living (Hall, 2019) with many examples shared in this research as well, regarding the damaging relationship between financial stress and poor mental health (section 4.5). It is beyond the remit of this research to specifically recommend actions to tackle poverty, but it recognises calls from wider research that addressing the issues that lead parents into poverty and so often trap them there, could be a game changer for parent mental health (Chakravorty, 2022, Enns et al., 2019).

8.2.3.2 Building a Supportive 'Village' around Parents

The proverb 'it takes a village to raise a child' affirms that raising children should be approached as 'a shared responsibility amongst many' (Reupert et al., 2022, p.2). As testified in multiple papers and reports (including a recent government report, HM

Government, 2023) it is ‘normal’ for parents to be supported in this role, expanded below:

> It is normal for all parents to need help, from wider family, friends, the community and sometimes from the state. This help should be available, responsive and free from stigma (MacAlistair, 2022, p.18).

The normalisation of support for parents has become lost though, behind messaging that parents are supported when something is ‘wrong’ (Jupp, 2022a) which creates stigma and fear (HM Government, 2023). It would be a ‘game changer’ for parents to be able to ask for advice and support in a normalised way without the pre-requisite that there must be a problem (section 6.5.2). It could benefit all parents by normalising the process of seeking and receiving support but this could be particularly valuable for parents with mental illness (van der Ende, 2016), have a child with additional needs (McAuliffe et al., 2021) and more broadly, ‘living in conditions of adversity’ (MacAlistair, 2022) because these are some of the demographics most likely to be socially isolated (section 5.4) and fear service-engagement (section 6.4.1.2). For a parent to disclose (rather than work hard to hide) problems that they are experiencing in parenthood, requires trusted relationships in safe spaces. Reducing the stigma of asking for help by normalising the process of parent support is a step towards achieving that goal. Creating safe spaces where parents feel able to honestly share their struggles and access peer and professional support in a timely manner, can be promoted by realising actions described previously in this section (see also, section 6.5), and as such, concludes this section of the thesis.

8.3 Reflections on multiple methods and integrated analysis

The final part of this discussion offers a reflection about the process of integrating data from multiple methods in a unified analysis. A pitfall of the integrated analysis was the volume of combined data, which felt overwhelming. This experience is not unique to multiple-methods or integrated analysis and any researcher must find ways of managing data volume. Another challenge was drawing together disparate data into an analysis that would tell a coherent story whilst also capturing the inherent messiness of human life and relationships but again, not an unfamiliar challenge in qualitative research and rather more, a strength of the approach (Braun and Clarke, 2022). In multi-perspective research (even if not multi-method) there can be dissonance between accounts but as explored (section 3.4.1) points of divergence are interesting rather than problematic (Farmer et al., 2006) and so again, does not create disadvantage. Certainly, multi-methods can create challenges in presenting the findings, but carefully considered non-traditional presentation, such as presenting some findings within the methods Chapter (section 3.4.2) can remedy this concern (O'Cathain, 2009). In summary, the potential drawbacks of integrated analysis were not always unique to this style and deemed worthwhile when compared with advantages, discussed next.

A benefit of integrated analysis across multiple methods was the potential for methodological triangulation (Farmer et al., 2006). Findings consistent across methods appear more credible because multiple sources identify the same phenomenon (Lincoln and Guba, 1985). For example, the issue of service closures is given weight by appearing as a concern in all four methods. However, that is not to say that the reverse is true and findings constructed from only one method are not credible or that divergent findings lack credibility. Indeed, there were occasions when an issue was identified in and deemed significant from only one method. For example, suicidal ideation and parenthood was only identified in the social media analysis, which highlights another strength of the approach, which is that more points of interest may be identified when exploring the topic from different approaches. Multiple methods can therefore, reveal more phenomenon relevant to the research question.

Sometimes, points of interest were under-developed from one method but could be developed more deeply when combined with data from other methods. For example, a survey comment about lack of local support when their child was self-harming (section 6.4.2.2) was an important point, but there were few other comments about geographical gaps in service provision in the survey. However, when combined with data from other methods, it contributed towards a larger concern regarding 'postcode lottery'. Similarly, underrepresented voices in this research were sometimes given more attention when related data were combined. For example, men were underrepresented in each stage of the research individually but when combined, there was a meaningful level of data (from multiple perspectives) about access to support for fathers. Previous research has identified underrepresentation of male voice in parenthood research (Yaremych and Persky, 2022). Integrated analysis from multiple methods is one possible approach to mitigate underrepresentation.

To conclude, the process of completing an integrated analysis on multiple methods was complex but rewarding. By bringing different data sets together the eventual outcome is greater than the sum of individual parts, as relationships between methods develop greater breadth and depth to the analysis.

8.4 Limitations

Limitations for each method were considered individually in Chapter 3. Here, there is consideration of limitations of the research study as a whole. To consider which voices are 'heard' in any form of research is critical but given the focus of this thesis on inequality, it is especially pertinent to consider diversity in the data sets and be transparent about where this has been lacking. As Elwood (2009, p105) writes, there is a tendency 'in all forms, of data, analysis and representation to silence or exclude' and it is acknowledged that there was underrepresentation of parents from ethnic minority backgrounds, LGBTQ parents, parents with a physical disability or chronic health condition(s), and young parents. These demographics have been identified in literature as being at greater risk of experiencing inequality and as such, the limited data pertaining to these groups is a significant limitation (Darwin and Greenfield, 2019; Keown et al., 2016; Swift et al., 2020; Wint et al., 2016). The phrase 'absence of evidence is not evidence of absence' applies here, as the lack of attention to issues impacting these populations in the findings chapters reflects a lack of data only and certainly does not suggest, an absence of inequality issues which has been identified in wider literature. The selection of methods, particularly parent voice methods, would have contributed to lower representation from these groups. The social media analysis was conducted in Mumsnet, known to be predominately used by white, married, middle-class women (Mackenzie et al., 2017) and despite purposeful efforts to include posts from original posters with more diverse characteristics, there was still underrepresentation from different demographics. The survey was posted on Mumsnet and also disseminated through the research team Facebook and Twitter accounts, which also were largely viewed and responded to by a narrow demographic (see Chapter 3). Collecting data from these virtual locations led to an under-representation of many populations at risk of inequality. The rationale for these remote methods was the COVID-19 pandemic and certainly, that created logistical challenges to engaging with parents and community groups in-person. The absence of engagement with parents in-person is recognised as a limitation that it would be advantageous to address in future research, with the pandemic restrictions now over. In particular, to engage with community groups that have relationships with under-represented parents.

8.5 Conclusion

Poor parent mental health is recognised as a risk factor for child outcomes and parent*ing* is established as a public health issue and intervention strategy. What has been argued in this thesis is that factors influencing parent mental health and wellbeing, including austerity, the pandemic, rising costs of living, and how these factors intersect with pre-existing experiences of inequality and stigma, need greater focus in debates and decisions that impact access to support for families, for the sake of parents themselves as well as for their children and wider relationships.

These conclusions have been developed by drawing on multiple methods and varying perspectives, integrated at the point of analysis, to take a broad perspective of the issues and impacts. The approach was found to be well suited to exploring parent mental health and wellbeing but equally, could be applied when approaching complex research questions. Indeed, the research process has somewhat mirrored the central ‘it takes a village’ framework of this research, by recognising that research, like child-rearing, benefits from the involvement of different people with different perspectives and contributions, brought together in common purpose.

To improve parent mental health and wellbeing, parents need access to essential resources, to social support, and (where required) services for themselves and their children, offered in a normalised and timely fashion without a prerequisite of crisis, in keeping with public health models of prevention and promotion as the foundations which underpin any later stage interventions. In order to achieve this goal, there needs to be a stronger, systematic, 'village' approach to supporting parent mental health and wellbeing which recognises inequalities and inadequacies in the current system and seeks to ensure all parents are supported. This includes access to universal supports that foster peer support and respond to needs for lower-level advice, early intervention offerings that respond to the first signs of problems emerging, and timely access to specialist professional support for more complex situations. These layers of support are a complete package and should not compete against each other because as has been shown, losses in one area ultimately bring problematic effects elsewhere, which impact the whole support landscape and the mental health and wellbeing of parents and families. Furthermore, whilst communities and the charitable sector make a significant contribution towards providing spaces of parent support within a broader 'village' model of support, there must not be an overreliance on precarious and unevenly distributed voluntary services for meeting critical needs of parents and families. A failure to improve equitable access to support for parents, particularly those experiencing challenging circumstances, risks long term adverse consequences for parents and children and as such, is not an area from which the state can abdicate responsibility.

Appendix A Combined Participant Information Sheet and Consent Form for Anonymous Online Surveys for Adult Participants

Study Title: Parenting places, pressures and support; seeking to promote parent mental health and wellbeing through an understanding of everyday pressures and opportunities for adults raising children, aged 0-17yrs.

