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Training Trusted Professionals: Strengthening the Response to Domestic Violence and Abuse

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# Training Trusted Professionals: Strengthening the Response to Domestic Violence and Abuse

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## Abstract

This article reports on an independent evaluation (2017-2021) of a domestic violence and abuse (DVA) training intervention delivered in three geographical areas in England. Initially designed as a standalone training day by Women's Aid Federation of England (WAFE), Trusted Professional developed into a whole-organisation approach. The intervention aims to create system change by targeting organisations (housing, children's social care, health and welfare services) likely to be in contact with victims/survivors to embed a needs-led, strengths-based approach.

The evaluation examined how the Trusted Professional intervention was used by practitioners and identified changes in knowledge, skills, confidence and attitudes. Methods included pre- and post-training questionnaires and interviews with participants, trainers and WAFE co-ordinators. Basic descriptive statistics were used to analyse the quantitative data; qualitative data was transcribed and analysed thematically.

Trusted Professional was regarded positively by participants. Practitioners reported increased knowledge and understanding of DVA alongside improved confidence and skills to respond to victims/survivors. Practitioners valued learning what language to use with DVA victims/survivors. Practitioners recommended refresher training and additional content regarding other forms of abuse or Minoritised groups. Recommendations address how the intervention might be better integrated with existing practice, especially for children's social care professionals, and extended more widely.

**Key Words:** domestic violence and abuse; training; workforce development; multi-agency.

## Introduction

Domestic violence and abuse (DVA) is recognised internationally as a public health concern and social problem (UNODC, 2019; WHO, 2021). Global and UK statistics consistently indicate that DVA is highly prevalent and gendered (UNODC, 2019; WHO, 2021). DVA has serious consequences including physical injury, mental health problems or death (UNODC, 2019).

The Domestic Abuse Act (2021)<sup>1</sup> in England and Wales defines DVA as extending beyond physical violence and including emotional, controlling, coercive, threatening behaviour and economic abuse. New functions, powers and offences include recognition of children as DVA victims and extends protections to young people aged 16 and over. The UK government's Tackling Domestic Abuse Plan (2022) recognises that more action is needed to support and train frontline practitioners, noting that statutory and non-statutory agencies do not always understand how to support victims/survivors, or correctly signpost to specialist DVA services (HM Government, 2022). The plan promises specific investment in training frontline practitioners likely to encounter DVA to better identify, respond and refer victims/survivors appropriately.

DVA victims/survivors present DVA-related needs to a wide range of public and third sector services which play an important role in DVA detection, providing an immediate response and directing victims/survivors to specialist support (Home Office, 2022; HM Government, 2022; Department for Levelling Up, Housing and Communities, 2023; NICE, 2014). DVA requires a unified multi-agency response which acknowledges gendering processes, is sensitive to the needs of victims/survivors at different points in their journey to receiving help and goes beyond signposting (Evans and Feder, 2016; Hester, 2011).

## Background

Evaluations of multi/inter-agency responses indicate that DVA training can establish communication channels, improve information sharing, increase effective risk assessment and appropriate responses (Tsantefski, et al., 2021). Practitioner competence and confidence to respond safely and effectively to adult victims/survivors and perpetrators can be developed through appropriate training (Szilassy, 2017; Szilassy et al., 2013). Below, we consider the evidence on training needs and initiatives for frontline practitioners working with DVA victims/survivors, focusing on those groups receiving Trusted Professional: Health, social care, housing and welfare services.

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<sup>1</sup> <https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-abuse-bill-2020-overarching-factsheet>

## Frontline practitioner responses to DVA

### *Health*

DVA is detrimental to physical and mental health (Home Office, 2022; WHO, 2021) with health practitioners identified as key in responding to DVA (NICE 2014; Gibson, 2020). However, healthcare practitioners may lack the capacity to address DVA or the skills and confidence to identify it (Trevillion et al., 2016; MacKenzie et al., 2019). Victims/survivors are reluctant to disclose DVA to health practitioners, including their GP, even when receiving treatment for mental health issues (Evans and Feder, 2016; Trevillion et al., 2016). Upon disclosure, they may encounter inappropriate responses (MacKenzie et al., 2019) including inappropriate referrals or non-referral (Neville and Sanders-McDonagh, 2015; Evans and Feder, 2016).

Training and organisational change within healthcare systems can increase DVA identification (Szilassy, et al., 2017) but there is uncertainty about the effect of interventions on referral to specialist DVA organisations or other outcomes (Feder et al., 2011). The IRIS (Identification and Referral to Improve Safety) training and support programme targets primary care clinicians and aims to improve recording and increase referrals to specialist DVA organisations (Feder et al., 2011).

Training interventions do not always produce sustained results. An evaluation of a maternity and sexual health service interventions following the introduction of DVA clinical guidelines, and one-day DVA training, found that although the training resulted in short-term changes in knowledge and practice, six-months post-training, routine enquiry had not been universally implemented (Bacchus et al., 2010). Midwives reported barriers including: the presence of partners/relatives during consultations, women's mistrust of health practitioners, language barriers and time constraints (Bacchus et al., 2010).

### *Social Care*

Social care has a key role with regards to DVA. While Children's Social Care (CSC) has become more sensitised to DVA, criticisms have focused on the nature of the response (Authors, 2010). Social care workers have reported a lack of training, skills and confidence regarding DVA (Humphreys and Campo, 2017) with families reluctant to engage due to fears of child removal (Authors, 2011). Training can have a positive effect on CSC detection, assessment and response to DVA (e.g. Healey et al., 2018). Joint training to support partnership working between CSC practitioners and specialist DVA organisations is also beneficial (Humphreys and Healey, 2017).

