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Evaluation of training for practitioners working with victim/survivors and perpetrators in homelessness settings.

1. Introduction

Through strategic and front-line cross-sector working, FLIC observed that homelessness practitioners have frequent contact with victims/survivors and perpetrators of DVA in homelessness settings. They noted the challenging circumstances within which homelessness practitioners operate, as well as some gaps in knowledge, skills, and confidence of practitioners to effectively identify DVA and respond appropriately. Consequently, FLIC collaborated with cross sector partners to develop guidance and a training package to improve identification, responses and referrals for victim/survivors and perpetrators into appropriate services and interventions.

1.1 Project delivery

In 2021/22 FLIC produced a guidance document[1] and provided free training sessions to Camden Housing First, St Mungo's, The Street Engagement Team at St Martins, and Westminster Housing First. Three online sessions were conducted with a total of 28 homelessness practitioners.

1.2 Learning outcomes from the training

The training was very well-received by delegates who reported that the material was tailored to their roles and the challenges they face in their work. All 17 post-survey respondents reported that they would recommend the training to others. The evaluation was conducted before delegates had a chance to put the learning into practice, but all survey respondents said it would influence their practice in the future.

Evidence of positive change in survey scores was demonstrated across all the learning outcomes. Examples of outcomes achieved included practitioners reporting being able to identify perpetrators' attempts to collude with staff, how to provide space and opportunity for victim/survivors to disclose DVA, how to carry out routine enquiry about DVA, the role and purpose of MARACs and how to navigate the parameters to their role or when to work in partnership with other services.

Some feedback indicated that the learning points about the gendered nature of DVA and the need to prioritise safeguarding and prevent harm to victim/survivors at all times, over everything else when working on any aspect of DVA, may not have been achieved for all delegates.

Training participants valued the opportunity to increase their knowledge, skills, and confidence to respond to DVA, and all delegates reported that the training would enable them to change their future practice. Assessing the impact on future practice and implications for victim/survivors and perpetrators requires more longitudinal evaluation.

1.3 Summary recommendations[2]

- Consider using the material for this training as a bolt on to an introduction to DVA to build participant knowledge over time and ensure that the learning outcomes are relevant for particular roles.
- Consider strengthening the messages around the gendered nature of DVA and the implications and risks facing specific groups, particularly women.
- Explore the feasibility of providing additional advanced sessions on DVA and additional training on specific topics included in DVA such as coercive control.
- Future evaluations should incorporate post-training assessment, such as training or surveys 6-12 months post-intervention to measure change over time in practice and difference made to individuals.

[1] https://www.shp.org.uk/news/guidance-launch-working-effectively-with-perpetrators-and-survivors-of-domestic-abuse-in-homelessness-settings

[2] Please see the evaluation report and the methodology in the appendix for more details.

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Evaluation conducted and report produced by Lisa Young, Dr Kelly Bracewell, and Dr Sarah Burch.

2. Introduction

2.1 Background literature and wider context

2.1.1 *The impact and scale of DVA*

DVA is a significant problem globally, resulting in high levels of physical, emotional harm and death (UNODC, 2019). Anyone can experience DVA, however evidence demonstrates that DVA is a gendered crime with women more likely to be victim/survivors, and men more likely to be perpetrators (Home Office, 2020). Women are more likely to suffer repeat victimisation, serious harm, and death from DVA (Home Office, 2020).

2.1.2 *DVA and Multiple disadvantage*

Research shows that many victim/survivors and perpetrators are likely to experience multiple disadvantage such as substance use, homelessness, involvement in the criminal justice system and mental ill-health (Radcliffe & Gilchrist, 2016; Harris & Hodges, 2019). The links between DVA and other forms of multiple disadvantage are broad ranging and often complex; the impacts and implications of these factors are again gendered and affect men and women differently (Savage, 2016; Reeve, 2018). For example, homelessness for women is often recognised as a direct consequence of fleeing DVA (Women's Aid, 2021), which places them at further risk of abuse.

