Department for Levelling Up,
Housing & Communities

Respite Rooms Pilot Programme Evaluation: Final Report

Prepared by IFF Research, on behalf of DLUHC

July 2023

This document/publication is also available on our website at www.gov.uk/dluhc

If you have any enquiries regarding this document/publication or write to us at correspondence@levellingup.gov.uk or

Department for Levelling Up, Housing and Communities
Fry Building
2 Marsham Street
London
SW1P 4DF
Telephone: 030 3444 0000

For all our latest news and updates follow us on Twitter: https://twitter.com/luhc

July 2023

Contents

Foreword....6
1. Executive Summary....8
1.2. Introduction....9
1.3. Policy background....9
1.4. Research design....10
1.5. Research findings....11
2. Introduction....16
2.1. Summary....16
2.2. Policy background....16
2.3. Existing knowledge....18
2.4. Research questions....19
2.5. Structure of this report....20
3. Research design and methodology....21
3.1. Summary....21
3.2. Testing the policy....21
3.3. Theory of Change....23
3.4. Designing the evaluation....24
3.5. Research design....25
3.6. Research elements....27
4. Respite Room design....31
4.1. Summary....31
4.2. Bid process and joint working....31
4.3. Respite Room design....35
4.4. Referral routes....39
4.5. Number and profile of service users....43
5. Respite Room outcomes....47
5.1. Summary....47
5.2. Providing support....47
5.3. Move-on....58
6. Respite Room impact....69
6.1. Summary....69
6.2. Impact Analysis Design....69
6.3. Impact on immediate housing situations....73
6.4. Impact on receipt of advice and support....75

6.5. Association between receipt of advice and support and entering safe or secure housing....76
6.6. Views on impact....78
6.7. What worked....81
7. Looking forward....82
7.1. Summary....82
7.2. Sharing learning....82
7.3. Future of Respite Rooms....83
8. Conclusions....86
8.1. Summary....86
8.2. Summary of findings by theme....86
Annex A Impact Analysis....91
A.1. Data collection....91
A.2. Propensity Score Matching....93
A.3. Sensitivity Analyses....96
A.4. Scoping interviews and data gathering....100
Annex B Literature Review....102
B.1. Contextualising Respite Rooms....102
B.2. Violence against women and girls and risk of homelessness....102
B.3. Needs and preferences....103
B.4. Supporting families....104
B.5. An intersectional approach....105
B.6. The COVID-19 pandemic and urgent housing needs....106
B.7. Literature Review Methodology....106
Annex C Design and Methodology: additional detail....112
C.1. Designing the evaluation....112
C.2. Stakeholder interviews....128
C.3. Project lead interviews....129
C.4. Case studies....130
C.5. MI Analysis....132
Annex D Summary of projects....133
D.1. Summary of projects....133
Annex E Topic guides and materials....134
E.1. Stakeholder topic guide....134
E.2. Local Authority project lead topic guide....138
E.3. Provider project lead topic guide....143
E.4. Project lead follow-up topic guide....148

E.5. Case study topic guide: staff 151
E.6. Case study topic guide: service users 155
E.7. Information materials 164
Annex F Ethics and data protection 168
F.1. Context of the project 168
F.2. Ethical considerations 168
F.3. Actions taken 169
F.4. Data protection 171
Annex G Data tables 174

Foreword

The Department for Levelling Up, Housing and Communities is pleased to publish the evaluation report of the Respite Rooms Pilot Programme.

The programme provided single gender, single sex short stay supported accommodation for victims of Domestic Abuse (DA) and Violence against Women and Girls (VAWG) experiencing, or at risk of, street homelessness. The pilot programme was a policy response to the needs of a diverse group of highly vulnerable people, who require intensive, trauma informed support to help them make choices and decisions around next steps for recovery.

The Department for Levelling Up, Housing and Local Government commissioned a combined process and impact evaluation to understand how the programme has been implemented and the effect it had on the outcomes of people engaged on the programme. Importantly, the evaluation was designed to provide crucial insights and learning about the best ways to address and support the complex needs of those who accessed Respite Rooms.

The evaluation design was informed by the lived experience of victims and survivors of domestic abuse, as well as a range of expert stakeholders and a separate scoping and feasibility study. This ensured the evaluation aims were appropriate and relevant to the programme design, and the impact measures were robust and valid.