Training alone may provide limited value (Healey et al., 2018). A more embedded approach can produce more consistent benefits and facilitate language change in child protection contexts (O’Leary et al., 2018). Evaluations in Australia found that training laid the groundwork for organisational and practice development, further supported through coaching (Healey et al., 2018; Humphreys and Healey, 2017). Leadership and organisational cultural change can also facilitate improved understanding of DVA and new practice models that prioritise effective DVA recognition and responses (O’Leary et al., 2018).

To transform culture, CSC has sought to implement new models of practice. Motivational interviewing has been piloted in safeguarding teams to achieve a strengths-based solution-focused approach to DVA (Bostock et al., 2018). Models such as ‘Safe and Together’ aim for practice to shift away from entrenched patterns of victim-blaming, to focus on interagency working and partnering with victims/survivors (Macvean et al., 2015; Tsantefski et al., 2021),.

### *Housing*

DVA is a housing issue (Irving-Clark and Henderson, 2020) and a key feature in women’s experience of homelessness (Mayock et al., 2015; Solace Women’s Aid, 2016). The availability of housing (refuges, social housing, private accommodation) can influence a victims/survivor’s decision to leave their perpetrator (Walker and Hester, 2019; Irving-Clark and Henderson, 2020).

There is, however, limited research on DVA and housing issues (Hastings et al., 2021, Henderson, 2019). Housing organisations vary regarding staff levels of DVA training (Irving Clark and Henderson, 2020). Women have described housing officers as unsympathetic and ‘uninterested’ in their DVA histories; or reported they lacked understanding and/or assumed that women were lying (Kelly at al., 2014; Irving Clark and Henderson, 2020).

Henderson’s (2019) research found good practice examples of housing providers’ responses to victims/survivors but noted a gap in responding to DVA perpetrators. Scottish Women’s Aid (2015) found that two-thirds of service providers delivering housing support and advice did not know if they could take action against a perpetrator; over a third of staff did not consider it part of their role. While some new initiatives are emerging (DAHA, 2020), further evidence regarding awareness training or whole organisational approaches to DVA is needed for the housing sector.

## *Welfare services*

The Department for Work and Pensions (DWP, no date) is responsible for welfare, pensions and child maintenance policy administering benefits to around 20 million customers. DWP employees, such as Job Centre staff, are highly likely to encounter DVA victims/survivors. Home Office (2022) guidance notes that staff must be able to support customers and lists a range of measures to help DVA victims/survivors, including work-related concessions and changes to payment arrangements.

Perpetrators can restrict financial independence or access to education, training, and employment (Cortis and Bullen, 2015), which can continue post-separation (Sharp-Jeffs, 2015). There is growing awareness of such abuse (Showalter, 2016; Sharp-Jeffs, 2015) and the economic and social costs of DVA are evidenced (Oliver et al., 2019). DVA guidance and toolkits for welfare and financial services (see Surviving Economic Abuse <https://survivingeconomicabuse.org/im-supporting-someone/resources-for-professionals/>) are available however, there is limited evaluation of their use or effectiveness. Given that employment status is crucial for financial independence, victims/survivors can benefit from employment support: it would be beneficial to understand what would better support DWP practitioners to respond to DVA.

## The Trusted Professional Model

This paper draws on the evaluation of the Trusted Professional intervention developed and delivered by the Women's Aid Federation England (WAFE) in three sites in England, having previously piloted the intervention elsewhere (Women's Aid, 2018). This study was part of the evaluation of a larger programme 2017-2021 (Authors, 2021) which aimed to achieve systemic change to policy, practice and commissioning by promoting early intervention and reducing the prevalence and impact of DVA.

Trusted Professional combined training with organisational development to improve frontline practitioners' expertise, confidence and responsiveness to DVA disclosure; strengthen organisation practice and enhance collaboration between agencies and DVA specialists. Influenced by survivors' accounts of the importance of a trusting relationship with a frontline professional, the intervention aimed to ensure that women experiencing DVA could access a range of support sources.

In the first phase of the evaluation, the intervention was delivered as a stand-alone training day. Building on early research findings (highlighting practitioners' need for ongoing support; internal and external facilitators and barriers to embedding change), it was developed into a more holistic systems-based or whole-organisation approach, studied in the second phase of the evaluation.

Whilst face-to-face DVA training for frontline staff and their managers was the key delivery mechanism across both phases, WAFE described the updated version as a 360-degree intervention, combining policy and practice reviews with training and development to ensure that professionals and organisations created space for action for victims/survivors. Kelly (2003) describes how women's 'space for action' is restricted by DVA and failure of responses to it.

Training sessions aimed to increase DVA awareness and practitioner responsiveness using prevalence statistics, group activities, case studies, discussion, role-play, and video. This covered what language to use when speaking to victims/survivors, how to start conversations, and explore concerns. Training provided detailed explanations of DVA, emphasising: coercive control, victims'/survivors' space for action, strength-based ways of working, power within services and systems, trauma-informed approaches, building change through language, record-keeping and self-care. The updated intervention included focus groups with staff and survivors prior to delivery to understand their views of services and highlight good practice. Findings directed organisational DVA policy development (such as introducing protocols for staff experiencing DVA) and informed practitioner reflection days post-training.

Implementation varied between the three sites depending on the strength of local networks and whether the intervention was embedded within local commissioning arrangements. It relied on central WAFE delivery undertaken by regional co-ordinators and trainers in partnership with local DVA organisations. This approach capitalised on local connections whilst reducing the burden on local services. Implementation of the enhanced intervention was delayed by the need to allocate time to development and building local commitment to the intervention, resource issues and Covid-19 restrictions. These delays impacted the evaluation data captured in Phase 2.