2.1.3 *Strategies for addressing DVA*

Traditionally, responses to DVA for victim/survivors have predominantly focused on improving safety and recovery through the provision of specialist support and refuge, designed, and delivered by and for women. Whilst a strong criminal justice response is required to address perpetrator behaviour, relying solely on these remedies appears to have limited effect on the scale and impact of DVA and homicide rates (Long et al, 2020; ONS 2021). Community interventions for addressing perpetrator behaviour have tended to include psychosocial educational programmes aimed at behavioural change (see Respect). Some positive outcomes have been observed in certain circumstances (Kelly & Westmarland, 2015), however, evidence for the effectiveness of perpetrator programmes remains patchy and inconsistent, and there is no agreed standardised approach.

The Domestic Abuse Act (2021) has recently brought the issues into focus by clearly defining what constitutes DVA in its various forms. It places a series of responsibilities onto professionals and services, advocated in the CCR model. The statutory guidance provides a perpetrator strategy, guidance around housing assistance for victim/survivors and emphasises the importance of recognising the gendered nature of DVA (Home Office, 2020).

A co-ordinated community response to DVA is reported to contribute to better outcomes. As such, there is an increasing emphasis on the role of housing providers, health services, and family support services to be upskilled around DVA, to improve routine enquiry, identification of victim/survivors and perpetrators and to know how to respond and refer to specialist services (Bacchus et al., 2011; Feder et al., 2010). Research demonstrates mixed results about the impact of training with regards to sustained learning and/or changes to practice (Bacchus et al., 2011; Feder et al., 2010).

2.1.4 *Knowledge and skills gap*

Housing and homelessness practitioners have regular contact with DVA victim/survivors and perpetrators through their work with rough sleepers or people in temporary, precarious, or mixed-sex hostel environments, which are often unsuitable due to the risks of VAWG (Reis, 2019). These circumstances require practitioners to have a level of knowledge and awareness about DVA and the appropriate interventions available. Although research in this area is limited, some studies have shown that skills and confidence amongst homelessness practitioners varies considerably, with practitioners reporting that they lack confidence and can feel ill-equipped to address these issues (Henderson, 2019; Mullins and Niner, 1996; Scottish Women's Aid, 2016).

2.2 Context and rationale for developing this training

Through strategic and front-line cross-sector working over the last eight years, FLIC observed the themes identified in the literature detailed above. This includes acknowledging the particular role that homelessness practitioners have in this area due to their frequent contact with victim/survivors and perpetrators in homelessness settings, the challenging circumstances within which practitioners operate, the importance of effectively identifying DVA and the gaps in knowledge, skills and confidence required for this work. Consequently, FLIC collaborated with cross sector partners to develop guidance and a training package for practitioners to improve responses and referrals for victim/survivors and perpetrators into appropriate services and interventions.

2.3 Training design and delivery

To develop this project, FLIC organised an initial roundtable to include representatives from the women's sector, the homelessness sector and perpetrator projects. Detailed discussion about the specific challenges, gaps and requirements informed the development of the guidance and training.

The training was underpinned by the recognition of DVA as a serious, pervasive, and gendered problem, often linked with multiple disadvantage including homelessness and problematic drug and alcohol use.

The learning outcomes aimed to support professionals to:

- Know how to effectively identify someone who is experiencing or perpetrating DVA in homelessness settings.
- Have increased awareness of perpetrator behaviours and increased understanding of the motivations behind perpetrator behaviour.
- Know what to do/say to make sure you are not colluding with perpetrators.
- Feel confident to work in partnerships with specialist services and other agencies to hold perpetrators to account and keep survivors safe.

FLIC produced a guidance document[3] and provided free training sessions to Camden Housing First, St Mungo's, The Street Engagement Team at St Martins, and Westminster Housing First. The original intention was to hold day long face-to-face sessions. However, due to increased Covid-19 restrictions towards the end of 2021, all training sessions were held online using the Zoom platform. Between November 2021 and January 2022 three training sessions were delivered to 28 delegates.

[3] https://www.shp.org.uk/news/guidance-launch-working-effectively-with-perpetrators-and-survivors-of-domestic-abuse-in-homelessness-settings

3. Key findings

This section of the report outlines findings about delegates' prior experience of contact with victim/survivors and perpetrators in homelessness settings, reflections on some of the challenges they face in their role and the need for training and guidance in this area.

