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ORIGINAL ARTICLE

Implementing Innovative Approaches to Integrating Adult and Child Focused Services when Responding to Families Affected by Domestic Violence: A Case Study Design

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Abstract

Purpose Whole family approaches which integrate adult and child focused services are often required when responding to families affected by domestic abuse, however little is known about how to enact and embed these approaches. The purpose of this study is to undertake a multifaceted examination of the complex and inter-related factors that can impact the implementation of integrated approaches in three regions of England.

Methods We utilized a case study design, conducting n = 53 in-depth qualitative interviews with a varied sample of practitioners, managers and senior leaders in three local authority sites in England, which were implementing different innovative whole family approaches. We analyzed the data using the core constructs of Normalization Process Theory.

Results Across the three case study sites, addressing domestic abuse within families was of high strategic importance. Having a shared understanding of the practice approach, why they were working in this way, and how this differed from what came before it was important to enacting and embedding the approaches. Regular structured opportunities to come together in multi-agency networks of participation supported reciprocal learning and resulted in joint enterprise. The implementation of the innovative approach was further supported by practitioners from different services thinking together and acting together.

Conclusions A clear and shared understanding of the practice model, along with regular opportunities for multi-agency and multi-professional networks to 'think together' and 'act together' in meaningful ways is most likely to support the implementation, integration and embedding of the innovative approach.

Keywords Domestic abuse · Multi-agency · Integration · Normalization Process Theory

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Introduction

Multi-agency working has been at the core of UK policy for safeguarding children and addressing domestic abuse for the past two decades (HM Government, 2003, 2023). This involves professionals from a range of agencies in contact with affected families collaborating together with the shared aim of improving outcomes. In addition to the significant harms to the adult victim/survivor of domestic abuse (World Health Organisation, 2013), there is well-established evidence documenting harms to the wider family including children. Current evidence shows that the risk to children starts from conception with pre-natal exposure to domestic abuse increasing the risk of miscarriage (Huth-Bocks et al., 2002), stillbirth and neonatal death (Anderson et al., 2002). Risks continue to be present post-birth and statistics show that child victims experience high levels of mental health problems in adulthood (Noble Carr et al., 2020; Oram et al., 2022) and are more likely to be victim to, or perpetrate, domestic abuse as an adult (Doroudchi et al., 2023). Additionally, recent figures show that in around a third of all cases of domestic abuse, there was at least one child under the age of 16 years living in the household (Office for National Statistics, Office for National Statistics, (Department for Education, 2023). Of the 403,090 'child in need' assessments completed in the England during the year ending March 2023, 51% identified domestic abuse as a risk factor (Department for Education, 2023).

When domestic abuse occurs within the context of parenting, a response from both adult and child focused health and care services is required (Barrett et al., 2024), resulting in whole family approaches being endorsed by a recent major independent review of UK child protection (MacAlister, 2022). Whole family approaches require multi-agency working between statutory, community and voluntary sector organizations (UK Government, 2023). A range of whole family models based upon multi-agency working have been introduced (Safe & Together Institute, 2023; Stanley & Humphreys, 2017), which seek to recognize the distinct and interrelated needs of adult and child victims/survivors and perpetrators of abuse (Stewart & Arnull, 2023). Collaborative, multi-agency models have been recommended to support an increased understanding, awareness and knowledge of domestic abuse (Department for Education, 2022). Previous evaluations of initiatives to improve integration between child and adult services working with families affected by domestic abuse have highlighted the potential of these approaches to improve joint working and practitioner skill development (Stanley & Humphreys, 2017). However an extensive literature identifies that many challenges of multi-agency working exist (Peckover & Golding, 2015). This is particularly attributed to practitioners, managers and senior leaders within and across the multi-agency context often operating within distinct organizational cultures with diverse interests, political agendas and practices (Hester, 2011; Torfing, 2019). When seeking to integrate child and adult focused services responding to the needs of families affected by domestic abuse, there is a need to recognize these institutional differences (Banks et al., 2008). System-level change, brought about by committed leaders with a focus upon effective coordination of collaboration activities between child and adult focused services has also been found to be important to successful integration (Banks et al., 2008; Turner et al., 2017).

Whole family approaches often require innovation to achieve the necessary changes across the system of organizations responding to families affected by domestic abuse. When attempting to introduce innovative approaches, it becomes important to contextualize the 'innovation journey' or process that has taken place to embed new structures and practices and recognize the important mechanisms that support an innovation to diffuse in order to improve organizational performance (De Vries et al., 2016; Van de Ven et al., 2008). Multi-level change within and across organizations is likely to be required to embedded new approaches (Currie & Spyridonidis, 2019; Dougherty & Dunne, 2011). Despite the importance of the innovation journey, and the complexity of this within the context of whole family domestic abuse support, there is a paucity of research examining how new approaches are implemented and become normalized. This study examines how whole family approaches to responding to domestic abuse are enacted and identifies key factors influencing implementation.