## Evaluation Methods

Ethical approval was received from the University of Central Lancashire. Almost 40 training sessions took place across three geographical sites (2017-2020). To measure change in knowledge, confidence, and skills to intervene in DVA, questionnaires were administered prior to and immediately following training sessions (99 completed in phase 1; 305 in phase 2). Those completing questionnaires were invited to participate in telephone interviews to explore their perceptions of the intervention, whether and how it had been used in practice. Contact details were detached and stored separately to maintain anonymity of questionnaire data.

## Sample

Participants consisted of 404 practitioners drawn mainly from children and families' services, DWP and housing (Table 1). Fewer health practitioners participated in the intervention. Almost one quarter of participants did not disclose the sector in which they worked.

*Table 1 Participating service sectors by geographical site*

	<b>Geographical Sites</b>			<b>Total</b>
	<b>1</b>	<b>2</b>	<b>3</b>	
<b>Sector</b>	n (site %)			n (%)
<b>Children and families</b>	46 (45%)	50 (62%)	70 (32%)	166 (41%)
<b>Department of Work and Pensions</b>	-	-	93 (42%)	93 (23%)
<b>Housing</b>	24 (23%)	-	-	24 (6%)
<b>Health</b>	-	-	20 (9%)	20 (5%)
<b>Youth Offending</b>	-	1 (1%)	-	1 (-)
<b>Unknown*</b>	33 (32%)	30 (37%)	37 (17%)	100 (25%)
<b>Total</b>	<b>103</b>	<b>81</b>	<b>220</b>	<b>404</b>

\*Phase 1 participants did not detail their service sector

Most participants (n=344: 85%) described themselves as female with 14% (n=56) male. Over half (51%, n=204) had six or more years of experience in their current job/field of work. Seventy-one percent (n=288) had previously received DVA training; this was most common amongst housing practitioners (n=22: 92%) and those working with children and families (n=141: 86%), in contrast to only 55% (n=11) of participants working in health and 29% (n=27) in DWP services.

## Measurement

### Pre/Post-Training Questionnaires

The questionnaires were designed to a) establish the extent of DVA enquiry amongst practitioners prior to training, and b) measure the immediate impact of the training on knowledge, beliefs, confidence and capability to recognise and manage DVA. The questionnaire was updated for phase 2. SPSS12 was used to analyse survey data.

Practitioners were asked how often in the previous six months they had asked about DVA when seeing women with 'DVA indicators', using a 5-point Likert scale from '1. Never' to '5. Always'. Seven potential DVA indicators (substance misuse, financial difficulties, childcare issues, injuries, antisocial behaviour, mental health difficulties, physical health issues) were listed. Descriptive analysis was used to examine responses.

Impact was measured across three domains: knowledge, beliefs, confidence. First, practitioners were asked to 'indicate how much you feel you know about the following' series of statements (eight in phase 1; 11 in phase 2) using a five-point Likert scale ranging from 'very little' to 'A lot'. Second, beliefs about DVA were assessed via 'true', 'false' or 'don't know' responses to mythical and 'true' statements (Figure 2). Finally, confidence and capability to recognise and manage DVA cases, were measured by 17 statements with responses on a scale ranging from 'strongly disagree' to 'Strongly agree' (Figure 3). Changes were measured using a Wilcoxon Signed-Ranks test which compares two sets of scores from the same participants.

### Interviews

Interviews were completed with 31 frontline practitioners, volunteers and service managers 3-6 months post-training (12 in phase 1; 19 in phase 2). Participants included: antisocial behaviour and nuisance case officers, housing caseworkers, neighbourhood officers, outreach workers, family support co-ordinators, family mentors, and early help practitioners. Researchers observed three training sessions (one in phase 1; two in phase 2) to assist understanding and contextualise data. Ten trainers and WAFE co-ordinators and three WAFE senior managers were also interviewed, generating 44 interviews which were recorded, transcribed, and entered into NVivo12. Thematic analysis (Braun and Clarke, 2006) was undertaken throughout data collection by comparing across participants and phases.

## Findings

### DVA enquiry prior to intervention

Participants were asked how often in the previous six months they had asked about the possibility of DVA and sexual violence and abuse (SVA) when encountering the listed abuse indicators. The 381 responses indicated that this had not been common practice. Only 40% (n=154) stated they had 'always' or 'nearly always' asked about DVA/SVA in that period. In phase 2 where job roles were captured, health practitioners (40%, n=8) and those working in the children and families sector (37%, n=62) were most likely to have asked women about DVA/SVA, this compared to 29% (n=7) of those working in housing and 28% (n=25) of DWP participants.

A higher proportion (67%, n=106) of those who stated they had 'always' or 'nearly always' asked about DVA/SVA in the previous six months, had identified new cases compared to those who had 'sometimes' (45%, n=44) or 'never asked' (16%, n=22). On identification, the most common responses were to provide information (78%; n=136), offer validating statements (70%; n=122) and ask the victim/survivor what was most important to them (69%; n=120).

Training observation found that participant knowledge was variable at the outset. Some participants might have benefitted from DVA awareness training prior to the intervention, particularly those with limited training, knowledge, or experience of working with DVA.