3.1 Delegate experiences of working with victim/survivors and perpetrators of DVA

All delegates reported some previous experience of working with victim/survivors and or perpetrators of DVA, although the extent of that experience varied. Some delegates demonstrated knowledge and experience of working with victim/survivors of different forms of abuse, and some had contact with high-risk cases:

"It came out that he was like even financially abusing her and multiple other people, so it was it was more than just physical…it's like putting her in debt to him, chasing her down for it and it was her payday again." (Delegate 01)

"She was at risk of death. It was quite obvious that this was going to escalate in that way. He had a lot of mental health issues. He was very paranoid." (Delegate 02)

3.2 Challenges facing homelessness practitioners in their roles

Training delegates described facing a series of challenges in their roles when working on the topic of DVA in homelessness settings.

3.2.1 Links between DVA and multiple disadvantage

The victim/survivors and perpetrators with whom practitioners work with frequently experience multiple forms of disadvantage such as homelessness, problematic drug and alcohol use as well as mental-ill health. In some cases, perpetrators use drugs or alcohol as coercive control mechanisms to prevent victim/survivors leaving. They and can also prohibit engagement with treatment.

It is therefore challenging to provide services to people experiencing DVA and multiple disadvantage, as their experiences can compound one another, placing individuals in situations of greater precarity and increasing the risk to the victim/survivor. This can create uncertainty about how best to intervene:

"When you have a couple that are using, and they were entirely fixated on funding and using substances and who are more often than not rough sleeping while they're doing it, then I kind of believe that there's always gonna be a DV element in all of it really. It is just that toxic so it's like at what point do you pick it all apart? (Delegate 02).

3.2.2 The presence of perpetrators

A frequently reported challenge facing practitioners is the presence of perpetrators who deliberately isolate victim/survivors and hinder their efforts to provide support or access to services.

Some delegates commented that in previous training or in other roles, they had been advised not to engage with perpetrators under any circumstances as this is perceived to be too risky:

"Generically services will say no you don't work with someone if the perpetrator is there, but actually is that manageable, is that realistic to do that? And maybe not…so yeah those can be some of the challenges." (Delegate 03).

However, avoiding all contact with a victim/survivor when the perpetrator is present can mean losing the ability to maintain any contact with vulnerable victim/survivors.

Less experienced delegates reported concerns about not knowing whether their actions or inaction might inadvertently make clients' positions worse and so welcomed guidance.

Delegates who had worked with perpetrator services also noted that these programmes were usually inaccessible to perpetrators experiencing homelessness.

3.2.3 Knowing when and how to have conversations about DVA

Delegates commented that people who experience a range of challenging circumstances simultaneously might view the nature of their relationship as a lower priority, and so timing about how and when to enquire or offer support around DVA could be difficult:

"…a lot of the time, their relationship with their partner isn't at the forefront of their mind, it's not their biggest concern. And as a result, we can't address it with them...I'm always very conscious of the fact that their support network is probably the thing that's kept them going this long. So, we have to be very careful about how we deal with that." (Delegate 06)

Similarly, delegates commented that it was hard knowing how and when to have conversations with victim/survivors to help them recognise, identify, and name abusive behaviour that they may be experiencing.

3.2.4 Effective partnership or multi-agency working

In line with providing a CCR, some delegates reported that they partner with other agencies to try to meet the needs of the people they work with, but not all were aware of the multi-agency DVA strategies available. Organisational strategies and priorities were reported to differ, sometimes making it difficult to work towards the individual's objectives. In some cases, where delegates were known to have a positive relationship and frequent engagement with clients, other professionals would sometimes expect the homelessness practitioner to work beyond the scope of their capabilities and the scope of the service:

"…everyone just would rather just delegate it to you. And I think because we do actually have the relationships that are like close, we're in this person's life every day, we speak to them every day…and it's like no, you know, recognize our professional boundary…this is our limit of what we can do and should be doing with her." (Delegate 01)

Delegates also reported that it can be challenging working with victim/survivors experiencing multiple disadvantage as they can be reluctant to engage with the multi-agency DVA mechanisms:

"…we ended up doing DASH RICs off the information we know, without them, knowing full well they're not going to engage with MARAC and things like that. (Delegate 06).