Researcher(s): Rachel Houweling, Dr Dianna Smith, Dr Andrew Power, Dr Rachel Dadswell

University email: reh1g18@soton.ac.uk

Ethics/ERGO no: 62637

Version and date: 1

What is the research about?

My name is Rachel and I am a PhD student at the University of Southampton in the United Kingdom. I'm also a mum and keen to know more about how we can better support parents. I am inviting you to take part in a study about how everyday places, activities and services impact parents. We want to understand more about these experiences and make suggestions to help promote good mental health and wellbeing for parents.

This study was approved by the Faculty Research Ethics Committee (FREC) at the University of Southampton (Ethics/ERGO Number: 62637

What will happen to me if I take part?

This study involves completing an anonymous questionnaire. Mostly, it will ask you to rate your answers on a scale with 5 choices but there are also some boxes where you can type in answers if you choose. Answering the multiple-choice questions should take about 5 minutes but if you choose to also write answers in the text boxes, it will take 10-15minutes. If you are happy to complete this survey, you will need to tick (check) the box below to show your consent. As this survey is anonymous, the research team will not be able to know whether you have participated, or what answers you provided.

Why have I been asked to participate?

We are looking for people to do the survey who are:

- Aged 18yrs or older and have capacity to consent
- Live in the UK
- Raising children aged 0-17yrs. We use the word ‘parent’ to include people raising children under different circumstance. You might be a birth, step, foster or adoptive parent or legal guardian. The child or children might live with you all of the time (full custody) or part of the week most weeks (shared custody).
- Are comfortable to think about what has been helpful and what has been more difficult for you as you raise children

What information will be collected?

The questions in this survey ask for information about what life is like for you and where you find support. You will be asked some broad questions about your circumstances, but nothing that could be used to identify you. You can choose ‘prefer not to say’ or leave blank any questions you don’t want to answer. The only question that you must answer is the one that asks for consent to complete the survey.

Some of the survey questions contain textboxes where you will be asked to type in your own answers. Please note that in order for this survey to be anonymous, you should not include in your answers any information from which you, or other people, could be identified. For example, please don’t include names of places or people, contact details or personal information. You do not have to answer all the questions if you do not wish to do so.

What are the possible benefits of taking part?

If you decide to take part in this study, you will not receive any direct benefits; however, your participation will contribute to knowledge in this area of research which is intended to inform support for parents.

Are there any risks involved?

The questions are general but without knowing your personal circumstances, we cannot be sure that you will not feel psychological discomfort and/or distress. If this happens, please skip the question that has upset you or stop the survey. You may want to contact the following organisations for support:

- The Samaritans: 116 123
- Family Lives: 0808 800 2222

What will happen to the information collected?

All information collected for this study will be stored securely on a password protected computer network and backed up on a secure server. Answers from multiple-choice questions will be compiled into data summaries or summary reports. Free-text answers will also be put together to look for similarities. Sometimes, quotes will be used as an examples, but details about the person who gave that quote will not be shared. Only the research team will have access to the full information shared in the survey. We will include data from surveys submitted between February and May 2021.

The information collected will be analysed and written up as part of the researcher's PhD thesis and will hopefully be published in a journal and report (perhaps alongside other parts of the research), so that it will be available to policymakers, commissioners, services and parents.

The University of Southampton conducts research to the highest standards of ethics and research integrity. In accordance with our Research Data Management Policy, data will be held for 10 years after the study has finished when it will be securely destroyed.

What happens if there is a problem?

If you are unhappy about any aspect of this study and would like to make a formal complaint, you can contact the Head of Research Integrity and Governance, University of Southampton, on the following contact details: Email: rgoinfo@soton.ac.uk, phone: + 44 2380 595058.

Please quote the Ethics/ERGO number above. Please note that by making a complaint you might be no longer anonymous.

More information on your rights as a study participant is available via this link: https://www.southampton.ac.uk/about/governance/participant-information.page

Thank you for reading this information sheet and considering taking part in this research.

☐ Please tick (check) this box to indicate that you have read and understood information on this form, are aged 18 or over, have full or shared parental responsibility for at least one child aged 0-17yrs, currently live in the UK, can give cons

Appendix B Anonymous Online Survey

1) Day-to-day

Please think back about the **last six months from today**, to think about how often you have done or felt the following. *If the children are not with you all the time, think about the days that they are with you for questions where that is appliable.*

I have used social media for advice, information and/ or support

Every day Most days Occasionally Rarely Never
N/A Prefer not to say

I have enjoyed doing things with my children

Every day Most days Occasionally Rarely Never
N/A Prefer not to say

I have worried about money

Every day Most days Occasionally Rarely Never
N/A Prefer not to say

I have had time for myself and my own interests

Every day Most days Occasionally Rarely Never
N/A Prefer not to say

I have felt lonely

Every day Most days Occasionally Rarely Never
N/A Prefer not to say

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I have felt bored

Every day Most days Occasionally Rarely Never
N/A Prefer not to say

I have felt stressed or overwhelmed

Every day Most days Occasionally Rarely Never
N/A Prefer not to say

I have had a physical health condition, illness or disability that has impacted on my ability to do things with my children

Every day Most days Occasionally Rarely Never
N/A Prefer not to say

I have slept well

Every day Most nights Occasionally Rarely Never
N/A Prefer not to say

I have been happy with the balance between time spent on my job (if applicable) and time with my family

Every day Most days Occasionally Rarely Never
N/A Prefer not to say

I have felt proud of how I am raising my children

Every day Most days Occasionally Rarely Never
N/A Prefer not to say

I have found it hard to cope, as a parent, with the COVID-19 changes to daily life

Every day Most days Occasionally Rarely Never
N/A Prefer not to say

I have worried about my children so much it has impacted my mental health and wellbeing

Every day Most days Occasionally Rarely Never
N/A Prefer not to say

2) People and Places

I am happy with the social support and help with raising children that I get from people in my life (i.e., partner, family and/ or friends as applicable)

Strongly Agree Agree Neither agree nor disagree
Disagree Strongly disagree N/A Prefer not to say

Since becoming a parent, I have made friends with other parents who I trust and feel supported by

Strongly Agree Agree Neither agree nor disagree
Disagree Strongly disagree N/A Prefer not to say

I am happy with the parent-related professional support that I have had from health/ support services (i.e. GP, Health visitor, specialist service)

Strongly Agree Agree Neither agree nor disagree
Disagree Strongly disagree N/A Prefer not to say

Even before COVID I had difficulty getting to groups/ activities/ classes offered to parents (i.e. because of times they run, location, costs, etc).

Strongly Agree Agree Neither agree nor disagree
Disagree Strongly disagree N/A Prefer not to say

There are places that I have avoided going to, or dreaded going to, out of worry of what people would think of me or my children

Strongly Agree Agree Neither agree nor disagree
Disagree Strongly disagree N/A Prefer not to say

I have avoided, delayed or otherwise ‘not done’ things that would be good for my mental health and wellbeing because since becoming a parent

Strongly Agree Agree Neither agree nor disagree
Disagree Strongly disagree N/A Prefer not to say

From my home, there are parks, playgrounds and outdoor areas that I can get to easily AND I felt safe to go there during daytime (before COVID)

Strongly Agree Agree Neither agree nor disagree
Disagree Strongly disagree N/A Prefer not to say

I have good access to the internet

Strongly Agree Agree Neither agree nor disagree
Disagree Strongly disagree N/A Prefer not to say

Even before COVID, I found it hard to get to ‘everyday essentials’, like the school, GP, food shops.

Strongly Agree Agree Neither agree nor disagree
Disagree Strongly disagree N/A Prefer not to say

I feel safe in the area where I live

Strongly Agree Agree Neither agree nor disagree
Disagree Strongly disagree N/A Prefer not to say

COVID-19 has disrupted places I would usually go for support

Strongly Agree Agree Neither agree nor disagree
Disagree Strongly disagree N/A Prefer not to say

During COVID-19 I have argued more often with the people close to me

Strongly Agree Agree Neither agree nor disagree
Disagree Strongly disagree N/A Prefer not to say

3) In your own words

These next few questions ask you to write in your own words, about your thoughts or experiences as a parent. You can write as little or as much as you like in each box, or nothing at all, but to keep it anonymous please do not share information that would obviously identify you. Thank you.

Where are the places that have mattered to you most/ helped you most as a parent (can be in the 'real world' or online)?

Where are the places that have been most difficult to access and/ or caused you distress (again, can be online or offline)?

What are the activities, stages or things about being a parent, that you have liked most?

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What are the activities, stages or things about being a parent that you have found most difficult?

How has COVID-19 impacted your health and wellbeing as a parent?

If you needed mental health support, who would you talk to/ contact?

Would you have any worries or difficulties in asking for mental health support?

What do you think could be done to better support the mental health and wellbeing of parents?

Any other comments?

3) **A bit about me**

These questions help us to understand a bit about the circumstances of people who have taken part in the study. That is useful because we can see if there are similarities of differences; such as did men and women give similar or different answers? It also helps us to see if we are hearing from some groups of people more than others. However, please feel free to skip or choose 'prefer not to say' to any question you do not want to answer.