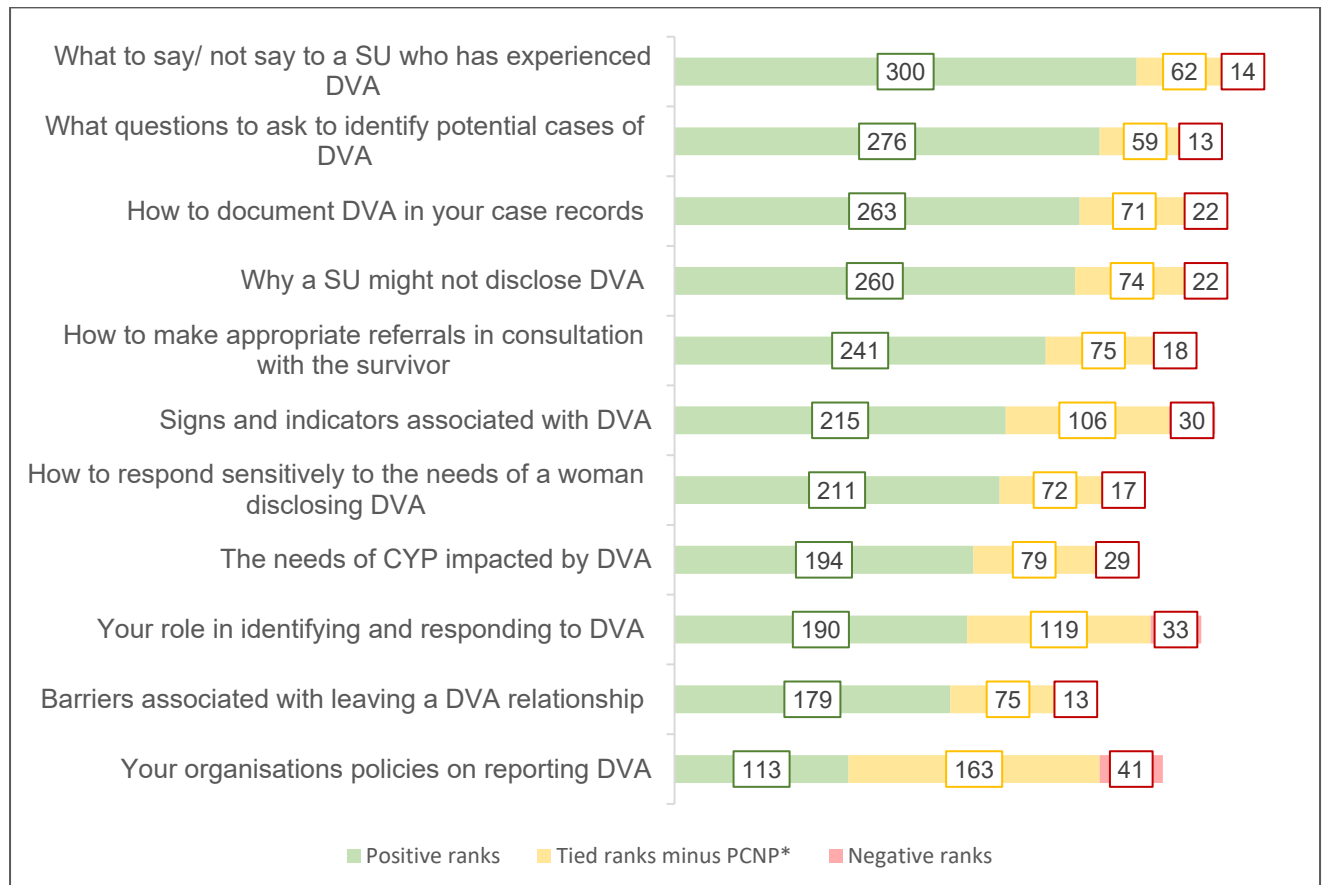
### Immediate impact of the intervention

Practitioners valued the opportunity to develop their knowledge, skills, and confidence to respond to DVA, associating this with improved practice. Where participants reported little new knowledge, they reflected that the training was important for reinforcing key messages and maintaining motivation. Overall, the impact of the intervention was reported as increasing understanding the dynamics of DVA: *'...everybody knows a little bit about domestic violence...but I certainly didn't understand the levels of violence and control...it opened my eyes.'* (Participant 24, Children & Families, Phase 2)

## DVA Knowledge

Post-training, increased DVA knowledge (positive ranks > negative ranks) was statistically significant for each of the eleven statements, ( $p < .001$ ) (Figure 1)

Figure 1. Pre/post-training changes in knowledge



\*CNPR=Positive Change Not Possible for this statement, participants indicated pre-training that they knew 'a lot'.

Pre-training, approximately one third of practitioners indicated knowledge gaps in key areas: 38% (n=153) indicated they knew little/very little about how to document DVA in case records; whilst 35% (n=141) knew little/very little about what to say/not to say to service users who have experienced DVA. Similarly, 31% (n=127) knew little/very little about how to make appropriate referrals in consultation with the survivor, and 31% (n=124) knew little/very little about what questions to ask to identify potential DVA. Consistently, a higher proportion (55%-69%) of the 93 participants working in DWP indicated they knew little/very little in these four areas compared to those working within other sectors.

The largest change was increased knowledge in what to say to service users who have experienced DVA, ( $z = -14.89$ ,  $p < .001$ ), and what questions to ask to identify DVA ( $z = -14.18$ ,  $p < .001$ ). Post-