The evaluation included interviews with Respite Room users, Respite Room providers and site visits to Respite Rooms. The Impact Analysis compared the outcomes of Respite Room service users against those of a matched comparison group of non-users. The multi-stranded approach has allowed us to answer a range of research questions, with complementary findings that provide a rich, holistic picture of the programme and the impacts it delivered.

Findings from the evaluation indicate that Respite Rooms have been highly effective in providing support to a group of very vulnerable people.

Over the course of the pilot, nearly 800 individuals accessed the Respite Rooms, where they were offered practical, emotional, specialist and additional wraparound support. Service users rated the support they received very highly, remarking on the trust and quality of relationships they built with support staff.

Overall, Respite Rooms appear to have a significant positive impact on service users. On average, Respite Room service users received a greater number of services than those in the comparison group. Two-thirds of Respite Room service users moved to safe or secure accommodation after leaving a Respite Room, compared to under half of the comparison group after three months. Respite Rooms was also successful in reducing the likelihood of users continuing (or starting) to sleep rough or live in homeless hostels or night shelters.

The Respite Rooms programme has been highly successful in providing accommodation and support to victims of DA and VAWG experiencing, or at risk of, street homelessness. The programme design enabled the 12 pilot projects to develop a variety of approaches tailored to service users in their area. It enabled vulnerable individuals, many of whom had previously failed experiences of engagement with other services, to achieve positive

outcomes via local move-on destinations. 10 of the 12 Local Authority pilot programmes are continuing, and by sharing the learning from the programme more widely we have ensured that the best practice from the pilot programmes is taken forward across the sector.

The Department would like to thank all the participants who gave their time to help make the Respite Rooms and the evaluation a success.

We would also like to thank all the individuals from across government and academia who have provided insight and expertise that has greatly assisted in the delivery of the evaluation.

The Domestic Abuse Policy Team have provided insight and advice and their continued support for the evaluation has been invaluable. Colleagues we would like to thank specifically include Miranda Abrey, Caroline Jackson, Sophie Chapman and Chris O'Neill.

I would also like to express my gratitude to the analysts who have worked tirelessly on the delivery and management of the evaluation; this includes Ralph Halliday, Jean Davis, Lan-Ho Man, Sean Howell, Eline Jaktevik and Tajkia Uddin.

Thank you also to the Local Authority staff for making this evaluation possible, with particular recognition of their commitment to regularly submitting the data relating to the Respite Rooms and the individuals accessing the programme.

We are also extremely grateful for the hard work of the team at IFF which carried out the fieldwork and analysis for the evaluation – Sam Morris, Aoife Ni Luanaigh, Lorna Adams, Caroline Hewitt, and Hollie Jones.

Finally, thanks to Dr Susan Purdon and Caroline Bryson of BPSR for all their work on the design and implementation of the impact analysis, which has ensured the evaluation delivered highly robust quantitative measures of the effect of the programme.

Stephen Aldridge

Director for Analysis and Data and Chief Economist

Department for Levelling Up, Housing and Communities

1. Executive Summary

1.1.1. The Respite Rooms Pilot Programme provided single gender, single sex short stay supported accommodation for victims of Domestic Abuse (DA) and Violence against Women and Girls (VAWG) experiencing, or at risk of, street homelessness. It provided vulnerable people with intensive, trauma informed support and helped them make choices and decisions around next steps for recovery. The programme started operation in October 2021 in 12 English Local Authorities (LAs). It ran for 18 months with funding of £5.4 million and provided 121 bedspaces.

1.1.2. DLUHC commissioned IFF Research, working in partnership with Bryson Purdon Social Research, to carry out an evaluation and impact analysis. The evaluation included a literature and data review, interviews with stakeholders, Respite Room providers and Local Authorities, and case study visits to six Respite Rooms. These included interviews with Respite Room (current and former) users and staff working with them. The Impact Analysis compared the outcomes of Respite Room service users against those of a matched comparison group of non-users.

1.1.3. Overall, the evaluation found the Respite Rooms programme was highly effective in providing support to a very vulnerable group of people.