The practitioner must then decide whether to proceed with a MARAC referral without consent and try to ensure that any resulting MARAC actions are relevant and appropriate to help prevent further risk.

The following sections details key findings about the outcomes and learning achieved for delegates from the training and accompanying guidance.

4. Learning outcomes from the training and guidance

4.1 Quality and experience of the training
The training was very well-received by delegates. All 17 post-survey respondents reported that they would recommend the training to others, and all agreed that the training would help them to change their practice in future.

A common theme was that the training had been specifically tailored to the particular role of delegates and the circumstances of the clients that they regularly support:

"I thought it was really, really helpful, the training. I definitely think It was helpful in terms of it being designed for our client group." (Delegate 04)

The training appeared to serve different purposes for delegates with various levels of previous experience in this area. For professionals who had less experience of working with DVA, the training was reported to help to increase understanding, gave them new perspectives, enhance skills, and provide strategies to improve their confidence to address these challenges.

"I think from that perspective it was like just a little, you know, a nice little awakening and you know to open my eyes…" (Delegate 01)

For delegates with more experience of this type of work, the training was considered useful to affirm and refresh their knowledge, validate their experiences, and provide confidence.

4.2 Delegates' knowledge, skills, and confidence levels
The training was designed to influence specific learning outcomes, and the next section illustrates evidence of changes in relation to the level of **knowledge, understanding, skills and confidence** of training delegates when working with victim/survivors and perpetrators of DVA.

Delegates reported feeling most confident in the pre survey about the need to **"work in partnership with other agencies for victim/survivors and perpetrators to access services they might need"** (3.6). Delegates reported feeling least confident before the training in relation to **"confidence about how to support survivors when the perpetrator is almost always present."** (2.1).

4.3 Changes in scores between pre/post training surveys
The table below demonstrates the changes in scores between the average pre survey score and the average post survey score for training delegates that completed surveys.[4]

[4] Findings taken from 19 responses to the PRE survey and 17 responses to the POST survey. Respondents were asked to score between 1 and 4 (1=disagree strongly; 4=Agree strongly).

Survey question	Pre score [1-4]	Post score [1-4]	Change
I feel I have awareness of the motivations behind perpetrator behaviour, such as coercive control	2.8	3.4	+0.6
I know how to identify common perpetrator behaviours, such as minimising/denying/blaming	3.0	3.07	+0.7
I understand the ways in which perpetrators are responsible for their own behaviours	3.1	3.5	+0.4
I feel I know how to identify someone who is experiencing domestic violence and abuse in homelessness settings	3.2	3.6	+0.4
I know what my responsibilities are as a practitioner if I identify or witness domestic violence and abuse taking place	3.4	3.6	+0.2
I understand the need to work in partnership with specialist services and other agencies for perpetrators and survivors to get the support they need	3.6	3.9	+0.3
I know what I can do/say to minimise colluding with perpetrators of DVA	2.3	3.2	+0.9
I know what to do/say to help survivors of DVA feel heard and understood	3.2	3.5	+0.3
I feel confident about how to support survivors when the perpetrator is almost always present	2.1	3.1	+1.0
I feel confident to work in partnership with local specialist services when I am supporting someone is experiencing domestic violence and abuse	3.3	3.6	+0.3

Positive changes between average pre and post scores were demonstrated across all questions. However, the largest changes between the average pre and post survey scores are in relation delegate confidence in **"how to support survivors when the perpetrator is almost always present"** and **knowing what I can do/say to minimise colluding with perpetrators of DVA"**. The questions that showed least change was **"knowing what responsibilities are as a practitioner if they witness DVA taking place"**.

4.4 Examples of the difference made by the training

The key outcomes and learning from delegate feedback are outlined below.