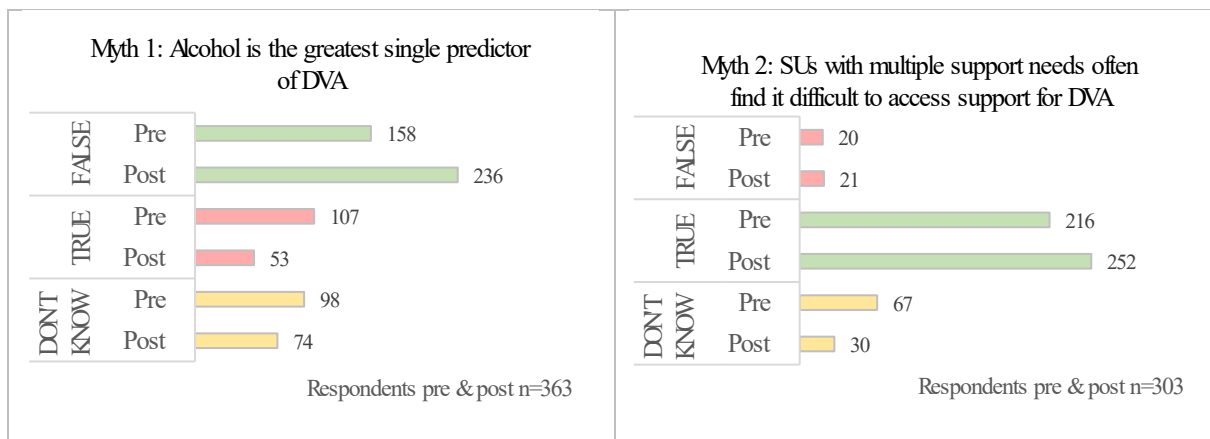
training 82% of participants (n=330) indicated that they knew quite a bit/a lot about what to say to service users; knowing little/very little had reduced from 35% (n=142) to just 3% (n=11). Similarly, 73% (n=295) felt post-training that they knew quite a bit/a lot about what to ask to identify DVA and knowing little/very little had reduced from 31% (n=124) to 3% (n=13).

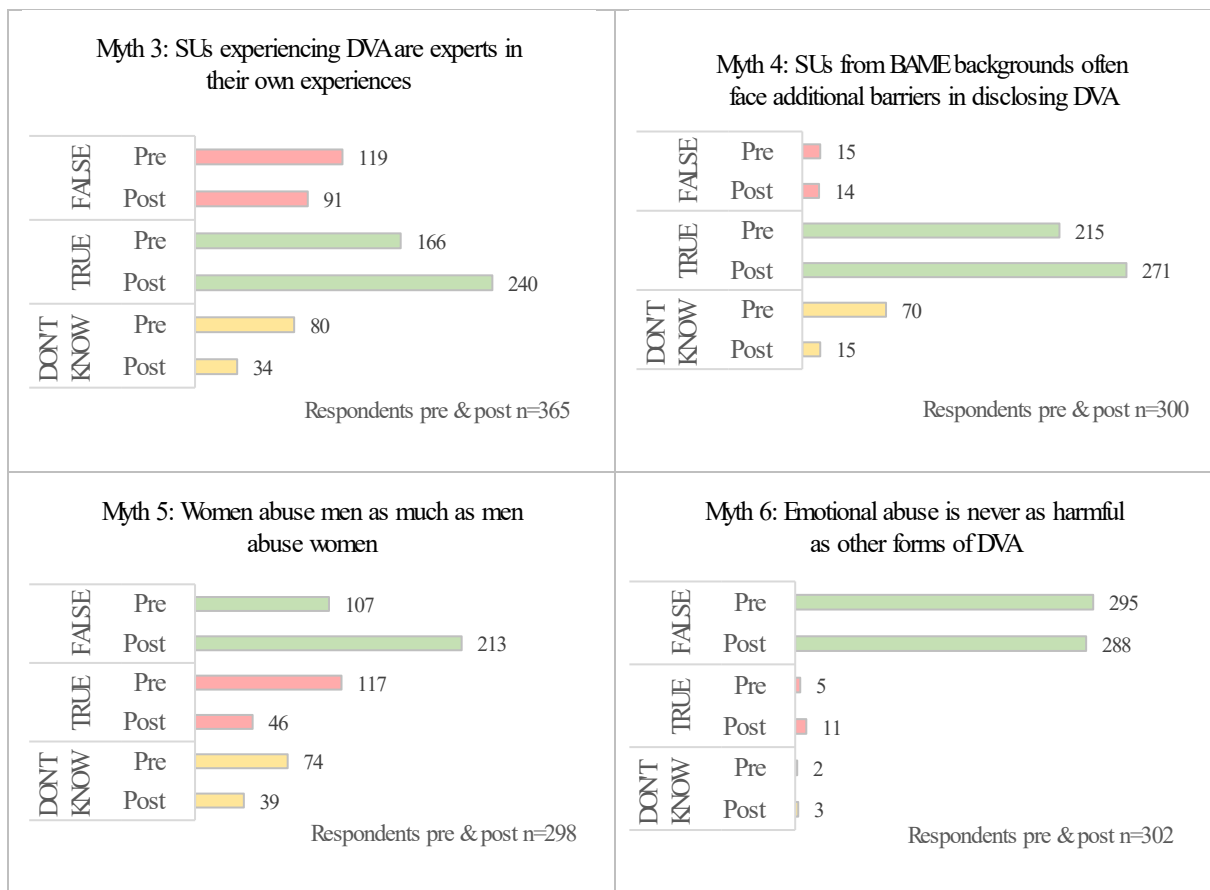
DVA knowledge improved post-training, regardless of professional sector. The highest proportion of positive ranks was found in the employment and health sectors. Trusted Professional also strengthened knowledge of local DVA resources. Pre-training, only 31% of practitioners (n=126) indicated adequate knowledge of resources in their community, increasing to 56% (n=227) post-training.

### Beliefs about DVA

Most practitioners showed positive changes immediately post-training. Change was considerable in some areas. For example, 106 participants who believed women abuse men as much as men abuse women (or did not know) pre-training indicated this was a false statement post-training (myth 5). This change was significant ( $z = -9.53, p < .001$ ). Post-training, fewer participants believed that alcohol was the greatest predictor of DVA (myth 1) ( $z = -7.63, p < .001$ ). The increase in participants believing service users were experts in their own experiences (myth 3) demonstrated a significant change post-training ( $z = -5.99, p < .001$ ) as did agreement that those from Black and Minoritised Ethnic (BAME) backgrounds often faced additional barriers to disclosure (myth 4) ( $z = -5.10, p < .001$ ). More participants agreed with the statement that service users with multiple support needs often found it difficult to access support for DVA (statement 2;  $z = -2.91, p < .01$ ).