How many children aged 0-17rs live with you?

1 2 3 4 or more Prefer not to say

Do these children aged 0-17yrs live with you:

All the time Some of the time A mixture (full custody of at least one child AND shared custody of at least one other child) Prefer not to say

What ages are these children? Please tick as many age groups as apply

0-5yrs 6-11yrs 12-17yrs Prefer not to say

How do you describe your gender?

Male Female Other Prefer not to say

What age-band are you in today?

18-19yrs 20-29yrs 30-39yrs 40-49yrs 50-59yrs 60yrs+ Prefer not to say

What is your ethnicity?

Asian British Asian any other background Black British Black any other background Mixed ethnicity White British White any other background Other Prefer not to say

How would describe your relationship status?

Single Heterosexual partner Same-sex partner Other Prefer not to say

Do you live in:

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England (North) England (Midlands) England (South) Northern Ireland Scotland Wales

No fixed area Prefer not to say

What would best describe where you live?

City Town Village Countryside No fixed area Not sure Prefer not to say

Did you grow up within about 10miles (roughly a twenty-minute drive) of where you live now?

Yes No Not sure Moved a lot as a child/ grew up in no fixed area Prefer not to say

Do you have a disability or long-term health condition?

Yes No Prefer not to say

If yes, there is the option to say what they condition or disability is:

How would you describe yourself (please tick as many as apply)?

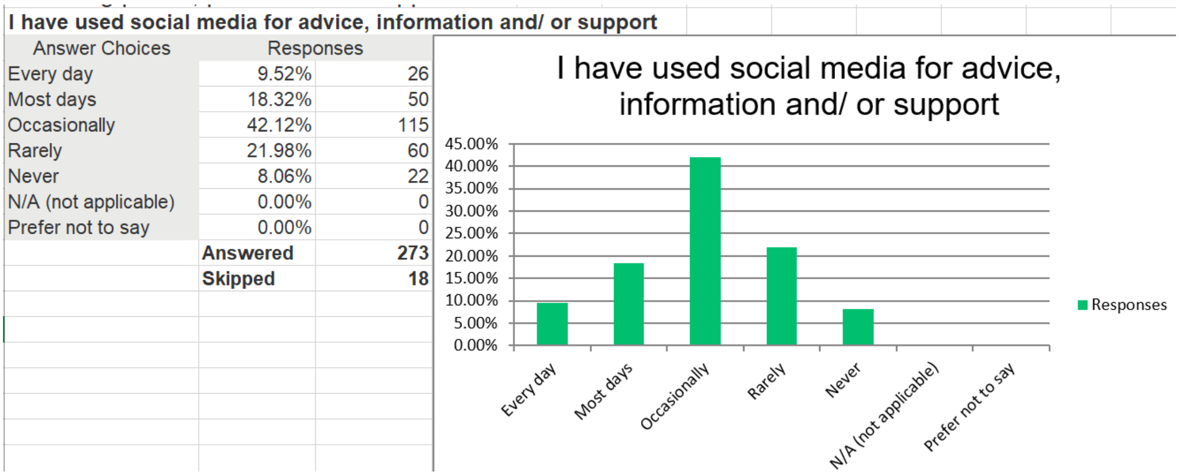
Stay-at-home parent Carer* Part-time worker Full-time worker Student Volunteer Other Prefer not to say

*A carer is someone who regularly gives unpaid care to a family member or friend who needs help because they have a physical or mental health condition, disability, addiction or are frail. This person might be elderly, an adult or child with additional medical, behavioural or educational needs or disability.

Thank you for sharing your time and your experiences by completing this survey. Your answers help us to understand more about the supports available for parents, the pressures they face and what might help. If you would like to talk to someone about parenting and/ or about mental health support, there are contact details below. Thank you once again.

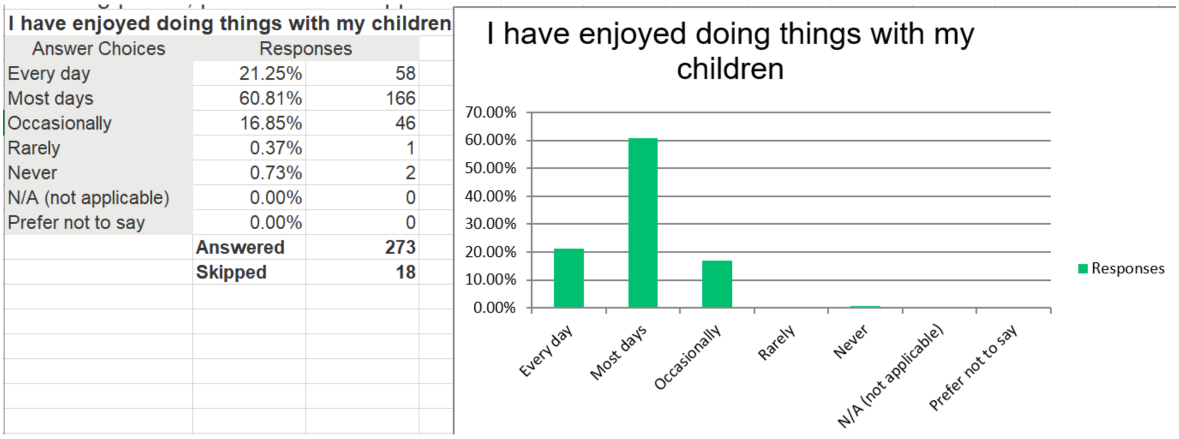
- The Samaritans: 116 123
- Family Lives: 0808 800 2222

Appendix C Survey Likert-scale Responses



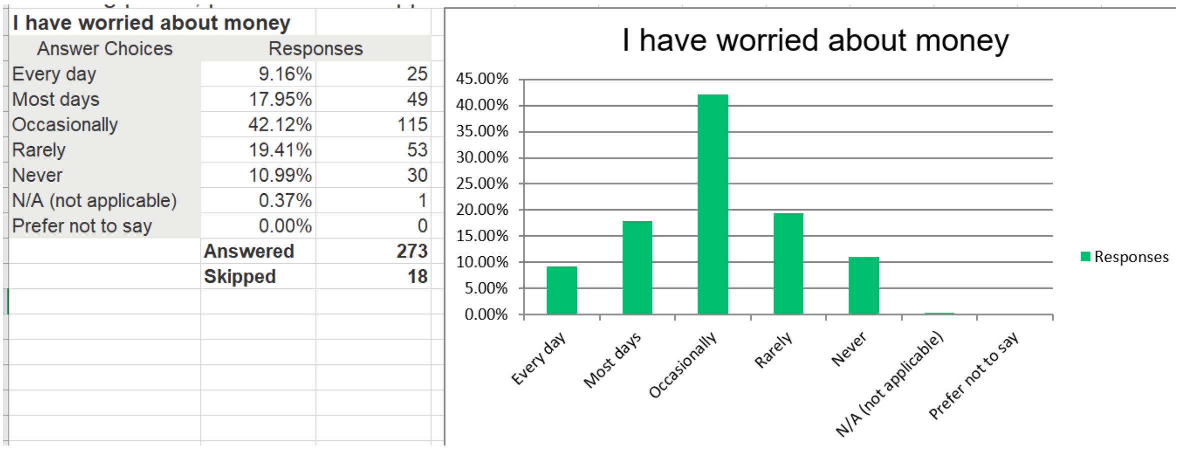
I have used social media for advice, information and/ or support

Answer Choices	Responses	
Every day	9.52%	26
Most days	18.32%	50
Occasionally	42.12%	115
Rarely	21.98%	60
Never	8.06%	22
N/A (not applicable)	0.00%	0
Prefer not to say	0.00%	0
	Answered	**273**
	Skipped	**18**



I have enjoyed doing things with my children

Answer Choices	Responses	
Every day	21.25%	58
Most days	60.81%	166
Occasionally	16.85%	46
Rarely	0.37%	1
Never	0.73%	2
N/A (not applicable)	0.00%	0
Prefer not to say	0.00%	0
	Answered	**273**
	Skipped	**18**

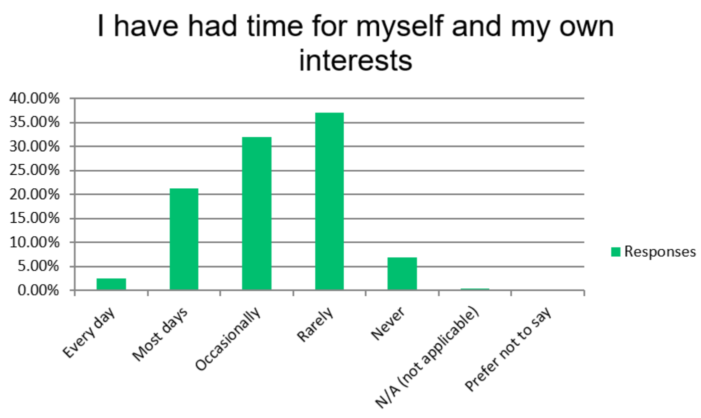


I have worried about money

Answer Choices	Responses	
Every day	9.16%	25
Most days	17.95%	49
Occasionally	42.12%	115
Rarely	19.41%	53
Never	10.99%	30
N/A (not applicable)	0.37%	1
Prefer not to say	0.00%	0
	Answered	**273**
	Skipped	**18**