Methods

This study utilized a case study design to allow the multifaceted examination of the complex and inter-related factors that can impact the implementation of innovative approaches to integrating adult and child focused services, when responding to families affected by domestic abuse. We identified a sample of six potential case study sites across England that were currently implementing an innovative approach by contacting domestic abuse leads within local authorities in England and undertaking web-based searches. Five of these case study sites were at a local authority level (geographical areas within England, holding local government responsibilities) and the remaining case study was a single service. Within our study, we broadly characterized innovation as the transformation of services or systems beyond what would be considered routine care (Hartley, 2013). Unlike service improvement which would generally be incremental, we define innovation as a dynamic process, which constitutes discontinuous change

Table 1 Characteristics of case study sites and interviewees (n = 53)

Case study site	Characteristics	Data collection	
		Service role	
1	Locally developed system-wide model; focused upon early intervention; low to moderate risk cases; weekly multi-agency meeting to discuss families & cascade information; domestic violence responder role within all agencies; specialist domestic violence practitioners; shared website	Children' social care[S] (n = 7), specialist domestic abuse[VCSE] (n = 7); Adult's social care[S] (n = 2); Early help/family support[VCSE&S] (n = 3); Housing[S] (n = 2); Probation[S] (n = 1)	Senior leader (n = 4); manager (n = 5), front-line practitioner (n = 13) **Total interviews n = 22**
2	Adopted the Family Safeguarding Centre's model– a strengths-based, whole family approach to child safeguarding. It brings together all professionals working with a family into in multi-disciplinary team with the goal of keeping more children safely at home with their families. The case study trained in essential approach and delivered model with high fidelity; integrated adult specialist workers (domestic violence, substance use and mental health) within children's social care (Child in Need teams); joint clinical supervision; joint workbook to support information sharing	Children's social care[S] (n = 5); specialist domestic abuse[VCSE] (n = 4); Mental health[S] (n = 2); Probation[S] (n = 1)	Senior leader (n = 3); service/ operational manager (n = 3); front-line practitioner (n = 6) **Total interviews n = 12**
3	Commissioned Safe and Together Institute to conduct assessment of current provision. The Safe and Together model is a suite of tools and interventions to help child welfare professionals and other systems become domestic violence-informed. It aims to keep children safe and together with the non-offending parent. The case study adapted system-wide model informed by assessment; specialist domestic violence provide case consultation to non-specialist workers and to deliver brief intervention delivered to perpetrators; domestic violence champion roles in range of services	Children's social care[S] (n = 8); Early Help/family support[VCSE&S] (n = 3); specialist domestic abuse[VCSE] (n = 6); Housing[S] (n = 1); Workforce Development[S] (n-1)	Senior leader (n = 2), service/ operational manager (n = 5); front-line practitioner (n = 12) **Total interviews n = 19**

S = statutory organisation; *VSCE* = voluntary and community sector organisation

(Brown, 2010). We met with senior leaders within each of the six potential case study sites and gathered information to determine the character of the innovation. We then presented an outline of each case study to two advisory groups (n = 6 practitioners; n = 3 people with lived experience) for discussion and selection. The advisory groups were asked to rank the case study sites between 1–6 (where 1 was the highest ranking), guided by the aim of the study and research questions. Total scores were calculated, with the lowest overall score indicating highest priority. The three innovative approaches that received the highest ranking were selected as case study sites for this project. Broad agreement was reached across the practitioner and lived experience groups. Discussions within the advisory groups highlighted that group members selected sites which they perceived to offer a high likelihood of benefiting families, and which had a broad population reach and varied approach from other highly ranked case studies.

The three selected case studies were LA wide innovations, which included integration of a range of LA, health and voluntary and community sector services and organizations. The characteristics of each of the three selected innovations are outlined below in Table 1.

Participant Recruitment

We recontacted the strategic leads across the three selected sites (n = 8) to discuss the study in detail and re-affirm interest in their site participating in the study. All strategic leads agreed site participation and provided individual consent to participate in an interview. Additionally, the strategic leads in each of the sites provided us with a list of professionals involved in the local innovative approach. Researchers contacted potential interviewees by email to introduce the study, invited them to participate and provided information sheets and consent forms. Potential interviewees were free to refuse to participate in interviews in accordance with our ethical procedures. A proportion of potential participants did not respond or refused participation. When this occurred, strategic leads were asked to provide further potential participants, however, information about who did/did not participate in the interviews was not shared. Interviews took place between April and August 2023 using video conferencing software, and on average lasted 55 min. Participants were asked to discuss the innovative practice approach within their area, their role within the implementation process and related experiences. Interviews were audio recorded, anonymized, and transcribed verbatim by a professional transcription service. Anonymised transcript data was stored in password protected folders on the university's back up system. The study was approved by the Faculty of Medical Sciences Research Ethics Committee, part of Newcastle University's Research Ethics Committee (Ref 2268/17833/2021).