Figure 2. Changes in beliefs about DVA





In all but one case (myth 6), there was positive change in beliefs post-training. This exception is likely because knowledge was high, or beliefs were already positive before training.

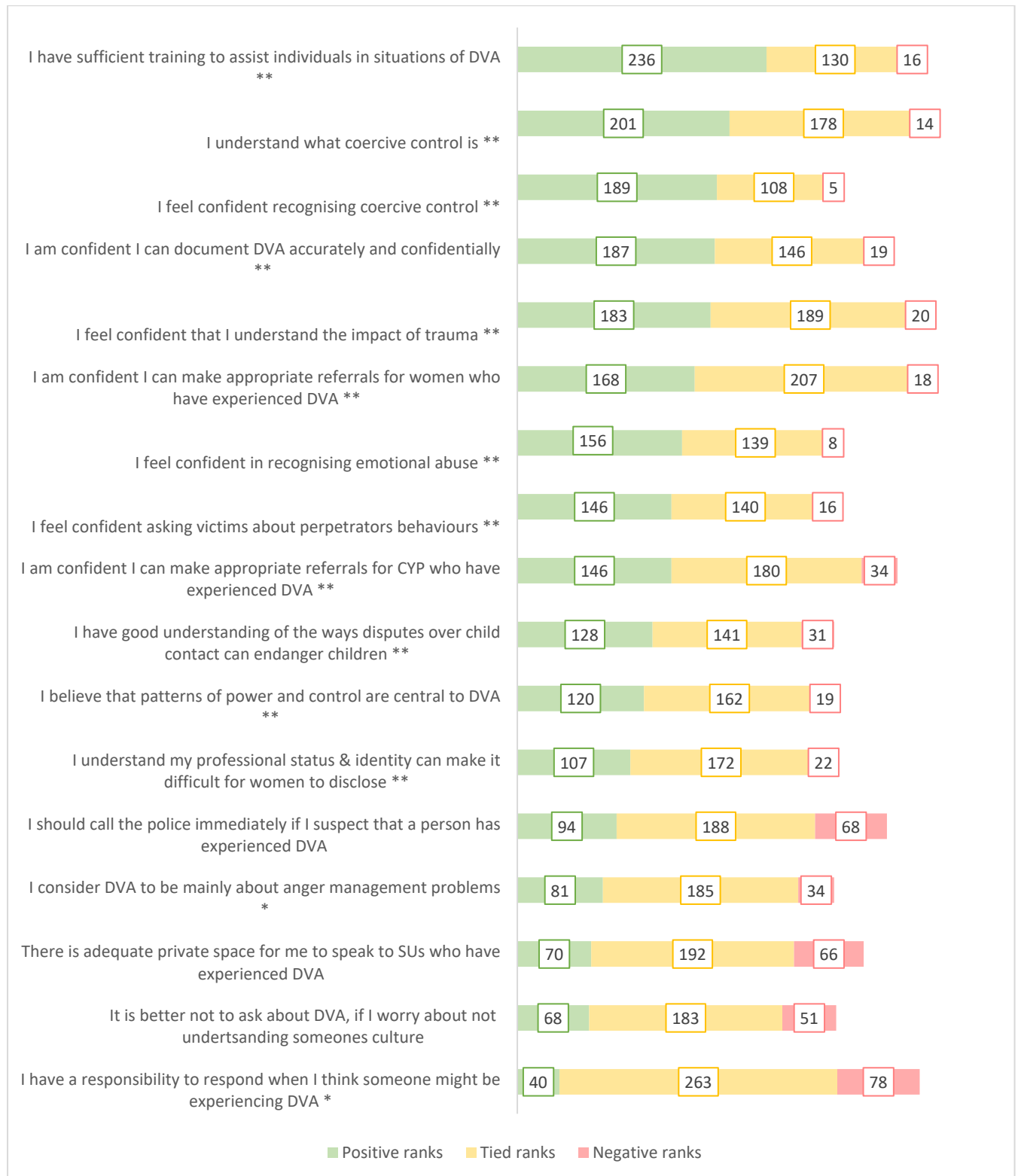
### Confidence and capability

Findings revealed an immediate positive impact on practitioners' confidence and capability to recognise the signs of DVA, knowing what to say to women experiencing it, and managing DVA cases. Increased awareness of how to document DVA and how to make appropriate referrals were strengthened post-training across all professional groups.

There was a significant relationship between DVA training and increased confidence and capability across all statements ( $z = -.15.25, p < .001$ ). Proportionally, the largest increase in confidence post-training was in capability to recognise coercive control ( $z = -7.51, p < .001$ ), and ability to assist individuals in situations of DVA ( $z = -13.02, p < .001$ ). Post-training, 92% ( $n=278$ ) of responding participants agreed/strongly agreed with the statement 'I feel confident recognising coercive control' (compared to 47% pre-training,  $n=142$ ). This shift is reflected in significant positive changes in recognising emotional abuse, understanding what coercive control entails, and belief that

patterns of power and control are central to DVA ( $p < .001$ ). These findings suggest an increased understanding of and therefore capability to identify individuals experiencing coercive control.

Figure 3. Pre/post-training changes in confidence and capability



Positive ranks signify increased confidence and capability from T1 (pre-training) and T2 (post-training). Tied ranks signify no change between T1 and T2. Negative ranks signify a decrease in confidence and capability from T1 and T2. Asterisks indicate difference between positive and negative ranks is statistically significant at the value of \* $p < .05$ , \*\*  $p < .01$ ; none signifies no difference.