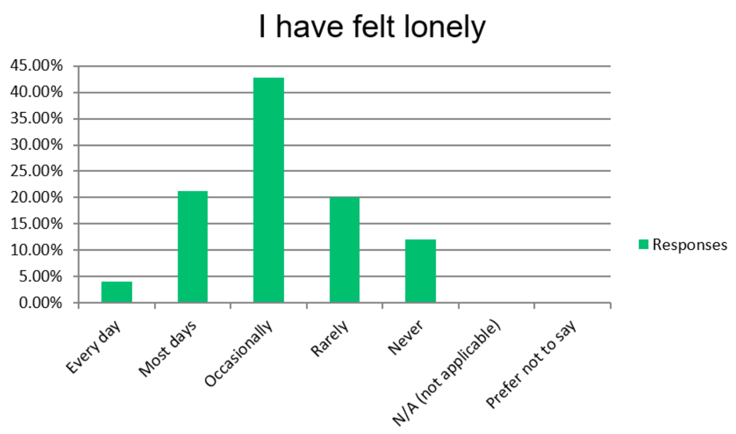
I have had time for myself and my own interests

Answer Choices	Responses	
Every day	2.56%	7
Most days	21.25%	58
Occasionally	31.87%	87
Rarely	37.00%	101
Never	6.96%	19
N/A (not applicable)	0.37%	1
Prefer not to say	0.00%	0
	Answered	**273**
	Skipped	**18**



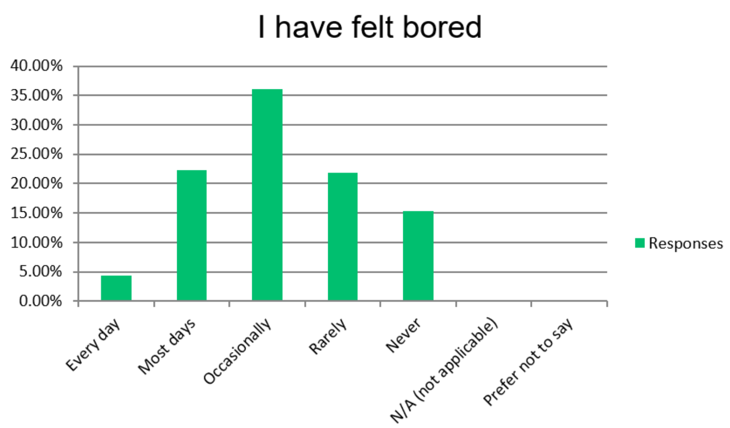
I have felt lonely

Answer Choices	Responses	
Every day	4.01%	11
Most days	21.17%	58
Occasionally	42.70%	117
Rarely	20.07%	55
Never	12.04%	33
N/A (not applicable)	0.00%	0
Prefer not to say	0.00%	0
	Answered	**274**
	Skipped	**17**



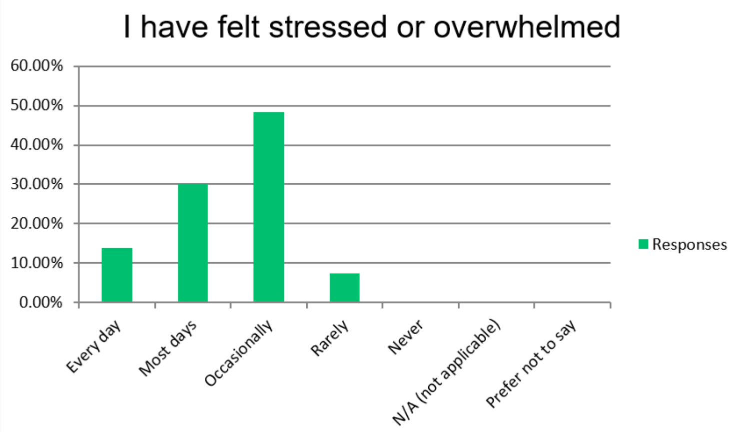
I have felt bored

Answer Choices	Responses	
Every day	4.38%	12
Most days	22.26%	61
Occasionally	36.13%	99
Rarely	21.90%	60
Never	15.33%	42
N/A (not applicable)	0.00%	0
Prefer not to say	0.00%	0
	Answered	**274**
	Skipped	**17**



I have felt stressed or overwhelmed

Answer Choices	Responses	
Every day	13.92%	38
Most days	30.04%	82
Occasionally	48.35%	132
Rarely	7.33%	20
Never	0.37%	1
N/A (not applicable)	0.00%	0
Prefer not to say	0.00%	0
	Answered	**273**
	Skipped	**18**



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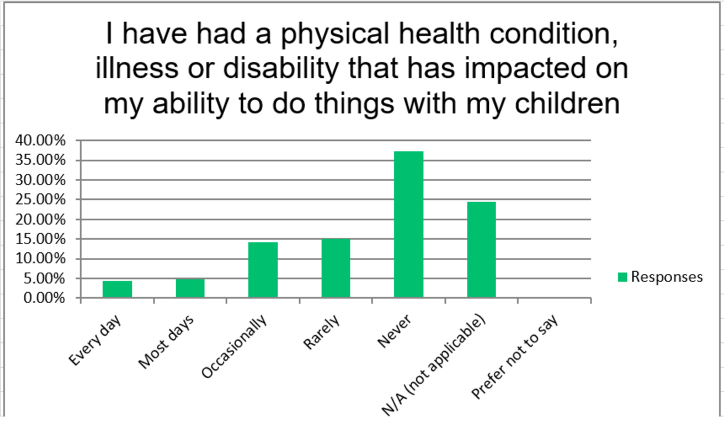
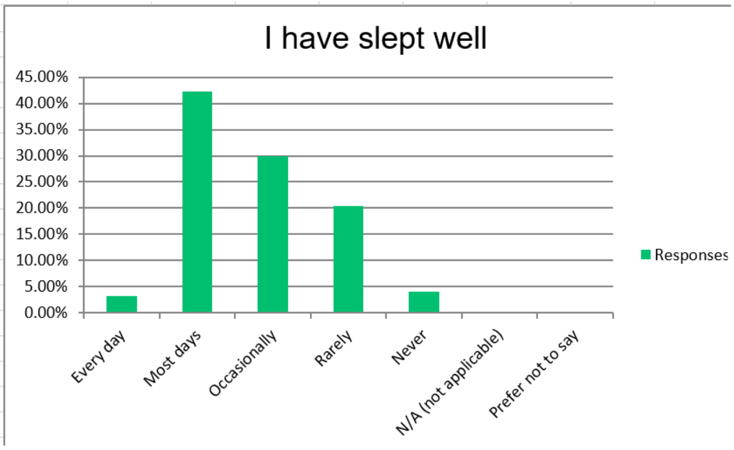
I have had a physical health condition, illness or disability that has impacted on my ability to do things with my children

Answer Choices	Responses	
Every day	4.38%	12
Most days	4.74%	13
Occasionally	14.23%	39
Rarely	14.96%	41
Never	37.23%	102
N/A (not applicable)	24.45%	67
Prefer not to say	0.00%	0
	Answered	**274**
	Skipped	**17**



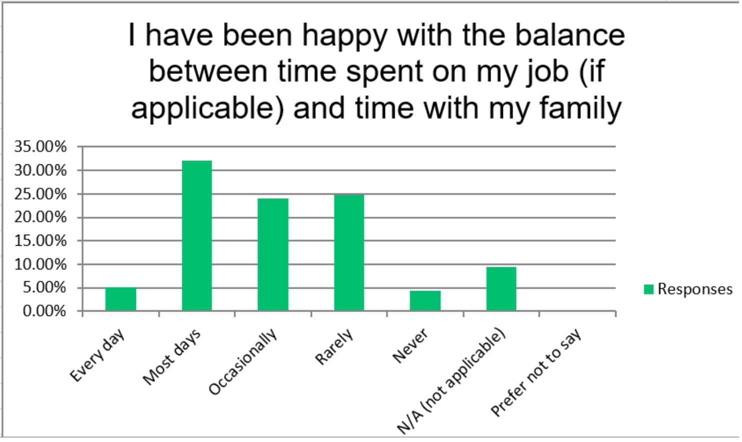
I have slept well

Answer Choices	Responses	
Every day	3.28%	9
Most days	42.34%	116
Occasionally	29.93%	82
Rarely	20.44%	56
Never	4.01%	11
N/A (not applicable)	0.00%	0
Prefer not to say	0.00%	0
	Answered	**274**
	Skipped	**17**