Data Analysis

Our approach to data analysis was twofold: first, we analyzed data thematically (Braun & Clarke, 2022) to examine how the innovative approaches were implemented in each study sites; second, we analyzed data theoretically using the updated Normalization Process Theory (NPT) framework (May et al., 2022). NPT provides a set of conceptual tools that support understanding of the type of work that gets done to affect change; how the work is done and to what effect. The framework originally consisted of four constructs: (i) coherence: the sensemaking work people do, individually and collectively, when faced with operationalizing the new practices, (ii) cognitive participation: the relational work people do to build and sustain a community of practice around the innovative intervention (iii) collective action: the operational work people do to enact the new practices, and (iv) reflexive monitoring: the appraisal work people do to understand the ways the new practices affect them and others (May et al., 2009). This framework has now been updated to include domains relating to context and outcomes. Within the framework, contexts are events in systems unfolding over time within and between settings in which implementation work is done. Outcomes are the effects of implementation work in context, which make visible how practice has changed as implementation processes proceed. The team met to discuss, review and refine the coded data. Similarities and differences between sites were examined to support the overall analysis. This process involved several rounds of coding with data management processes supported by NVivo 12 (QSR International, 2018). Findings from across the three sites are presented below, organized by the core NPT constructs: context, coherence, cognitive participation, collective action, reflexive monitoring and outcome and further organized by thematic data.

Findings

Participant Characteristics

The study participants were employed within child focused (n=27) and adult focused (n=26) services, and held senior leader (n=9), managerial (n=13) and practitioner (n=31) roles. Participants were employed in a range of organizations from health (n=3), social care/local government (n=27), housing (n=3), probation (n=3) and community and voluntary organizations (n-17). Further details of participants per site are provided in Table 1.

Context

Across the three case study sites there was recognition of the prevalence of domestic abuse and its strategic importance. In addition to the volume of cases, participants highlighted that cases were often considered to be complex and challenging for practitioners to manage. This resulted in high levels of burden and stress within the workforce and services being overwhelmed by demand. In particular, the high proportion of child in need assessments that identified domestic abuse as a risk factor was a strategic driver for change, alongside a recognition that domestic abuse could not be responded to effectively unless services worked together.

> Police can't arrest their way out of things, probation can't keep people in prison, housing, it's got to be a whole-sector approach. Every sector has their own processes and governance and thresholds, but when we come together, actually we can do great things (Strategic Manager, Domestic Abuse, case study 1).

> Domestic abuse can be so complex and nuanced that actually social workers are trained in social problems, but they've got to know so much about so many other things; neglect, mental health, you name it, they've got to know about it. So, it was about trying to support the frontline practitioners in understanding and responding to domestic abuse effectively and safely (Strategic lead, domestic abuse, case study 3).

The strategic responsibility for responding to domestic abuse was held within children's services in all sites. This deliberate positioning was reported to be helpful in aligning priorities. Whilst all the case study sites sought to achieve a multi-agency response, there was variation in how the sites formulated and planned the interventions and their component parts. Both case study 2 and 3 chose to implement an established, evidence-based whole family model for safeguarding children in families affected by domestic abuse. Case study 2 made a formal application to the Centre for Family Safeguarding Practice to become an adopter of the model (The Centre for Family Safeguarding Practice, 2023). They sought to implement the model with a high degree of fidelity, which is a requirement of the adoption. Whilst case study 3 sought advice from the Safe and Together Institute for adopting the model and adapting their approach (Safe & Together Institute, 2023). Within case study 3, this resulted in a hybrid approach informed by the Safe and Together model and blended with other, locally developed practice models. Case study 1 however took a broader system-wide approach, which was focused upon achieving a cultural shift

across the workforce, whereby domestic abuse was positioned as 'everyone's business'.

Coherence

The extent to which people individually and collectively understood the innovation they were involved in and how it was operationalized varied across the case studies. This was influenced by both the presence of a clear and consistent practice model and the activities undertaken within the case study site to build coherence across the individual, organizational and strategic levels.

A Clear Practice Model

Within case study 2, a high level of coherence to the innovative approach was evident. Participants had formed a shared understanding of the approach, which was aided by explicit principles underpinning the practice approach and theory of change detailing how the approach may 'work'. Within this case study site, there was a substantial focus upon distinguishing the innovation from previous practice approaches. New multi-disciplinary teams were formed, participants had undergone substantial training and new systems had been introduced. Participants were able to clearly describe what they were doing, why they were working in this way, and how this differed from what came before. Partners within the case study were all trained in the core practice approach of the model, and each partner also underwent specific training and supervision relevant to their role within the model. This resulted in a strong sense of the model wherein partners collectively agreed the purpose of the approach taken and clearly understood their individual role within it.

> "But what the family safeguarding model does, it isn't just bringing those people together to inform the plan. It's identifying individual responsibilities and agencies' responsibilities within that plan (service manager, children's social care, case study 2).

The coherence within the innovative approach was less evident within case study 3. This case study had also opted to implement an approach informed by an established practice model, which was intended to be adapted to the local context. However, there appeared to be limited activities focused upon understanding and planning how this local adaption would be accomplished, or how it built on what was already present. In the absence of this sense-making, the innovative approach blurred and became somewhat diluted by competing priorities and approaches. The frontline practitioners were typically able to describe the multi-disciplinary approach, and usually demonstrated a level of understanding about their involvement in some components of the model but lacked understanding of the 'whole'.

> I mean we're about to refresh [name of model 1] again so… You're constantly learning about areas of emerging practice or you haven't quite got the wording right and people aren't quite doing the right thing (strategic lead, children's social care, case study 3).