Improvements were confirmed in service manager interviews, as well as frontline workers' ability to identify strategies to engage individuals about their DVA experiences. Training provided examples of how and which questions to ask, improving confidence to start those conversations which practitioners had found difficult previously: *'...the thing that I walked away with more than anything else, was to be professionally curious, to be unafraid to ask questions'* (Participant 15, Children & Families, Phase 2). Across the interviews, practitioners confirmed increased confidence to think differently and ask questions intended to facilitate disclosure. *'It's definitely gave me more confidence to actually speak to the people that I believe may be suffering...'* (Participant 2, Housing, Phase 1). One of the trainers delivering the intervention reflected: *'It takes away the fear element of opening a can of worms...and not being frightened to ask about it, which is really good'*. (WAFE Trainer 2).

## Longer-term impact

Practitioner interviews undertaken 3-6 months post-training provided understanding of the extent to which learning was retained and used in practice. They indicated that the intervention assisted with: introducing the subject of DVA, asking questions, challenging unacceptable situations and responding in a survivor-led manner. They reported increased intent to ask relevant, probing questions:

*when people have attended...I asked questions at that point that I wouldn't have asked before, just to make sure people were safe and things were OK.* (Participant 11, DWP, Phase 2)

Interviewees shared examples of increased confidence in responding to and prioritising DVA disclosure and taking a survivor-focused approach:

*...it just built that confidence, in that...once the woman's said something, that they know how to handle that situation. So, they know that actually...they're going to need a longer time.* (Participant 22, DWP, Phase 2)

This shift might require practitioners who usually anticipate dealing with service users in a one-off or time-limited appointment to adjust their pattern of work. Often, practitioners described a 'survivor-led approach' as enabling and supporting victim/survivors' own choices and actions:

*...after the training, we understood that...we're not to try and fix it, that we're not to make suggestions of what the person should do...let them know that you are available to help or you do know places where they can get help, when they are ready... (Participant 22, DWP, Phase 2)*

*The person who is being affected, should have the most say. It has to suit them; you can't impose solutions on people. (Participant 24, Children & Families, Phase 2)*

However, for some practitioners, the Covid-19 pandemic restricted opportunities to put their learning into practice.

Participants highlighted the importance of providing tangible examples to embed learning. Suggestions from practitioners for more tools and resources in phase 1 were remedied in phase 2:

*Lots of tools...we went through lots of activities that workers could use with women...supervising the team I've got some new suggestions, new strategies that I can use with the staff... (Participant 31, Children & Families, Phase 2)*

Participants would have liked more information about other forms of abuse including DVA in same-sex relationships, male victims/survivors, older victims/survivors, so-called 'honour-based violence', child to parent violence, work with perpetrators, and the impact on children.

Practitioners reported a need for refresher training to embed learning in policy and practice, especially where there was a significant timelapse between receipt of training and practice opportunities. Continued training was identified as important for practitioners to remain updated about local service provision and developing confidence. It was also associated with opportunities for ongoing support and guidance from specialist DVA organisations.

## An organisational approach

Phase 2 interviewees in all sites reported increased confidence in respect of supporting DVA victims/survivors where policies and practices meant practitioners were not working unsupported.

Support took different forms including the availability of an identified person *'that you can go to, to ask questions'* (Participant 11, DWP, Phase 2), to *'double check that I was doing things correctly'* and look over new paperwork (Participant 24, Children & Families, Phase 2), and *'to unburden, unload...have that conversation...to allay your own doubts and fears and worries'* (Participant 25, Housing, Phase 2). Interprofessional support was important for feeling confident in DVA work. For example, the availability of a DVA specialist such as an IDVA which, together with the confidence derived from the training, meant staff could *'have some of those [DVA] conversations themselves. Whereas, in the past, they might have just onward referred.'* (Participant 31, Children & Families, Phase 2).

Whilst the number of Phase 2 interviews was limited (n=19), evidence suggests that the whole organisational approach was important in ensuring that learning was retained and informed practice. This should be fully tested by further research.

## Mechanisms of change

Identifying the appropriate language to use when speaking to victims/survivors was reported by managers and frontline practitioners as helpful in facilitating the process of building trust with victims/survivors and opening dialogue:

*...one of the key learning points was...the use of our language when we're dealing with survivors...how we use our language, how we work with survivors to...support them to feel safe and build up that relationship of trust.* (Participant 30, Children & Families, Phase 2)

Authenticity could be enhanced when training materials were delivered by those with relevant experience and where it was *'obvious that they were passionate about what they were delivering'* (Participant 16, Children & Families, Phase 2). Trainers recognised the value of situating content within the experiences of both those delivering and the audience:

*...people that are delivering it are allowed to make small changes...put themselves into it...hopefully, you adapt them slightly, to the people in the room.* (WAFE Trainer 2)

Understanding and valuing different professional roles was considered central to influencing post-training practice. One Practitioner remarked that it was *'really great...that the facilitators and trainers'...used the information from the people with lots of experience, to...help feed the session.'* (Participant 11, Housing, Phase 1). This highlights the value of trainers understanding professional

practices, attitudes and values that determine practitioners' approach to their work, described as 'institutional empathy' (Turner et al., 2017).

For some organisations, the policy element of Trusted Professional was not implemented due to the ways in which organisational policies were agreed or developed - in partnership with other local organisations or through Government guidelines and legal responsibilities. A needs-led and trauma-informed approach to working with DVA was widely supported by participants. However, it was acknowledged that conflict could occur in organisations working with children and families that prioritise safeguarding children and adopt a risk-led model of intervention. While practitioners working with children and families appreciated the importance of a needs-led approach, they raised concerns about how this could be achieved alongside ensuring children's safety. Victims'/survivors' fear of children being removed was identified as a barrier to DVA disclosure and accessing services:

*...social workers do have a stigma attached to them...they're scared...of social workers and scared to be honest with them and...really access that support* (Participant 30, Children & Families, Phase 2)

WAFE co-ordinators and trainers identified the potential for tension suggesting that additional training material addressing children might be appropriate.