1.1.4. Over 16 months, the Respite Rooms admitted 792 individuals and offered practical, emotional, specialist and additional wraparound support. Service users rated the support they received very highly. The Respite Rooms allowed time for staff and residents to form one-to-one informal relationships and build trust.

1.1.5. Move-on outcomes and stay length varied substantially by Respite Room but were generally positive given the target group. A lack of suitable move-on provision was a major challenge, with most service users taking a longer time to move on than originally envisaged.

1.1.6. Key factors in determining successful move-ons included: the level of complex needs among service users; the proportion of service users with No Resource to Public Funds (NRPF); organisational effectiveness; having a diverse range of move-on services locally; and sufficient stay length to enable trust to be built between staff and service users. Stay length was longer than envisaged; providers felt that stays of several months would be more appropriate for women with very high needs.

1.1.7. Overall, Respite Rooms appear to have a large and statistically significant positive impact on service users. Respite Room service users received an average number of 4.03 services whilst in a Respite Room, compared to 2.53 among the comparison group. 65% of Respite Room service users moved to safe or secure accommodation after leaving a Respite Room, compared to 48% of the comparison group after three months. Respite Room users were notably less likely to continue (or start) rough sleeping or living in homeless hostels or night shelters.

1.1.8. The Respite Rooms programme has been highly successful in providing accommodation and support to victims of DA and VAWG experiencing, or at risk of, street homelessness. The programme design enabled the 12 pilot projects to develop a variety of approaches tailored to service users in their area. It enabled vulnerable

individuals, many of whom had previously failed experiences of engagement with other services, to achieve positive outcomes via local move-on destinations.

1.1.9. This was a complex and challenging evaluation because of the nature of the programme (intensive support aimed at a relatively small number of people) and the need to conduct depth research with very vulnerable people. Its success demonstrates that useful and robust data can be gathered from similar programmes to inform policy and design.

1.2. Introduction

1.2.1. This report summarises the final findings of the evaluation of the Respite Rooms pilot programme, an initiative to provide supported accommodation suitable for victims of Domestic Abuse (DA) and Violence against Women and Girls (VAWG) experiencing, or at risk of, street homelessness.

1.3. Policy background

1.3.1. **Existing evidence**

1.3.2. There is strong evidence that VAWG and homelessness are strongly linked. Safe accommodation is important in preventing further VAWG, such as further incidents by the same perpetrator or victimisation by other perpetrators in the future. Recognising that VAWG and homelessness are linked issues and often experienced by the same people, the Respite Rooms pilot was an intervention bridging the gap. The programme worked between existing street homelessness and DA and VAWG provision, aiming to help individuals with needs in both areas.

1.3.3. Respite Rooms built on the learning gained through the Green Room project in Westminster which pioneered this concept in the UK, to provide high needs supported accommodation for victims of DA and VAWG who are also experiencing, or at risk of, street homelessness.

1.3.4. **The pilot programme**

1.3.5. The Respite Room Programme was set up to trial an approach to providing single gender, single sex short stay supported accommodation to support individuals with intensive, trauma informed support and help them make choices and decisions around next steps for recovery. The programme had a particular focus on women who may have been living on the streets or in otherwise very precarious situations, with drug or alcohol dependency or mental health issues alongside histories of DA and VAWG. These individuals were targeted as they were unlikely to approach statutory services or the National Domestic Abuse Helpline. The trial programme started operation in England in October 2021 in 12 local authorities (LAs).

1.3.6. The pilot programme was originally designed to span one year. However, this was extended to 18 months and funding increased from £3.7 million to £5.4 million, providing 121 bedspaces. The service was targeted at those in need of high level of support and who might not, for various reasons, be willing, eligible, or able to use a conventional refuge. Services were designed to cater for service users with drug or alcohol

dependency or mental health issues alongside experiences of VAWG or DA. Respite Room spaces were designed for short-term stays, but with intensive, trauma-informed support to enable service users to make choices and decisions around next steps for recovery[1]. They were also, importantly, intended to create a base for referrals to other specialised accommodation and support.

1.3.7. It was initially expected that the length of an individual's stay would be on average two weeks, but as the pilot progressed it become apparent that a two-week stay was not a sufficient period of time for the majority of individual Respite Room service users.