Case study 1 chose not to adopt an established practice model but sought to work closely with an inclusive range of partners to negotiate a locally developed system-wide approach. There was extensive consultation, engagement and training of frontline staff in all services which provided an opportunity for building a shared understanding and appreciation of the approach to be formed. Central to the coherence building activity within this approach was the alignment of priorities across the partnership and the work that went into negotiating the place-based approach with all parts of the system. A range of components were agreed between partners, with each having an intended causal relationship to the aim of achieving shared responsibility throughout the system for domestic abuse. This consisted of regular multi-agency meetings for low and moderate risk cases, the establishment of a team of specialist domestic abuse practitioners who were employed by a voluntary and community sector organization. A training program to upskill non-specialists to become 'domestic abuse responders' was provided. Additionally, a shared website hosted by the council enabled different services to provide information about their service remit and the ways in which they could support families affected by domestic abuse. The process by which these components were agreed, and ways in which partners contributed to them, appeared to support a strong sense of coherence.

> You still have to bring them on board, you have to have those senior leaders really on the same page and being able to keep going with domestic abuse in the way that we want it to. And then bringing partners with us as well…all partners have got to have common aims, and it's really important for us to do that negotiation, do that influencing, do that really soft work with them, to get them to a point where, actually, we're all working together on those commonalities (strategic lead, domestic abuse, case study 1).

The Importance of Coherence at All Levels

Where coherence was most evident, there was commitment to the practice model at an individual, organizational and strategic level. In case study 2, the innovation was limited to

families where a child had been assessed as being a 'Child in Need' (described within the Family Safeguarding model as the 'middle services'). This approach enabled a strong partnership to be achieved at the onset between a discrete number of organizations who jointly applied to adopt the approach. These partners then underwent an intensive period of coherence building activity within the early implementation phase to support cultural change where it was perceived to be most likely to make a difference for families. By containing the reach of the innovation initially, partner organizations within site 2 were able to participate in an intense period of coherence building activities, with a plan to be extended to include early help and children in care at a later stage. As a result, each partner organization demonstrated that they had a clear sense of their role, what was expected of them, and the ways in which they would need to flex their practice to meet these expectations. As a result, all parties across all levels were able to commit to the model.

> I think everyone was open to it. I think the senior management bought into it. I think middle management and social workers all bought into it. I think that, like I say, the adult practitioners we got on board, and particularly the ones that I worked with, were absolutely on board with it (frontline practitioner, domestic abuse, case study 2).

Within both case study 1 and 3, an independent advisor was brought into the area to review the current domestic abuse provision. Within case study 1, it was identified that there was a need to intervene earlier with families experiencing low or moderate risk domestic abuse. Substantial effort was then made by the strategic leads to share the findings of the review with key partners and agree upon an appropriate, early response. Throughout the implementation process, these strategic leads championed the innovation to engage with strategic leaders alongside senior and middle managers within the range of health and social care services in the area. Innovators invested time, energy and other resource to forge partnerships and jointly agree how best to realize the strategic goals of the locally developed approach.

> I also do think what has made a particular difference is the buy-in of the very senior leadership across [area name], from the Chief Executive and the directors of services who recognize that that really is a problem, and that they have supported staff to make that a priority across all areas of work (strategic lead, children's social care, case study 1).

Within case study 3 there was an acknowledgement that, thus far, there was not a coherent strategic approach to responding to domestic abuse. This case study site had also brought in an independent review of their domestic abuse provision and made recommendations. However, there had been a lack of engagement with partners across the study site with regard to the development of the innovative approach. Additionally, though there had been some strategic discussions to inform the development of the forthcoming domestic abuse prevention strategy in the area, which was anticipated to be an important step in agreeing a joint approach Despite this, the extent to which this represented a truly collaborative approach was unclear.

> I guess what will be interesting in the next 12 months, with the city revising its strategy… Having a new strategy, I should say, because the strategy runs out this year. The degree to which we [council] are much more in that space as an influencer, and can bring, maybe, this learning, the Safe and Together model. That was really only the [name of council] that engaged with that (service manager, domestic abuse, case study 3).

Cognitive Participation

Across the case study sites similar activities and processes were introduced to support multi-disciplinary networks and practices to develop. These activities centered around opportunities to share knowledge and expertise within supportive environments, although the exact nature and form differed.

Thinking Together

Both case study 1 and 2 brought a range of professionals together within formal meetings and were successful in supporting multi-disciplinary discussion and generating a sense that 'we're all in this together'. Within case study 1 this consisted of a weekly multi-agency meeting with membership from a wide range of professionals working in the locality. The group largely had two functions; they provided advice to practitioners who applied to attend the meeting and discuss a case, and they received regular written and verbally presented information about topics and available services to ensure they had up-to-date relevant knowledge which they could cascade.

> I think that's one of the most successful things that have come out of [multi-agency meeting name] is because it is… it's not owned by- it's a collective and because we're coming at it from all different angles. We have all different roles and responsibilities. People have different information to share, and it's cascaded

> quite quickly (frontline practitioner, Early Help, case study 1).