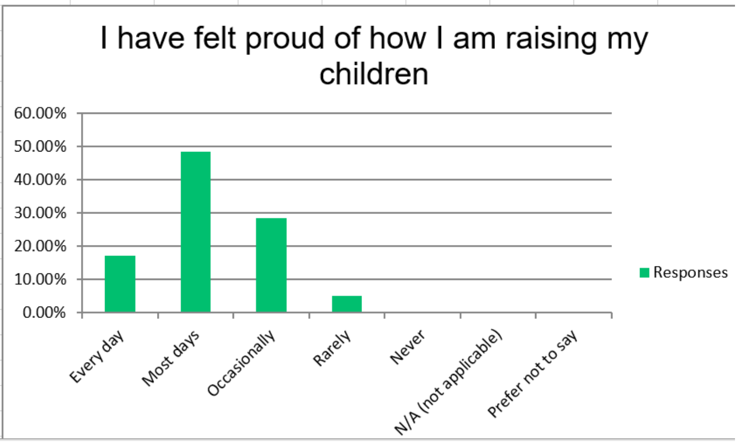
I have been happy with the balance between time spent on my job (if applicable) and time with my family

Answer Choices	Responses	
Every day	5.11%	14
Most days	32.12%	88
Occasionally	24.09%	66
Rarely	24.82%	68
Never	4.38%	12
N/A (not applicable)	9.49%	26
Prefer not to say	0.00%	0
	Answered	**274**
	Skipped	**17**



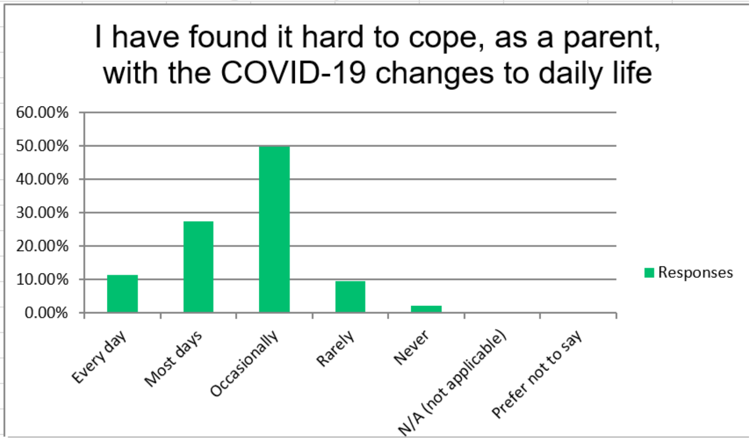
I have felt proud of how I am raising my children

Answer Choices	Responses	
Every day	17.15%	47
Most days	48.54%	133
Occasionally	28.47%	78
Rarely	5.11%	14
Never	0.36%	1
N/A (not applicable)	0.36%	1
Prefer not to say	0.00%	0
	Answered	**274**
	Skipped	**17**



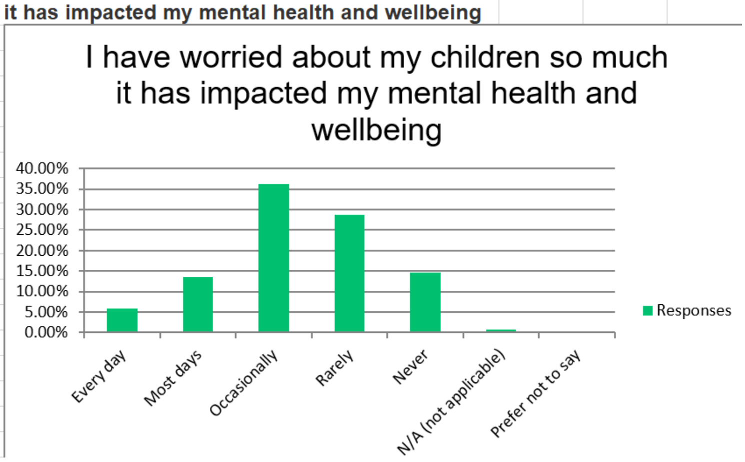
I have found it hard to cope, as a parent, with the COVID-19 changes to daily life

Answer Choices	Responses	
Every day	11.31%	31
Most days	27.37%	75
Occasionally	49.64%	136
Rarely	9.49%	26
Never	2.19%	6
N/A (not applicable)	0.00%	0
Prefer not to say	0.00%	0
	Answered	**274**
	Skipped	**17**



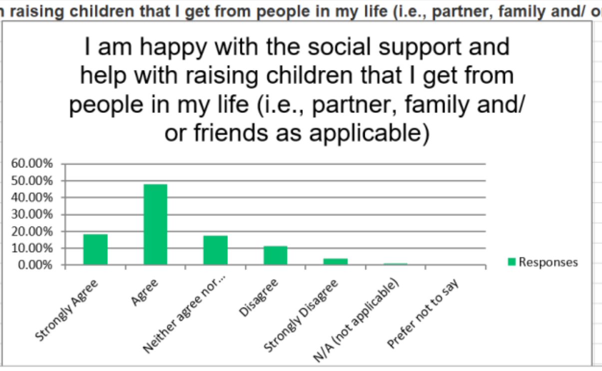
I have worried about my children so much it has impacted my mental health and wellbeing

Answer Choices	Responses	
Every day	5.84%	16
Most days	13.50%	37
Occasionally	36.13%	99
Rarely	28.83%	79
Never	14.60%	40
N/A (not applicable)	0.73%	2
Prefer not to say	0.36%	1
	Answered	**274**
	Skipped	**17**

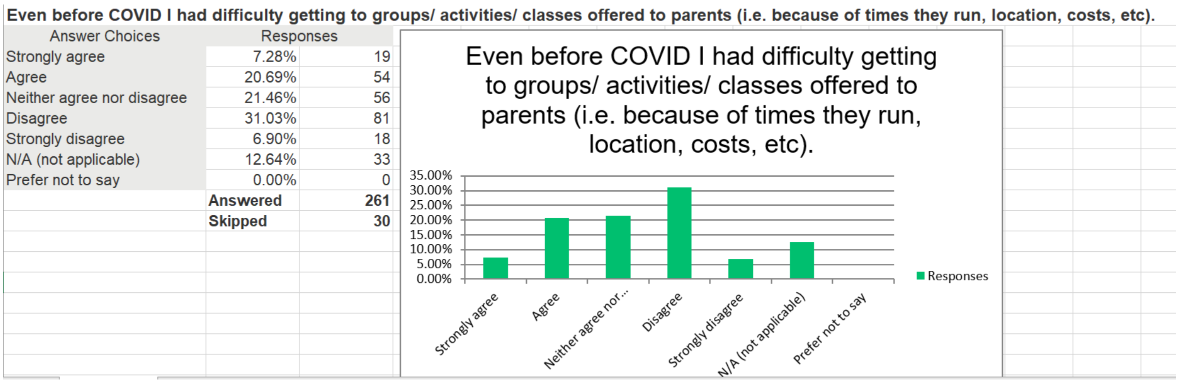


I am happy with the social support and help with raising children that I get from people in my life (i.e., partner, family and/ or friends as applicable)

Answer Choices	Responses	
Strongly Agree	18.39%	48
Agree	47.89%	125
Neither agree nor disagree	17.62%	46
Disagree	11.11%	29
Strongly Disagree	3.83%	10
N/A (not applicable)	1.15%	3
Prefer not to say	0.00%	0
	Answered	**261**
	Skipped	**30**