4.4.1 ***Identifying DVA in homelessness settings***

Although it was acknowledged that it is not always easy, delegates reported that the training contributed towards their ability to better identify DVA in homelessness settings, and recognise different forms and sometimes subtle indicators of DVA:

"…understanding kind of like the visual signs as far as like, the emotional signs. Because a lot of like, especially with like, coercive control, it's not exactly blatant..." (Delegate 03).

The training also helped to increase delegates' confidence and skills to have conversations and make routine enquiry about relationships and DVA:

"It was about how to spot domestic abuse and how to start having those conversations with victim survivors, or the people that you suspect - how to open it up and how to actually start having that dialogue. And that's the bit that I felt quite uncomfortable about." (Delegate 02)

One delegate commented that having been made aware of the potential for DVA to take place, and what this might look like, in future they would provide more opportunities for victim/survivors to be open about their experiences:

"…now it's in my mind, I'm gonna start questioning everything and making sure that the survivor has that place to speak freely. Any situation that they experience, instead of just taking what the partners just say as like law." (Delegate 03).

4.4.2 ***Enhanced support for victim/survivors***

Examples of learning were provided about how practitioners can explicitly make victim/survivors aware of coercive and controlling behaviour, offering opportunities for them to speak about how they feel or to talk through the support options available:

"…giving the women like a little bit of insight as to like. OK, well, this is what's really going on there like you know, did you realize that? Or you know, can we talk about that further?" (Delegate 01)

Delegates also recognised the impacts of DVA on the victim/survivor's identity and self-esteem and that by being there, offering support or a listening ear, practitioners can help enormously:

"a lot of the time, the survivor just kind of loses their sense of identity. And so, it's kind of like rebuilding that now, in a way saying, like, you are worthy of anything that you want… I am here for you." (Delegate 03).

4.4.3 ***Identifying and addressing perpetrator behaviour***

Examples of learning outcomes include the strategies and tactics used by perpetrators of DVA, for example isolating victim/survivors, minimising or denying their actions and trying to manipulate professionals to encourage victim blaming:

"…the specific bit in the training around how a perpetrator might try and almost charm you and like try and collude with you like about the victim/survivor, and it is just being aware of that."
(Delegate 04).

Having guidance around how to manage such sensitive interactions and conversations when the DVA perpetrator is almost always present was beneficial:
"…like tips of what to do in different tricky situations, which I think we do encounter. Such as if the perpetrator is always around and if they won't let you have your own time with [the victim/survivor]."
(Delegate 05)

Providing separate designated practitioners for each person accessing the same service was advocated as a helpful way to provide space for victim/survivors to either get respite, receive important support, or make disclosures:

"Our service can sometimes work with a couple that have two different workers, and maybe trying to like get them to have appointments at the same time. So, they have to be separate for like a time period." (Delegate 02)

Some delegates also commented on their improved ability to challenge perpetrators appropriately within the context of their practitioner role and identified this as an area where they would change their practice in future.

4.4.4 *Knowledge of practitioner responsibilities*

Delegates indicated enhanced knowledge about their responsibilities as a practitioner if they identify or witness DVA. In the survey, the number of delegates who reported that they strongly agreed that they understood their responsibilities increased from 5 to 10 delegates between the pre and post survey. Examples of this included delegates knowing where and how to share relevant information to safeguard the adult victim:

"It was just nice to understand…the processes in regards to like safeguarding these incidents were very useful, because, you know, you can witness something and then just be like, what do I do now? (Delegate 03)

Another commented that they had learned about the role and purpose of MARAC, including how and when to refer, as well as the types of MARAC actions that can be requested during the meeting to increase victim/survivor safety:

"I had never previously considered referring into MARAC in order to challenge a decision made around support or housing provision. Thanks! (Survey respondent)

Interviewees confirmed their improved confidence to manage a wider range of situations linked to DVA and confidence around decision making or acting on information:

"Definitely felt like I would be able to manage the situation a little bit better, instead of just being like, 'Oh, what do I do?' …it installed a bit of confidence, I suppose like afterwards, by dealing with the situation and understanding that, you know, I do have now have the tools and the knowledge..." (Delegate 03)