Nevertheless, participants working with children and families indicated attitudinal shifts towards a strength-based approach emphasising victim/survivor empowerment. Effective communication skills and information were highlighted as important in responding to this barrier:

*'it's not automatically a safeguarding...some people feel, oh I'm going to lose my kids...it's not until they realise that that's not going to happen, there's support there to help keep the family unit together.'* (Participant 29, Children & Families, Phase 2)

However, in some sites the decision was taken not to extend Trusted Professional to CSC as the gap in perceptions of DVA risk was considered too great:

*'we deliberately didn't target the police or children's social care. We just thought...they are almost too entrenched and their outcomes are quite different to ours.'* (WAFE Manager 1)

Other sectors, such as health, proved difficult to engage within the time available.

## Discussion

Trusted Professional had a positive short-term impact on knowledge, attitudes, confidence and capability to recognise, respond and manage DVA cases, and on beliefs about DVA immediately post-training. Interviews with practitioners who received the intervention provided evidence of embedded learning.

A range of learning strategies has been found to contribute to effectiveness in DVA training programmes (Turner et al., 2017). Trusted Professional included experiential and practical examples and discussion on what language to use and how to respond appropriately to DVA. Future research could measure changes in knowledge and practice more systematically over a longer period.

One-off training sessions are insufficient to support culture and service system change (Mildon, Dickinson, and Shlonsky, 2014). Effective interventions require regular 'booster' sessions post-training which promote consultation and collaboration with local DVA organisations (Turner et al., 2017). Trusted Professional developed into a holistic systems-based intervention intended to provide opportunities for frontline practitioners to reflect on their practice. Organisational support aimed to improve consistency and provide practitioners with a named DVA specialist, so increasing confidence in work with DVA cases. Learning can also be sustained and enhanced by refresher training.

Trusted Professional drew on the expertise of trainers and co-ordinators from the specialist DVA sector, so ensuring that training content was perceived as authentic and rooted in experience. The use of local DVA services to co-deliver the intervention meant that local knowledge and networks maximised implementation opportunities and created valuable links for future work. However, recruiting targeted organisations was challenging and few health practitioners participated in the intervention. The future sustainability of Trusted Professional is uncertain as it moves from a free intervention to one where participating organisations are expected to meet the costs of the intervention alongside freeing up staff time.

Post-training interviews illustrated how training translated into practice, particularly where it was supported by organisational cultures conducive to the intervention's philosophy. More challenges were encountered where organisations conceptualised risk differently to the intervention's survivor-led approach. Competing organisational and professional priorities within the context of multi-agency work could also be problematic (see Hester, 2011; Liang et al., 2013). There were tensions inherent within service provision, particularly for practitioners who were primarily child focused (e.g.

children and families services) compared to those who might be more adult-focused (e.g. employment services), indicating a need for an interagency response to embed collaborative or co-ordinated change. The intervention needs to develop strategies to adapt or challenge organisational priorities and working practices which may be antithetical to survivor-led and strengths-based approaches. This could be facilitated by moving beyond single agency training and establishing ongoing availability or co-location of DVA expertise within public services (Blacklock and Phillips, 2015).

The US Greenbook initiative (Banks et al., 2008) demonstrated the value of integrating training programmes within a multi-agency response and highlighted the importance of co-ordinating system change in child welfare agencies with other collaborative activities between public services and DVA specialist organisations. However, delivery of an integrated DVA policy and practice response is not without its challenges: in information sharing, communication and, as noted in this study, differing perceptions of and responses to risk (Peckover and Golding, 2017; Turner et al., 2017). These different approaches can be reinforced by in-house training (Bacchus et al., 2010; Feder et al., 2011), creating challenges for integrated approaches (O'Carroll et al. 2016).

## Study Limitations

We were unable to investigate whether promising effects of the intervention were sustained longer-term. Further data about the implementation and impact of the whole organisational approach would be beneficial. It would be particularly useful to investigate practitioner responses to specific needs, including those from marginalised communities (i.e. BAME, disabled, and older victims/survivors). Not addressing the experiences of victims/survivors using services is a further limitation.

There were difficulties for quantitative analysis. In Phase 1 the questionnaire differed between sites and practitioner groups coupled with large amounts of missing data. These were partly remedied in Phase 2 with a single questionnaire administered across practitioner groups.

## Implications for Research

Further evidence is required to assess the longer-term effectiveness of the Trusted Professional intervention. The current evidence is primarily focused on improvements in practitioners' knowledge

and attitudes. The benefits of system change and outcomes for victims/survivors could be measured in future evaluations. More widely, further research is required concerning other practitioner perspectives on responding to DVA and associated training.

## Conclusion

This study provided evidence of the short-term impact of a DVA training intervention developed and delivered by specialist DVA organisations for frontline practitioners in a range of services. It has highlighted the need for organisational change to support and sustain changes in practitioner knowledge, skills and confidence. It appeared effective with a wide range of organisations, particularly statutory sector organisations where DVA is regularly encountered. The training could be tailored to reflect different practitioner groups' knowledge and awareness of DVA.

This study indicates that many frontline practitioners need to be better equipped to recognise DVA and respond effectively. Finding ways to resolve tensions between risk-led models of intervention and strengths-based approaches remains an ongoing challenge to collaborative or co-ordinated change. Further research is required to fully assess the longer-term benefits of Trusted Professional. Sustainability of the intervention requires careful auditing to assess the viability of the whole-organisation model. However, the intervention's capacity to engage with and shape the practice of a range of frontline practitioners offers the prospect of a more sensitive and relevant response to DVA for many more victims/survivors.

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