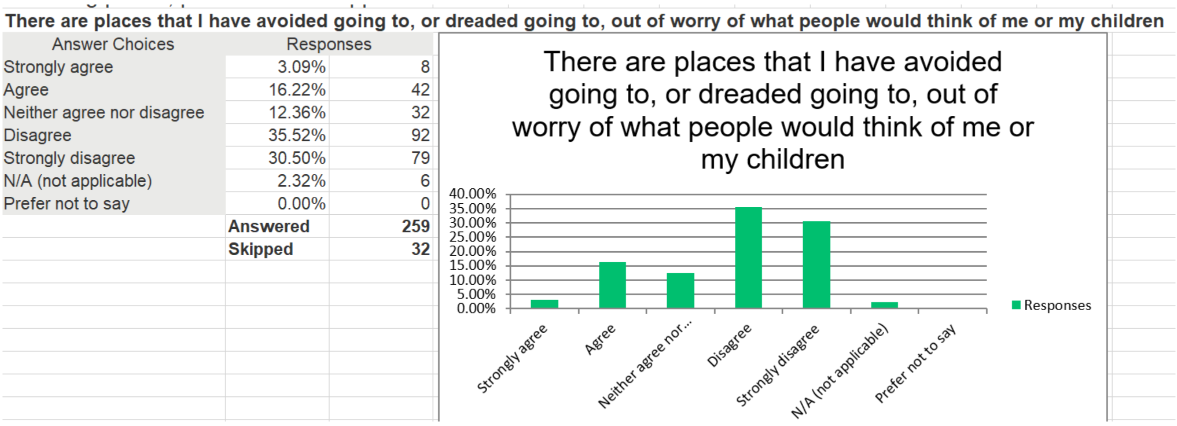


Appendix C



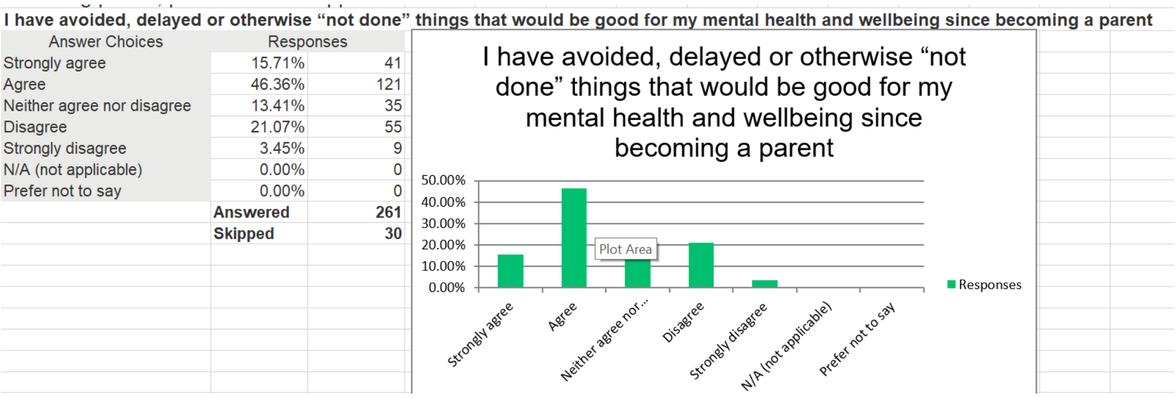
Even before COVID I had difficulty getting to groups/ activities/ classes offered to parents (i.e. because of times they run, location, costs, etc).

Answer Choices	Responses	
Strongly agree	7.28%	19
Agree	20.69%	54
Neither agree nor disagree	21.46%	56
Disagree	31.03%	81
Strongly disagree	6.90%	18
N/A (not applicable)	12.64%	33
Prefer not to say	0.00%	0
	Answered	**261**
	Skipped	**30**



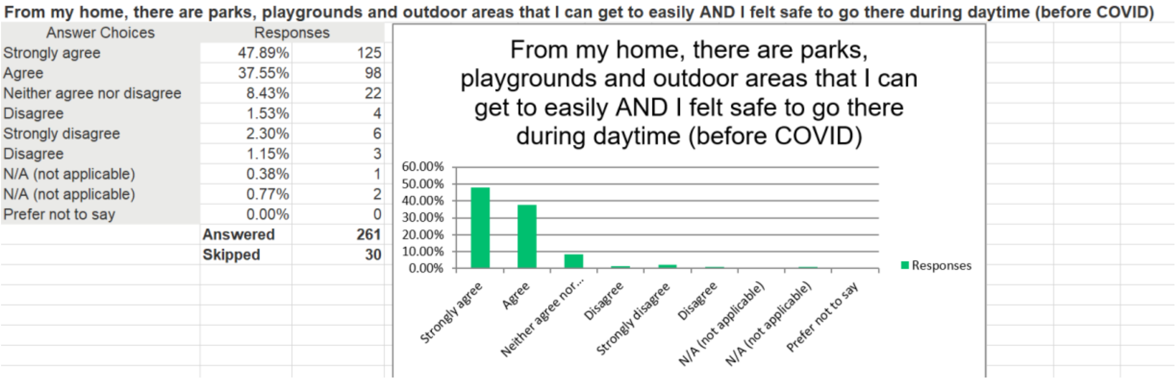
There are places that I have avoided going to, or dreaded going to, out of worry of what people would think of me or my children

Answer Choices	Responses	
Strongly agree	3.09%	8
Agree	16.22%	42
Neither agree nor disagree	12.36%	32
Disagree	35.52%	92
Strongly disagree	30.50%	79
N/A (not applicable)	2.32%	6
Prefer not to say	0.00%	0
	Answered	**259**
	Skipped	**32**



I have avoided, delayed or otherwise "not done" things that would be good for my mental health and wellbeing since becoming a parent

Answer Choices	Responses	
Strongly agree	15.71%	41
Agree	46.36%	121
Neither agree nor disagree	13.41%	35
Disagree	21.07%	55
Strongly disagree	3.45%	9
N/A (not applicable)	0.00%	0
Prefer not to say	0.00%	0
	Answered	**261**
	Skipped	**30**

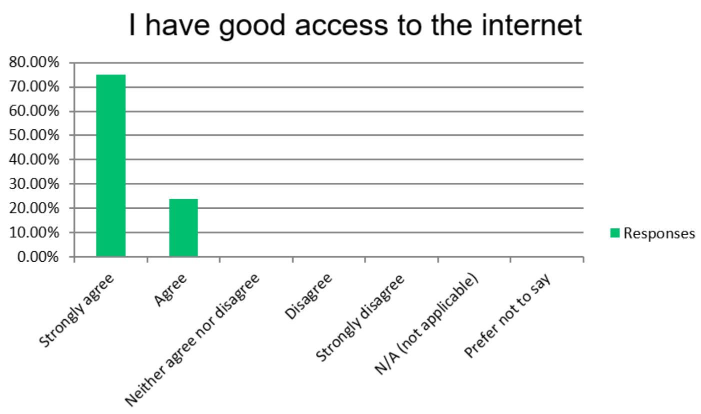


From my home, there are parks, playgrounds and outdoor areas that I can get to easily AND I felt safe to go there during daytime (before COVID)

Answer Choices	Responses	
Strongly agree	47.89%	125
Agree	37.55%	98
Neither agree nor disagree	8.43%	22
Disagree	1.53%	4
Strongly disagree	2.30%	6
Disagree	1.15%	3
N/A (not applicable)	0.38%	1
N/A (not applicable)	0.77%	2
Prefer not to say	0.00%	0
	Answered	**261**
	Skipped	**30**

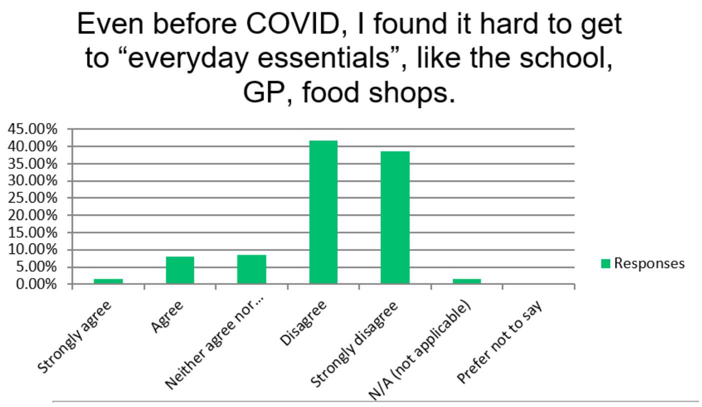
I have good access to the internet

Answer Choices	Responses	
Strongly agree	75.10%	196
Agree	23.75%	62
Neither agree nor disagree	0.38%	1
Disagree	0.38%	1
Strongly disagree	0.38%	1
N/A (not applicable)	0.00%	0
Prefer not to say	0.00%	0
	Answered	**261**
	Skipped	**30**



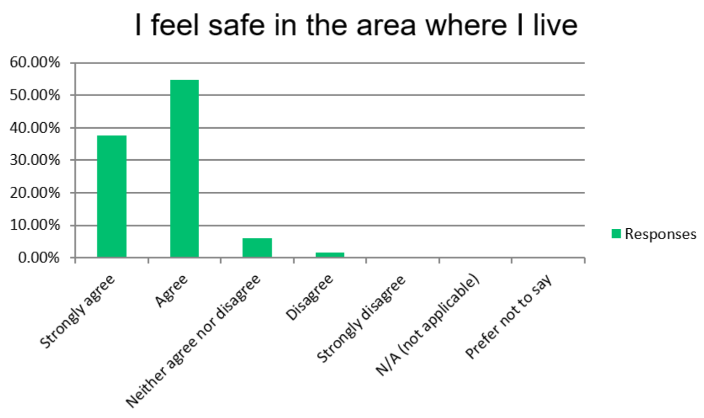
Even before COVID, I found it hard to get to “everyday essentials”, like the school, GP, food shops.