1.3.8. **Evaluation aims**

1.3.9. In order to assess the outcomes and impacts of these pilot projects, and understand what value there is in the Respite Room model of delivery, DLUHC commissioned IFF Research, working in partnership with BPSR, to carry out this evaluation. Research questions covered nine key areas:

- Joint working to deliver Respite Rooms
- Access to Respite Rooms
- Supporting vulnerable individuals
- Additional support
- Move-on destinations
- Geographical variation
- What works
- Sharing learning
- Future of Respite Rooms

1.4. Research design

1.4.1. **The feasibility study**

1.4.2. The design for the evaluation was developed through a feasibility study, carried out by IFF Research, in partnership with BPSR, and completed in January 2022. This feasibility study identified a number of challenges the policy would face and which the evaluation would have to consider, which are outlined in Chapter 2. The study developed a route to carry out the evaluation, including risks and challenges, described in Chapter 3. A Theory of Change has been used as a basis for this evaluation and is shown in full in Annex C. The feasibility study also considered the possibility of an Impact Analysis for Respite Rooms, providing quantitative insight into the impact of the pilot projects. This was judged feasible and is included in Chapter 6.

1.4.3. The feasibility study found that a comprehensive Value for Money assessment was not appropriate for this project because it would have underestimated programme outcomes and impacts, which were likely to take longer to materialise. However, an Impact Analysis was probably achievable. Additional interviews carried out from August to December 2022 with LA and provider staff confirmed that the evaluation approach was appropriate, and helped to refine the design for the Impact Analysis.

[1] MHCLG (2021) *Respite Rooms Trial Programme: Prospectus.* May 2021.

1.4.4. **The evaluation design**

1.4.5. The methodology designed in the feasibility study was then further developed at the scoping stage of the evaluation itself in August and September 2022.

1.4.6. The research included key elements, carried out between September 2022 and February 2023:

- Stakeholder interviews, with national policy stakeholders.
- Project lead interviews, with LA and pilot project provider leads.
- Case studies, with six of the 12 pilot projects, including service user and staff interviews.
- Management Information analysis, analysing data collected from projects during the course of the evaluation by DLUHC.
- Impact Analysis, aiming to provide a quantitative assessment of impact.
- Reporting and presentations, including a large-scale online workshop in February 2023 to share knowledge with Local Authorities across England.

1.5. Research findings

1.5.1. **Respite Rooms design**

1.5.2. The concept of the Respite Rooms was based on the Green Room, Westminster and an example in Spain. These models both identified that the traditional DA refuge could not meet the very highly intensive support needed by this cohort of DA / VAWG victims, and that provision of specialist trauma support required a different approach. The concept of Respite Rooms was widely felt to be one which fulfilled an important gap in existing provision for women.

1.5.3. Due to the small scale of the pilot for Respite Rooms for men – two beds in Liverpool – it was less clear from the evaluation where this provision might sit if introduced elsewhere. This specific provision was successful in helping men with a lower level of immediate need but who were vulnerable and would be (or had been) abused or exploited on the streets or in accommodation for homeless men.

1.5.4. **Design successes and challenges**

1.5.5. The design of Respite Rooms generally worked well, and the procurement process was generally well received by LAs and providers. LAs with existing relationships with providers were able to get the Respite Rooms operational more quickly than those where such relationships did not exist.

1.5.6. In some areas, two or more organisations delivered core Respite Room provision, and in some of these it took time to develop effective joint working and clear leadership. Constructive and well-maintained links with other organisations who might interact with residents or bring referrals were crucial as often Respite Room users accessed the programme through existing links with other local services.

1.5.7. In areas where the LA maintained centralised control over referrals, this sometimes posed challenges in engaging people who were mistrustful of ‘authority’. This

sometimes resulted in inappropriate referrals or difficulties for eligible service users in accessing the service.

1.5.8. Despite these difficulties, the programme reached a good range of service users experiencing DA and VAWG with complex needs (including substance abuse and mental health problems). In a couple of areas, substantial numbers of service users had No Recourse to Public Funds (NRPF). Some services encouraged out of area referrals, while others seemed to limit it, especially where LAs had centralised control over referrals. The specific groups reached varied greatly by project, depending on the organisation leading it.