4.4.5 *Partnership working*

Delegates commented that after hearing in the training how their colleagues managed similar situations, they had a better understanding of how to work in partnership, appreciating the parameters of their role and the need not to assume all responsibility: *"I suppose the main thing was that because I always like kind of like take on all the tasks by myself, and just to understand that this is not okay. You shouldn't be doing that".* (Delegate 03)

Delegates reported practical strategies such as partnering up with support workers from other services to provide separate support to victim/survivors and perpetrators by co-ordinating appointment times, thereby providing more private space for disclosures, reducing risk, sharing responsibility as well as vital information around safeguarding.

4.5 Longer term impact of the training

The evaluation was conducted almost immediately after the training sessions. As such it was too early for delegates to provide examples of direct changes to their practice as a consequence of the training or to report direct impact to victim/survivors or perpetrators. However, all 17 post-training survey respondents reported that the training would change their practice when working with DVA victim/survivors and perpetrators who experience homelessness in the future. Some examples of the changes that delegates would seek to make include:

- Proactively conduct routine enquiry about client relationships and DVA
- Ensure that victim/survivors have increased opportunity and space to speak to workers freely and disclose experiences of DVA.
- Take a more proactive and solution focussed approach during MARAC meetings to request partner services to undertake relevant and appropriate actions.
- Explore the 'Team around Me' (TAM) approach as a potential way to improve multi-agency working to support victim/survivors.
- Appropriately challenge perpetrator narratives of losing control

4.6 Facilitators of learning

The features of the training that delegates found helpful in facilitating successful learning include:

The expertise and approach of the trainers: *"They both just instilled confidence in decision making because sometimes it is going to be making difficult decisions and the last thing you need at that point is to be second guessing yourself."* (Delegate 02).
Examples and case studies to make the topic relevant to the practitioner roles: *"it's always good to just refer back to notes…because if a similar situation happens, like in real life, then you have the knowledge and you have the tools to kind of like retrace your steps."* (Delegate 03)
Accompanying guidance to supplement the training: *"I definitely would, would go back through, go to the toolkit if I'm concerned about client safety. Just even having that knowledge on kind of how to identify… The kind of questions to ask initially…"* (Delegate 05)
Interactive activities: *"One of the things I really enjoyed was there was lots of interactive sessions throughout it and are that kept me energized. It kept the energy in the room up."* (Delegate 02)
Honest reflection about the challenges of this complex work and learn from the experiences of other practitioners: "*I really enjoyed seeing the sort of video of workers from FLIC talk about their experiences of working with victim/survivors and perpetrators and hearing them sort of say 'actually, it is really hard.'"* (Delegate 04)

5. Challenges and barriers to implementation of the training

This evaluation documents many positive findings about the training and learning outcomes, however it is important to note that challenges were also identified. These relate to some aspects of the training delivery and implementation, and some areas of learning that were not as successful as others.

5.1 Recruitment of participants

The training was offered free to whole teams to encourage group take up and to enable team members from all levels of the organisation to share experiences, promoting a whole team, reflective response. However, in practice not everyone in a team could be available, and some were required to respond to emergencies and provide duty cover. Given that teams were already stretched due to operating in the context of the Covid-19 pandemic, this was problematic:

"So sometimes we'd have people kind of engaging with the training, but then going to have to answer reception in the hostel, which just doesn't work for the learning." (PL1)

In these circumstances, the capacity for engaging fully in the training and learning was limited:

"…it's just impossible. You cannot give people free training because they don't have the capacity to do it, essentially. So that was a challenge." (PL2)

5.2 Practical challenges with delivery

One of the main challenges identified was the need to switch to online delivery of training at short notice due to the increased Covid-19 restrictions at the end of 2021. This meant that the length of the session was reduced and was reported to impact on the potential for meaningful group discussion of complex topics:

"…one of our biggest challenges was that we always envisaged that this would be a face-to-face training, because we felt it was such a kind of emotive issue, which hadn't really invited reflection and kind of personal engagement. And it's not… 'this is the right, and the wrong answer,' you know, there's lots and lots of kind of thinking around situations. And it's always kind of specific to each couple or each situation. So, we were really disappointed not to be able to do that." (PL1)