Answer Choices	Responses	
Strongly agree	1.53%	4
Agree	8.05%	21
Neither agree nor disagree	8.43%	22
Disagree	41.76%	109
Strongly disagree	38.70%	101
N/A (not applicable)	1.53%	4
Prefer not to say	0.00%	0
	Answered	**261**
	Skipped	**30**



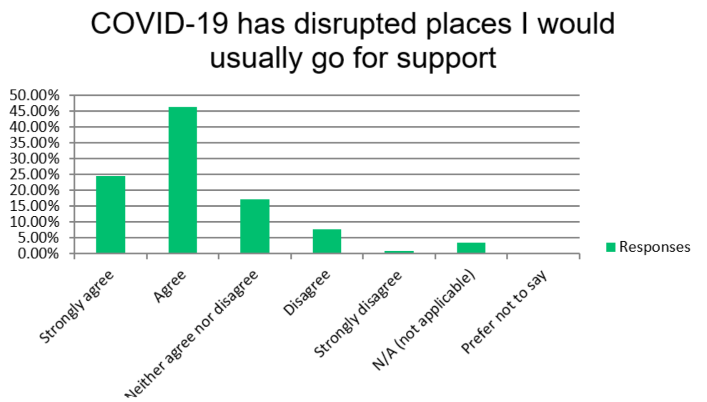
I feel safe in the area where I live

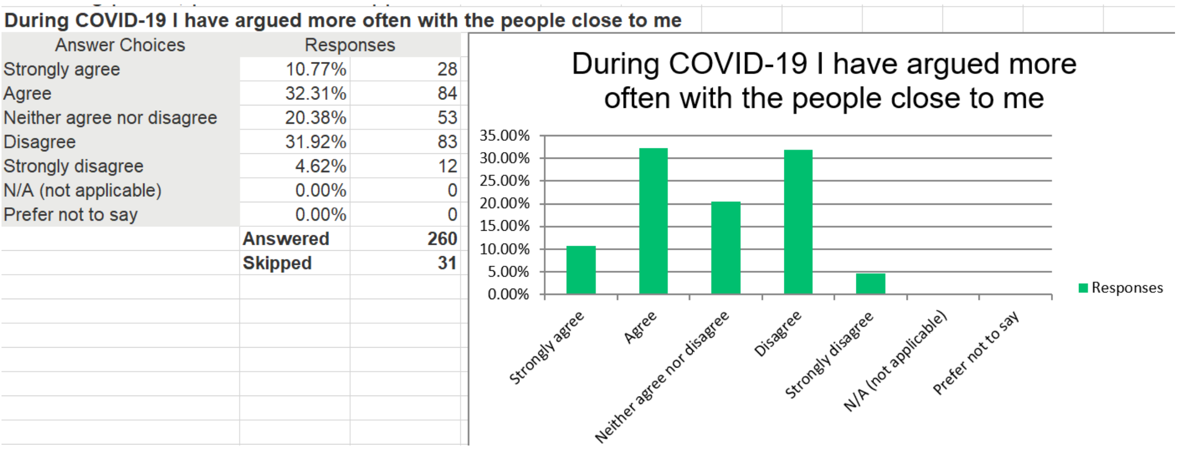
Answer Choices	Responses	
Strongly agree	37.69%	98
Agree	54.62%	142
Neither agree nor disagree	6.15%	16
Disagree	1.54%	4
Strongly disagree	0.00%	0
N/A (not applicable)	0.00%	0
Prefer not to say	0.00%	0
	Answered	**260**
	Skipped	**31**



COVID-19 has disrupted places I would usually go for support

Answer Choices	Responses	
Strongly agree	24.52%	64
Agree	46.36%	121
Neither agree nor disagree	17.24%	45
Disagree	7.66%	20
Strongly disagree	0.77%	2
N/A (not applicable)	3.45%	9
Prefer not to say	0.00%	0
	Answered	**261**
	Skipped	**30**





During COVID-19 I have argued more often with the people close to me

Answer Choices	Responses	
Strongly agree	10.77%	28
Agree	32.31%	84
Neither agree nor disagree	20.38%	53
Disagree	31.92%	83
Strongly disagree	4.62%	12
N/A (not applicable)	0.00%	0
Prefer not to say	0.00%	0
	Answered	**260**
	Skipped	**31**

Appendix D List of Offerings in Asset Map

Asset map for final thesis.csv

Appendix E Participant Information Sheet: Semi-structured Interviews

Study title: Exploring spaces of parent support in Hampshire, to better understand inequality and promote parent mental health and wellbeing.

Researcher name: Rachel Houweling

ERGO number: 70469

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve. Please read the information below carefully and ask questions if anything is not clear or you would like more information before you decide to take part in this research. You may like to discuss it with others but it is up to you to decide whether or not to take part. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

The interviews are a part of my PhD study at The University of Southampton, funded by The South Coast Doctoral Training Partnership. My PhD is focused on understanding inequalities potentially impacting the mental health and wellbeing of parents and exploring options for better promoting parent mental health and wellbeing. The interviews are to explore the perspectives of those who support parents (in a paid or volunteer role) about issues impacting parents in Hampshire and thoughts on what could be done to develop parent support opportunities.

Why have I been asked to participate?

You have been asked to participate because you work or volunteer in a role that supports parents in Hampshire. I am hoping to interview approximately 15-20 people who meet these criteria.

What will happen to me if I take part?

You will be invited to take part in ONE interview of 45-60 minutes. This can be scheduled during business hours, or in an evening or weekend, depending on your preference. Given the ever-changing pandemic situation, interviews will take place online via Microsoft Teams. The researcher will email you a link that can be used to open Microsoft Teams (whether or not it is downloaded to your device). The interview will be audio and video recorded. If you do not want to be video-recorded, you can turn your camera off. However, it is necessary that the interview is audio recorded so that the researcher can transcribe the interview for analysis. Recordings will be stored on a password protected computer until transcribed. When the recording has been transcribed, the original recordings will be deleted.

Are there any benefits in my taking part?

There are no direct benefits to you. However, you will be contributing your perspectives about parent support needs and opportunities to a PhD study, findings from which will be shared with Hampshire County Council and potentially, research publication.

Are there any risks involved?

Interviews will be conducted online via Microsoft Teams. No physical risk is involved beyond the usual risks associated of using electronic devices in everyday life. The interview topic will focus on your perspectives about parent support in the context of your professional/ volunteer work. If you should become distressed at any point during the interview you can pause or suspend the interview and the researcher may signpost you to places of support.

What data will be collected?

We will ask for your name, gender identity, and age-band. We will also ask how long you have worked/ volunteered in parent support and the type of service that you currently work/ volunteer in. This information will be stored on The University of Southampton research filestore, which is a network that can only be accessed via password. Only the research team will have access to this data, which will be stored for ten years and then destroyed in accordance with University of Southampton policy.

Will my participation be confidential?

Your participation and the information we collect about you during the course of the research will be kept strictly confidential.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

The transcript of your interview will be stored anonymously on a password protected computer, using a pseudonym instead of your real name. Only this pseudonym (never your real name or identifiable details) will be shared in reports or publications linked to this research. There will be one document, stored separately on a password protected computer, that will link your real name and pseudonym. This will only be able to be accessed by the research team.

Do I have to take part?

No, it is entirely up to you to decide whether or not to take part. If you decide you want to take part, you will need to sign a consent form to show you have agreed to take part. If you want to withdraw from the study after initially providing consent, please just advise the researcher and the interview will be cancelled.

What happens if I change my mind?

You have the right to change your mind and withdraw at any time without giving a reason and without your participant rights being affected. If you withdraw before the interview, or up to six weeks after the interview, all data pertaining to you will be destroyed. After six weeks from the interview, analysis would have begun and it may no longer be possible to withdraw your data from the study.

What will happen to the results of the research?

Your personal details will remain strictly confidential. Research findings made available in any reports or publications will not include information that can directly identify you without your specific consent.

Where can I get more information?

For more information, please contact myself or one of my supervisors on the contact details below:

- Rachel Houweling: reh1g18@soton.ac.uk
- Dr Dianna Smith: D.M.Smith@soton.ac.uk
- Dr Andrew Power: A.Power@soton.ac.uk

What happens if there is a problem?

If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions. Contact details above.

If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

Data Protection Privacy Notice

The University of Southampton conducts research to the highest standards of research integrity. As a publicly-funded organisation, the University has to ensure that it is in the public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, ‘Personal data’ means any information that relates to and is capable of identifying a living individual. The University’s data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for ten years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you.

Thank you for taking the time to read the information sheet and considering taking part in the research.

Appendix F Consent Form

Study title: Exploring spaces of parent support in Hampshire, to better understand inequality and promote parent mental health and wellbeing.

Researcher name: Rachel Houweling

ERGO number:70469

Please initial the box(es) if you agree with the statement(s):

I have read and understood the information sheet (24 January 2022 v1) and have had the opportunity to ask questions about the study.	
I agree to take part in this research project and agree for my data to be used for the purpose of this study.	
I understand my participation is voluntary and I may withdraw (at any time) for any reason without my participation rights being affected.	
I understand that if I withdraw from the study up to six weeks after the interview, my data will be removed,	

but more than six weeks after interview it may not be possible to remove the data.	
I understand that I may be quoted directly in reports of the research but that I will not be directly identified (e.g. that my name and the name of the service where I work/ volunteer will not be used unless specifically agreed).	
I understand that taking part in the study involves audio and the option of video recording which will be transcribed and then destroyed for the purposes set out in the participation information sheet.	
I understand that my personal information collected about me such as my name or where I work/ volunteer will not be shared beyond the study team.	