Within case study 2, these multi-agency meetings initially centered around weekly group supervision meetings within the integrated team, wherein the children and adult focused practitioners would come together to discuss families and jointly agree how best to respond to the family's needs. This approach later developed to include external partners involved in the family's care. These group supervision meetings were found to facilitate more regular, focused and detailed conversations than what was generally available through existing Child in Need or Child Protection review meetings. Importantly, this approach was reported to enhance the legitimacy of the practice response, particularly when working with partners outside of the practice model.

> But I think it was also interesting to be able to have them [external partners] involved in the RAG rating [risk assessment] because we could get an email that they feel something is way higher risk than we might assess it as, or vice versa…We usually come to an agreement of what we feel the RAG rating is together, rather than it just being external professionals saying one thing, and us saying another (frontline practitioner, mental health, case study 2).

In case study 3, the 'thinking together' about domestic abuse did not occur specifically through multi-agency meetings. Instead, social workers supporting families affected by domestic abuse requested case consultation from specialist domestic abuse practitioners employed by a local community and voluntary sector organization, who would support risk assessment and provide advice and guidance on how best to respond to the needs of the family. These case consultations, which were requested on a case-by-case basis, enabled children's social care practitioners to access specialist advice and guidance and provide opportunities for knowledge development in line with the practice approach. Within this site, the ambition of the innovation had been to remove victim-blaming language and approaches from all services responsible for supporting families affected by domestic abuse. The training which had been introduced was voluntary and sought to raise awareness on a range of domestic abuse related topics. Unlike case study 2, training did not directly address the practice model. As such, much of the coherence building activity was led by the domestic abuse practitioner during these case consultation sessions.

> So in terms of victim blaming language… it's a very common sentence that we come across in reports… "She let him in", "She let him back in the house" and I'm like, "Oh my God. I hate that." That's a strong word, hate, but when I see that, it triggers it straightaway for me and I'm thinking, "Actually, does she?" This conversation was like, "Well, how do I reword it?" I was like, "It's not just rewording that little, tiny bit. You would have to reword the whole sentence, let's be honest, but just sort of highlighting that actually, putting that responsibility on the perpetrator, and actually he has been so intimidating that she's got no choice than to let him in (frontline practitioner, domestic abuse, case study 3).

Building Networks of Special Interest

The system-wide approach taken in both case study 1 and 3 benefitted from the introduction of a 'network of special interest'. Herein, non-specialist practitioners within a wide range of services underwent additional training to enhance their skills and knowledge, enabling them to take on additional responsibilities for domestic abuse. These 'domestic abuse responders' and 'domestic violence champions' (as they were known in their respective case studies) would come together as a network in regular meetings. As members of a community of practice, they saw value in the network and their related role. Network meetings were used to help members stay up-to-date with key topics, practice developments and legislation, which they could then take back to their organizations, with a view to influencing wider practice.

> We've got to keep getting that information out there and training people around responding to those needs. And picking up on those little things that you might notice and having those- because it can be difficult conversations but having them in a sensitive way. And that's why I think the domestic abuse responders and the networking meetings, you're creating this network of people that are able to feed that back into their environments as well so they're able to speak to their colleagues (frontline practitioner, Early Help, case study 1).

Collective Action

Acting Together: Integrating Child and Adult Focused Practitioners

All three case study sites reported that a combination of specialist domestic abuse (employed by community and voluntary sector organizations) and generalist roles (employed by statutory organizations) were required to enact the innovative approaches. However, the most

successful example of 'acting together' was evident within case study 2. Within this case study, co-located muti-agency and multi-professional teams consisting of social workers from children's social care working alongside adult practitioners specializing in domestic abuse, substance use, and mental health were operationalized. Whilst specialist domestic abuse practitioners conducted direct work with families, there were often occasions when the domestic abuse practitioner would provide support in the form of resources, advice and coaching to children's social workers to enable them to provide better care to a family, particularly in situations where the parents did not consent to working directly with the domestic abuse practitioner. The approach to collective action was thought to result in better care for families and helped trusting relationships to be built between practitioners. Both within the meeting and in-between, practitioners reported increased collegial conversation and working practices.

> We come out of that group supervision with a very effective support plan where every professional knows where we're now taking this, and how we're going to support the family, and what our goals for the next four weeks are going to be (frontline practitioner, domestic abuse, case study 2).

Whilst this specific model of routinely implemented collective action was unique to case study 2, specialist community and voluntary sector domestic abuse workers were an essential part of all case studies. Within case study 1 and 3 specialist domestic abuse practitioners worked within early help and children's social care teams. In contrast to case study 2 where all cases were considered the joint responsibility of the multi-agency team, children's and adult service practitioners in these sites would request a contribution from the specialist domestic abuse practitioners, when they considered this to be appropriate. Whilst positive examples of joint working were evident, the cooperative task-based approach utilized in case study 3 typically resulted in services remaining fragmented. At times, there was a lack of shared vision and approach to responding to the needs of the family.

> Now I think that risk assessment takes, at least, an hour. So, [specialist community and voluntary sector domestic abuse provider] do do it, if we request it. But sometimes, there's a bit of a delay, because there are only so many workers….. Sometimes I'm like, "I'll just go and do it myself," because it's quicker than having to wait for the worker (frontline practitioner, children's social care, case study 3).