Other practical challenges included lack of familiarity amongst some delegates with how to engage in the online interactive activities, which sometimes impacted on the extent to which the whole group could participate: *"People didn't know how to do it, so I think it's just so we ended up not using it."* (Delegate 01)

5.3 Challenges in ensuring learning outcomes are met

By condensing the material, the training assumed a certain level of knowledge and understanding of DVA, rather than starting with basic awareness raising. This, coupled with differing levels of experience and expertise in this area amongst delegates, indicated that the learning outcomes were not achieved for all delegates.

5.3.1 The gendered nature of DVA

The training material contains case studies to broaden delegates' understanding about DVA, by highlighting that this is something that can affect anyone. The training and accompanying guidance also include evidence to illustrate the gendered nature of DVA.

Some delegates commented that they found it interesting to hear about experiences and case studies that included diversity of victim/survivors and perpetrators, particularly where they had not heard of examples previously. However, some feedback illustrated that the learning points about the gendered nature of DVA might not have been taken on board by all delegates, for example:

"Because I suppose it's a stigma…around domestic violence is that the woman is always the survivor, and, you know, the male, is always, you know, the perpetrator." (Delegate 03).

This suggestion of 'stigma' here is misleading, given the wealth of data, including homicide statistics about how DVA impacts differently according to sex in the UK (ONS, 2021).

The trainers noted these challenges and reported that they would like to strengthen the focus on violent resistance in the training as a way of moving beyond simplistic or misleading understandings:

"…we think we could have gone into more detail about violent resistance and kind of working out who the primary aggressor is, and stuff like that. So, I think teams really struggle sometimes. And then you get a lot of victim-blaming, and you know, 'they're both as bad as each other' and all of that stuff." (PL1)

5.3.2 *Prioritising the safety of victim/survivors when working with DVA*

One delegate expressed that although the training was aimed at working with survivors as well as perpetrators, the session and some case studies tended to focus more on how to prevent harm to victim/survivors:

"I think that was one of the case studies that was sent was about this, when the perpetrator was staying in a B&B, and the survivor was living outside of B&B due to like coercive control, etc., and like how best can we manage the risk of those people? But it just seemed like it was mainly aimed at how to minimize the risk of a survivor." (Delegate 03).

This indicates that the learning point about the need to prioritise safeguarding and preventing harm to victim/survivors at all times, over everything else when working on any aspect of DVA, may not have been achieved for all delegates.

5.4 Implementation of the data collection process

The evaluators designed a survey to evaluate the learning outcomes for all delegates. The move to an online session meant that the survey was implemented onto the online Zoom platform. Technical challenges with

this process meant that collection of survey data was patchy and inconsistent, reducing the quality of data available and the extent to which the outcomes could effectively be measured.

5.5 Delegate suggestions for improvement

- That training on DVA and how to address perpetrator behaviour should be mandatory for homelessness practitioners
- Build in follow-up support for practitioners to embed the learning and practical strategies.
- Allow more time to cover complex topics, as well as more breaks in the sessions.
- Develop advanced sessions for delegates.
- Bolt these sessions onto entry level DVA awareness training for those with less experience of working in this area.
- Include more case studies and circulate some of the materials beforehand to provide time to read and reflect before the session.

6. Conclusions

Practitioners in homelessness settings are often in contact with victim/survivors and perpetrators together, through outreach or working in mixed homeless or temporary accommodation. Given their unique access to marginalised communities, alongside the need to build knowledge and capacity of practitioners in this field to help identify, respond, and prevent DVA as early as possible, a clear rationale was developed for creating the training and accompanying guidance and resources.

This training, designed in collaboration with cross sector services, aims to meet a particular need for homelessness practitioners who have contact with both victim/survivors and perpetrators of DVA who also experience multiple disadvantage. Three online sessions were conducted with a total of 28 homelessness practitioners with a varying degree of prior experience or knowledge of DVA.