Name of participant (print name)………………………………………………………………………………

Signature of participant………………………………………………………………………

Date………………………………………………………………………………………

Name of researcher (print name)………………………………………………………………………………

Signature of researcher ………………………………………………………………………

Date………………………………………………………………………………

Appendix G Topic Guide: Semi-structured Interviews with Hampshire Parent-Support Service-Providers

Introduction

1. Thank participant.
2. Introduce self and process
3. Confirm consent verbally in audio recording.
4. Stop recording and re-start to begin interview.

Questions

About the Service

1) What does your service do? Why is it needed? Who is it for and how does it support parents? How is it funded (is this long-term or grants based)? How has the service changed over time? Did it change during COVID?

2) How do parents find out about your service? What do they need to do to be able to access it? Referrals, costs, transport, support, language, etc.

3) What would you describe as the strengths/ assets of this service? What are the challenges faced by this service? In an ideal world, what would your 'perfect' version of this service look like? Where

would it be, who would use it, what would it do, etc? How does that differ from what you can offer today? Why?

About Service-users

4) Can you describe a bit about the demographics or characteristics of people who most typically attend your service? For example, gender, age, ethnicity, health conditions, social circumstances etc.
5) Are there parents that you think would benefit from your service but who do not attend? Why? What barriers do you think they face? Are there parents from any particular backgrounds or circumstances that you think are particularly unlikely to access your service/ are under-represented in your services? Again, consider for example, gender, age, ethnicity, health conditions, social circumstances etc.

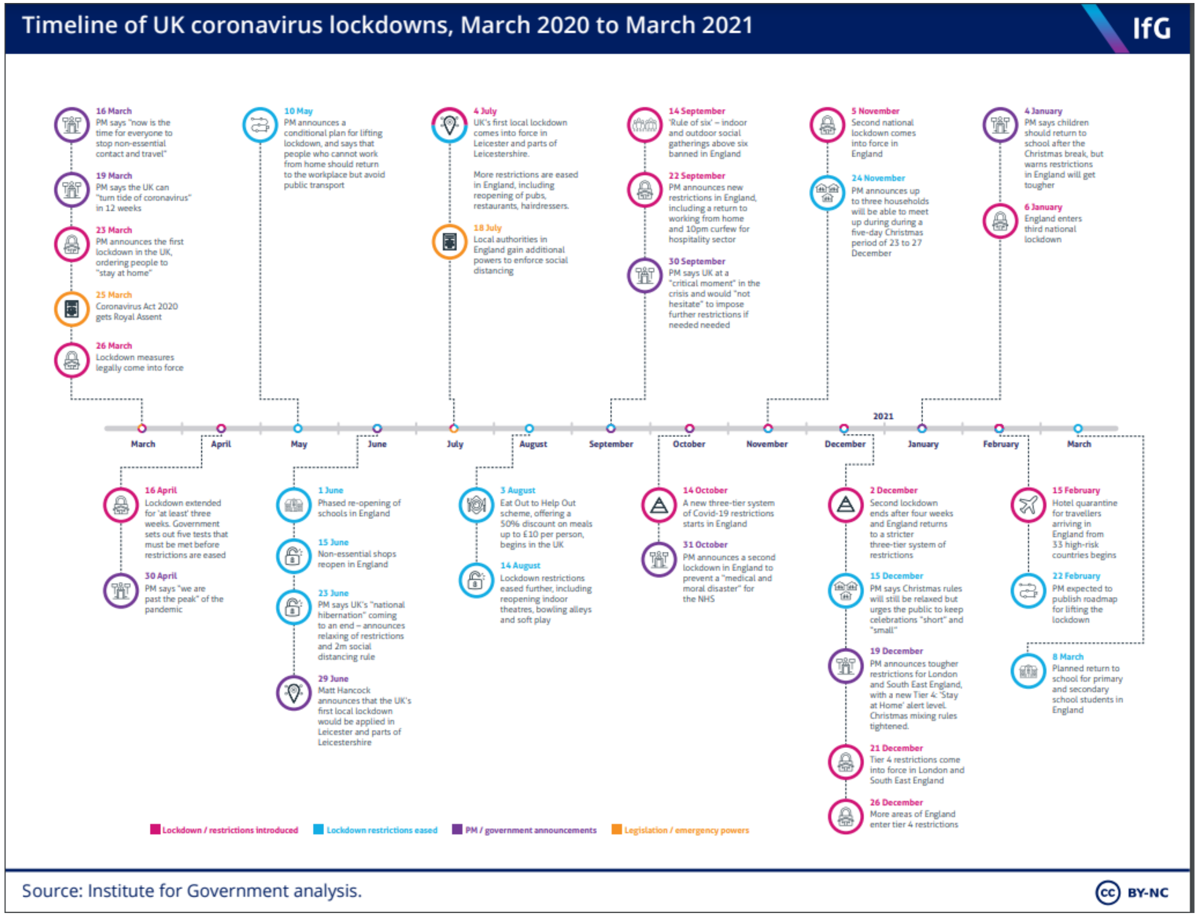
6) Thinking more broadly (including parents who access your service but other parents too) what do you see as the main issues impacting mental health and wellbeing for parents today?

6b) What are the main issues impacting parents' access to support (social or professional)? Do you think parent needs have changed over time? In what ways? Have some things got 'better' or 'worse'?

7) If you had a magic wand that you could use only once, to make **one** thing happen to promote the mental health and wellbeing of parents in Hampshire, what would it be? You can create something new or take something away/ make it disappear. But only one wish.

Thank you. Questions and comments.

Appendix H Timeline of COVID-19 Restrictions (Institute for Government Analysis, 2021)



Timeline of UK coronavirus lockdowns, March 2020 to March 2021

16 March
PM says "now is the time for everyone to stop non-essential contact and travel"

19 March
PM says the UK can "turn tide of coronavirus" in 12 weeks

23 March
PM announces the first lockdown in the UK, ordering people to "stay at home"

25 March
Coronavirus Act 2020 gets Royal Assent

26 March
Lockdown measures legally come into force

16 April
Lockdown extended for 'at least' three weeks. Government sets out five tests that must be met before restrictions are eased

30 April
PM says "we are past the peak" of the pandemic

10 May
PM announces a conditional plan for lifting lockdown, and says that people who cannot work from home should return to the workplace but avoid public transport

1 June
Phased re-opening of schools in England

15 June
Non-essential shops reopen in England

23 June
PM says UK's "national hibernation" coming to an end – announces relaxing of restrictions and 2m social distancing rule

29 June
Matt Hancock announces that the UK's first local lockdown would be applied in Leicester and parts of Leicestershire

4 July
UK's first local lockdown comes into force in Leicester and parts of Leicestershire.

More restrictions are eased in England, including reopening of pubs, restaurants, hairdressers.

18 July
Local authorities in England gain additional powers to enforce social distancing

3 August
Eat Out to Help Out scheme, offering a 50% discount on meals up to £10 per person, begins in the UK

14 August
Lockdown restrictions eased further, including reopening indoor theatres, bowling alleys and soft play

14 September
'Rule of six' – indoor and outdoor social gatherings above six banned in England

22 September
PM announces new restrictions in England, including a return to working from home and 10pm curfew for hospitality sector

30 September
PM says UK at a "critical moment" in the crisis and would "not hesitate" to impose further restrictions if needed needed

14 October
A new three-tier system of Covid-19 restrictions starts in England

31 October
PM announces a second lockdown in England to prevent a "medical and moral disaster" for the NHS

5 November
Second national lockdown comes into force in England

24 November
PM announces up to three households will be able to meet up during during a five-day Christmas period of 23 to 27 December

2 December
Second lockdown ends after four weeks and England returns to a stricter three-tier system of restrictions

15 December
PM says Christmas rules will still be relaxed but urges the public to keep celebrations "short" and "small"

19 December
PM announces tougher restrictions for London and South East England, with a new Tier 4: 'Stay at Home' alert level. Christmas mixing rules tightened.

21 December
Tier 4 restrictions come into force in London and South East England

26 December
More areas of England enter tier 4 restrictions

4 January
PM says children should return to school after the Christmas break, but warns restrictions in England will get tougher

6 January
England enters third national lockdown

15 February
Hotel quarantine for travellers arriving in England from 33 high-risk countries begins

22 February
PM expected to publish roadmap for lifting the lockdown

8 March
Planned return to school for primary and secondary school students in England

🟥 Lockdown / restrictions introduced
🟦 Lockdown restrictions eased
🟪 PM / government announcements
🟧 Legislation / emergency powers

Source: Institute for Government analysis.

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