Supporting Information Sharing

An important facilitator of collective action was the ease with which information was shared. Information sharing protocols were in place across all three case studies. Information was typically shared verbally in case consultations, multi-agency meetings or group supervisions. Additionally, within case study 2 there was a shared 'workbook' recording system which aimed to support practitioners to continually share information about a family case in a way that minimizes duplication of recording. Close working arrangements, achieved through co-location in case study 1 and 2 or through the domestic abuse responder/champions role, were considered important in supporting informal conversations about how best to support families.

> The conversations they [domestic abuse responders] are having, it's the other members of staff that can hear those conversations and pick up parts from them. That's why, like I was saying, we've got input from health, from police, probation, education, YOS [Youth Offending Service], but if they're not actually in the building with you, you don't get the benefit of hearing those conversations or, "Can I just speak to you about this? (manager, children's social care, case study 1).

Reflexive Monitoring

Across the three case studies, the impact of the innovation and its component parts was appraised by leaders, managers and practitioners. This was conducted both formally and informally based upon the extent to which it was thought to improve both family outcomes and working practices. Participants utilized a combination of quantitative and qualitative sources of evidence in their monitoring of the innovation. In addition, there was often much emphasis placed upon anecdotal and intuitive evidence of the value of the approaches taken.

Better Outcomes for Families

Within all case studies, participants reported that they perceived the innovation to be having a positive impact upon family outcomes. Routinely collected data was utilized to demonstrate positive outcomes, for example, a reduction in the numbers of cases being referred into a Multi- Agency Risk Assessment Conference (MARAC) or being subject to child protection plans was highlighted as evidence that early, preventative intervention was benefitting families. These findings were then fed back to colleagues within the case study to further galvanize efforts. However, it was anecdotal and intuitive evidence that was most often

emphasized by participants across the case studies. Participants often reflected upon specific changes in service provision that they perceived to be of benefit to families and resulted in more responsive care, reduced victim-blaming and improved safety plans for adult and child victims/survivors. Direct feedback from families was also highlighted as an important means of monitoring service provision.

> At the end of every client, when we close their case, we're confident that they're safe and secure, and they're happy to move on with their life, we do what's called a SUSS review, which is a service user satisfaction survey review. It's only three questions, but, more often than not, they want to expand and say, "My IDVA was brilliant. She helped me turn my life around"…So that's lovely to hear (frontline practitioner, domestic abuse and mental health, case study 1).

In case study 2, group supervision was highlighted as a useful mechanism to support both communal and individual appraisal of the practice approach. Practitioners often commented upon the challenges and emotional impact of safeguarding children and families affected by domestic abuse. Group supervision provided an opportunity for practitioners to pause and acknowledge the cases where families had been supported to achieve better outcomes than might otherwise have been possible. In this sense, group supervision was both restorative and reinforcing of the practice.

> Seeing the massive amount of work that has gone in, seeing the results, the outcomes, and family's lives that have been changed because of the model, that makes me know it works (frontline practitioner, domestic abuse, case study 2).

Improving Working Practices

Across all case study sites, the extent to which the innovation was perceived to improve working practices was reflected upon by participants. Such benefits often included an increased sense of professional skill, attributed to the new structures and support mechanisms implemented within the innovation. Practitioners who did not specialize in domestic abuse reported feeling more confident in their practice because of 'thinking together' and 'acting together' with specialist domestic abuse practitioners.

> I think we've got better with doing safety plans, as agencies. I think that we… Especially with [name of specialist community and voluntary sector domestic abuse service], they do a template of a safety plan now. I think that really helps us to focus on other things other than just the fact that if you were to leave this is what you need to do to leave, these are all the contact numbers (frontline practitioner, children's social care, case study 3).

Case study sites reported that reflexive monitoring was used to continually improve practice, and address aspects of the innovation that are not working. In these circumstances, sites often reflected and evaluated their own processes, looking for opportunities for quality improvement.

> I think, because it was something new, we were all learning, so every single individual that was involved within the model, from managers to us, as practitioners, everyone was learning. So, there was a lot of tweaking. When tweaking does happen in regards to "Okay, this is not really working; maybe let's put this in place, or let's put that in place," you'll find that things change from time to time… but, to be honest, every tweak that has been done has made things better (frontline practitioner, domestic abuse, case study 2).

Whilst case study 2 focused upon opportunities for reflexive monitoring which supported positive reinforcement of the practice model, case study 3 took a 'problem-solving approach' to appraisal. In particular, a reporting mechanism linked to a specific component of the innovation which was being piloted for 1 year, was introduced. Stakeholders in this case study site were mindful that they had a limited period of funded time during which to demonstrate impact and hence, experienced increased pressure to address any barriers to implementation promptly.

> When something is not working, [senior leader's name] is usually aware because we do have- so we would try and address it with the social worker. If it doesn't work, we would have to go a little bit further. So there's a complaint process basically. Not complaint as such, but it's just about concerns, how do we escalate it in a way. So we could go to the management, speak to them. If it doesn't work either, then we go to [senior leader] and then it goes above and above and above…We have to make sure that we're monitoring it appropriately because that was the only way we would get the contract further (frontline practitioner, domestic abuse, case study 3).