6.1 Outcomes

Preliminary findings about the quality and overall experience of the training are encouraging. The learning material aligns well with the specific challenges that the delegates face in their work.

Evidence of positive impact was demonstrated across all the learning outcomes. The areas where delegates reported having less knowledge and experience prior to the training, including how to support survivors when the perpetrator is almost always present and knowing what to do/say to minimise colluding with perpetrators of DVA, were reported to be amongst the largest shifts in scores between the pre and post surveys, suggesting that the training is meeting the skills and knowledge gaps of delegates.

Evidence of outcomes being achieved included being able to identify perpetrators' attempts to collude with staff, how to provide space and opportunity for victim/survivors to disclose DVA, how to carry out routine enquiry about DVA, the role and purpose of MARACs and how to navigate the parameters to their role or when to work in partnership with other services.

Some feedback indicated that the learning points about the gendered nature of DVA and the need to prioritise safeguarding and prevent harm to victim/survivors at all times, over everything else when working on any aspect of DVA, may not have been achieved for all delegates.

Training participants valued the opportunity to increase their knowledge, skills, and confidence to respond to DVA, and all delegates reported that the training would enable them to change their future practice. Assessing the impact on future practice and implications for victim/survivors and perpetrators requires more longitudinal evaluation.

6.2 Facilitators to learning

The main facilitators to achieving positive learning include the dynamic nature of the training, the sharing of practical strategies for working with victim/survivors and perpetrators, the supplementary guidance as reference material after the training and the interactive, small group discussions to learn from others and keep sessions lively and interesting.

6.3 Challenges of delivery

Some challenges were noted in the delivery of the training due largely to Covid-19 and the switch to online sessions at short notice. This impacted on the content, participation, and quality of survey data collection. Delivering sessions to whole teams who also had to cover their case work proved challenging and impacted on learning and engagement in the session.

Overall, the training was reported to be helpful for practitioners facing challenging circumstances. It increased their knowledge, skill, and confidence to carry out their role with victim/survivors and perpetrators that experience multiple disadvantage, respond appropriately, safeguard individuals and encourage their engagement in appropriate services.

7. Recommendations

Recommendations for strengthening future design, delivery and implementation include:

7.1 Training material

- Consider developing distinct levels of training for those who have more/less experience in this area to ensure that the learning is appropriate.
- Consider using the material for this training as a bolt on to an introduction to DVA to build participant knowledge over time and ensure that the learning outcomes are relevant for particular roles.
- Consider screening participants prior to sign up to ensure that participants have a level of existing knowledge and awareness of DVA including the gendered nature of DVA.
- Consider strengthening the messages around the gendered nature of DVA and the implications and risks facing specific groups, particularly women.

7.2 Recruitment and delivery

- Develop longer sessions that allow more time to discuss complex issues – or cover less material in one session, creating additional sessions to cover more material if necessary.
- Broaden the awareness of the availability of training to the wider homelessness sector to encourage uptake.
- Avoid training whole staff teams at the same time - for instance, by training smaller groups from whole staff teams - to facilitate participation and ensure that case work can be covered.
- Consider training mixed groups of homelessness practitioners from different organisations so that teams can learn from one another during sessions.
- Develop materials that are appropriate for both online sessions as well as face to face. Although face to face is often the preferred method, online options can reach a wider audience in a shorter space of time.
- Explore the options (requirements, resources, timescales) required to provide follow-up support and guidance for professionals undertaking the training to embed the learning into their practice and provide opportunities for reflective practice.
- Explore the feasibility of providing additional advanced sessions on DVA and additional training on specific topics included in DVA such as coercive control.

7.3 **Evidence and measuring impact**

- Further longitudinal evaluation is required to assess and capture the longer-term benefits of implementing the learning and materials. Future evaluations should incorporate post-training assessment, such as training or surveys 6-12 months post-intervention to measure change over time.
- Where online platforms are used, pre and post surveys should be incorporated directly into the process to achieve higher survey response rates.
- To measure reach and potential impact over time, training information and accompanying survey data should be consistently collected using a single process, e.g., numbers and roles trained, organisations reached, as well as pre and post survey scores for individuals.

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