Implementation Outcomes

Within implementation science, 'outcomes' refers to the effects of the work undertaken to enact and embed the innovations (for example, the extent to which the model had

become normalized). These implementation outcomes varied across the case study sites. At times this could be seen as relating to the combination of the four core constructs of NPT (coherence, cognitive participation, collective action, and reflexive monitoring) as well as the scale of the innovation attempted and the stage of implementation. Case study 3 appeared to be earlier in their innovation journey as compared to the other case study sites. Whilst they had made progress in implementing the model, it was yet to be normalized within practice, with key barriers for normalization apparent.

> "Is it effective?" It becomes effective if actually, as a social worker, you say, "Do you know what, I've got quite a lot of level of knowledge and competence around this now. I don't need the specialist service, necessarily, there because they've given me the skills that I can actually go in and do this work or have the confidence to make sure that I've covered everything in an assessment or I've really understood the victim's perspective or I've asked the difficult question to the perpetrator." So, over time, it may be that there is less of a need but, I suppose, I'm a little bit skeptical about that because I just see the size of the issue and the extent to which the system is so stretched. I suspect there will still be a strong argument that you need, still, specialist services sitting close to us for some considerable time really (Strategic lead, Children's Social Care, case study 3).

Case study 1 was implementing an innovation on a system-wide scale. Whilst the implementation journey was on-going, there were a number of components within this ambitious approach that were highlighted as being successfully implemented. The combination of these components was thought to have greatly impacted upon the system response to families affected by domestic abuse in this site and produced an innovation which is likely to be sustained.

> And it's [multi-agency arrangements] just growing and growing all the time, which is really positive. And I think those conversations are happening now more than they were ever happening.I think it's moving in the right direction (frontline practitioner, Early Help, case study 1).

> I know, for example, that Domestic Abuse Responders project has just grown and grown, from being a really small group within the council, to now being external and other agencies. Then there's a whole training programme around it so that it feels like the things that are needed to be put in there to keep it going, we do have the continued networks. There's a continued training programme, so that should keep running(strategic lead, Children's Social Care, case study 1).

With this case study, the specialist domestic abuse practitioners were becoming normalized within the system. Host organizations had recognized the benefits of the specialist roles and identified their own sources of sustainable funding.

> Our seconded officers, the first two years, were government grant-funded…But now those services, our adult services and our mental health services are looking to fund their own domestic abuse support positions (strategic lead, domestic abuse, case study 1).

Within case study 2 the innovation had been focused upon a specific part of children's services, with substantial planning, enacting and embedding activity undertaken. This had resulted in practice being normalized, and as a result, the site was beginning to consider opportunities for diffusion.

> We are looking at using the model and rolling it out further. So, for example, what we're looking at the moment in [case study area 2] is how we can use the family safeguarding model for our children in care. (service manager, children's social care, case study 2).

Discussion

Our study has applied the lens of NPT to examine the work that different sites undertook to implement and normalize innovative approaches to integrating child and adult focused services when responding to families affected by domestic abuse. We identified a range of factors that were enabling in this task. These are: having a receptive context which includes strategic buy-in; a clear and shared understanding of the practice model; and regular opportunities for multi-agency networks to 'think together' and 'act together' in meaningful ways. We found that the presence of these enablers is most likely to support implementation in a way that may achieve normalization of the approach.

The importance of context is extensively discussed in the implementation literature (Dryden-Palmer et al., 2020; May et al., 2016; Pettigrew et al., 2004; Pfadenhauer et al., 2017). Within our study we found all three case study sites reported local contexts that were receptive to the innovation. Whilst we recognize the necessity of this, it was the way in which these cases in our study implemented the innovation within its specific context that differed between sites and produced different outcomes. The presence of a clearly articulated practice approach was found to be particularly

important in building coherence within multi-agency structures which consisted of adult and child focused services. Recent research suggests that when team members understand and organize their knowledge and actions around collective goals, roles tasks and abilities, they build multi-agency 'teamness' (Cooke et al., 2024) and shared team identity (Ashforth & Schinoff, 2016). This in turn fosters cooperation (Mathieu et al., 2000) and enables them to coordinate their actions. Within our study, the two case studies (case study 1 and case study 2) which achieved a clear practice model went about this in distinct ways. One site (case study 2) adopted an established model and implemented it in a discrete part of the system inclusive of a small number of partners, with an intention to utilize the learning to support diffusion, whilst the other (case study 1) implemented a system-wide, locally developed model with a large number of partners. Both appeared successful, as each case study site ensured that all relevant partners involved, fully understood, and were committed to the innovative approach being implemented.

Previous research examining approaches to integrating child and adult focused services have highlighted the importance of effective coordination of collaboration activities between organizations (Banks et al., 2008; Turner et al., 2017), clear communication (Stanley & Humphreys, 2017), the need for knowledge and skill development (Stanley & Humphreys, 2017) and the importance of maintaining relationships (Banks et al., 2008). However, less is known about the action and activities that may facilitate this. Given the cultural shift that is required to integrate adult and child focused services responding to families affected by domestic abuse, it is likely that systems and their component parts will be required to engage in reciprocal learning (Wenger, 2010). The development of 'communities of practice' were found to be a key enabler of innovation within our study. Each case study reported mechanisms for facilitating interaction between multi-agency and multi-professional partners to 'think together'. However, this appeared to work best when the community was bound together by a sense of joint enterprise within the community's learning, mutuality and by a shared repertoire of communal resources (for example through shared language, tools, sensibilities) (Wenger, 1998, 2010). High frequency multi-agency meetings with an emphasis upon shared learning and shared responsibilities, and group clinical supervisions, were found to be particularly useful in generating this joint enterprise. Moreover, this nurtured a sense of belonging and commitment within the community, which has been found to enhance collaborative working (Carraro et al., 2024). We found that unidirectional consultative approaches were important for imparting knowledge and to instruct on a case-by-case basis. However, they were less likely to generate the necessary mutual engagement and energy for system-wide change. Further, opportunities for practitioners, managers and strategic leaders to reflect together upon the impact of the innovation both in terms of the benefits for families and practitioners was important for galvanizing the community around the innovation and reinforcing the approach. In particular, we found the use of anecdotal evidence wherein practitioners discussed the families improving case and team reflexivity to be particularly enabling. Such approaches have been found in previous research to support alignment within teams (Tesler et al., 2017).

Across all three case study sites, we found examples of positive inter and multi-agency working which consisted of a combination of specialist and non-specialist domestic abuse practitioners from adult and child focused services from both statutory and community and voluntary sector organizations. However, the extent to which practitioners participated in collective action varied from states of co-operation and coordination (wherein practitioners share information, resources, some roles and responsibilities to achieve mutual benefit), to co-ownership (wherein practitioners commit themselves to a shared goal and make significant changes in their practice to achieve it) (Cheminais, 2009). Recent research has highlighted that for team members to progress beyond the simple execution of tasks towards a proactive practice approach which aligns to a shared model, they must first understand what the aim of the innovation was and commit to their role in realizing this (Carraro et al.). Such an approach facilitates the on-going adaption necessary to integrate innovative approaches within complex systems (Greenhalgh & Papoutsi, 2019). Within our study, where good levels of coherence and cognitive participation were achieved, collective action tended to be based upon the practice of 'us' and 'we'. Strong leadership was key in facilitating the sort of sense-making activity that is required to implement innovation, alongside key partners who are agentic in the implementation process.

Strengths and Limitations

This study makes a valuable contribution to the limited research base which examines how to enact and embed innovative approaches to integrating adult and child focused services responding to domestic abuse. The case study design has resulted in rich data, with sufficient flexibility to provide insights which can inform practice and future research. Our rigorous methods and application of NPT supports the transparency and trustworthiness of the findings. This study has a number of limitations that should be considered when interpreting the results. We collected a large amount of qualitative data in semi-structured interviews conducted across three case study sites and worked closely with leads

within the case study sites to achieve a varied sample, and perceived data saturation had been reached. However, we recognize that key informants may have been missed, which limited the potential for 'new' codes and themes to emerge [2]. This approach to data collection allowed us to access rich accounts of factors which helped or hindered implementation. However, it should be recognized that participants may have emphasized successes or downplayed challenges due to personal or professional investment in the innovation or social desirability. It should be noted that our focus upon implementation required data collection with those involved in the provision and organization of the innovative approaches, and not the families in receipt of them. Whilst the effectiveness of the services was outside of our current scope, these important voices are missing. Hollow innovations which are not based upon evidence of effectiveness should not be sustained, as they offer limited on-ground impact. Further research into the integration of adult and child focused services responding to families affected by domestic abuse should consider the effectiveness of innovative approaches as this relates to its stage of normalization.

Implications for Policy and Practice

Our study has highlighted a number of key lessons for implementation which are of relevance to policy and practice. These are:

- Having a clear practice model is essential to successful implementation. Time should be taken to agree this model with all relevant partners at all levels (strategic, managerial and practitioner). Training and/or coherence building activities which enable partners to differentiate the innovative model from the previous approach and integrate this into their competing practice demands may benefit coherence to the model.
- Regular structured opportunities for multi-agency groups to 'think together' and embark upon reciprocal learning may facilitate communities of practice to evolve based upon a shared enterprise.
- Whilst co-operative and collaborative task-orientated approaches support inter-agency practice, 'acting together' requires a multi-agency co-ownership model consisting of specialist and non-specialist practitioners focused upon a shared mission.
- Communal reflection upon the benefits of the innovative practice approach upon families and working practices may be both restorative and reinforcing for practitioners.

Enacting these learnings in meaningful ways is most likely to support implementation in a way that may achieve the normalization of innovative multiagency approaches to responding to the needs of families affected by domestic abuse.

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Data Availability The authors do not have ethical approval to make the data available.

Declarations

Conflict of Interest The authors declare they have no competing interests.

Ethical Approval The study was approved by the Faculty of Medical Sciences Research Ethics Committee, part of Newcastle University's Research Ethics Committee (Ref 2268/17833/2021).

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