1.5.9. Respite Rooms designed their spaces to be as 'friendly' and home-like as possible to encourage informal interaction between residents and with staff. Secure and stable environments were considered key to success, as was an element of privacy, widely considered to be an improvement over the communal accommodation in the initial 'prototype' Green Room in Westminster. Support quality and accommodation quality were generally considered of equal importance.

1.5.10. Problems in design included close proximity to 'problem' services where perpetrators might live, or drugs might be available. The distance from these services did not need to be large (i.e. only a few streets) for a service to be successful. Indeed some project leads emphasised the importance of geographical proximity for engaging with potential service users through outreach and through contact with current or previous service users.

1.5.11. **Respite Room outcomes**

1.5.12. Over 16 months, the Respite Rooms admitted 792 individuals. The types of support offered in the Respite Rooms varied from practical and emotional support, to formal support provided by specialists and additional wraparound support. Some Respite Rooms provided greater levels of support than others. Some gave all users a standard set of types of support (always in addition to bespoke support), while others took a more targeted approach, with all support tailored to individual service users.

1.5.13. Overall, all forms of support envisaged by DLUHC in the design of the Respite Rooms were provided although some with greater reach than others, in terms of number of service users reached. Some services did not offer all forms of support, and the proportion of service users who engaged with each type of support varied by Respite Room. Some support was tailored by need and was not relevant to all service users. In other cases availability was limited (e.g. qualified counsellors were mentioned as difficult to source), and so support was targeted at those in most urgent need.

1.5.14. Some services offered additional forms of support, involving opportunities and activities for the women, forming part of a trauma-informed approach, centred on individuals. Many staff reported that residents needed support with basic life skills, as well as with the problems in their lives which Respite Rooms had been originally designed to address.

1.5.15. Outcome successes and challenges

1.5.16. Outcome successes and challenges included:

- 792 people with experience of DA/VAWG were admitted to and helped through the Respite Room pilot programme.
- Service users rated the support they received very highly, and often said it was quite unlike any support they had received elsewhere.
- Several service users noted that the Respite Room programme had helped them connect with people and 'normal life'.
- Staff emphasised the importance of the opportunity provided by Respite Rooms to form one-to-one informal relationships to build trust.
- The small size of the Respite Rooms programme made the informal additional support more deliverable.
- A lack of suitable move-on provision was reported to be a major barrier to provision by most of the Respite Rooms, with most service users taking a longer time to move on than was envisaged in the programme design.
- Difficulties with move-on included the lack of local accommodation services with low or medium support, finding housing providers who were willing to take service users with a history of rent arrears or debts, and high pressure on housing stock in some areas.
- However, longer length of stay in services was not solely due to move-on difficulties. Providers believed a length of stay measured in months would be more appropriate for most women with the highest level of needs, in large part due to the need to build trust over time and increase the chance of a sustainable, positive outcome.
- Move-on outcomes and stay length varied substantially by Respite Room, and some projects were certainly much more successful than others in achieving initially positive moves.
- Key factors in determining success in achieving move-ons included the level of complex needs among service users, and the proportion with No Resource to Public Funds (NRPF), but also:
    - Organisational effectiveness
    - A diverse range of move-on services available locally, ideally with strong links to the provider.
    - An environment in and around the service which enables service users to get away from their previous problems.
    - Sufficient stay length to enable trust to be built between staff and service users.

1.5.17. Respite Room impacts

1.5.18. For this evaluation the impact of Respite Rooms has been measured using an Impact Analysis, comparing the outcomes of Respite Room service users against those of a matched comparison group of non-users, having controlled for observed differences in characteristics and circumstances before the Respite Room service users entered the service. This ensures that like is being compared to like. The comparison group aims to represent what would have happened to the Respite Room service users if they had not gone into a Respite Room. The method is described in more detail in Chapter 6.

Overall, Respite Rooms appear to have a large and statistically significant positive impact both on the proportion of service users moving to safe accommodation and on the proportions receiving advice and support. For example, 65% of Respite Room service users moved to safe or secure accommodation after leaving a Respite Room, compared to 48% of the comparison group after three months. Overall, Respite Room service users had received an average number of 4.03 services whilst in a Respite Room, compared to 2.53 among the comparison group. This measured impact was robust, and positive outcomes remained through a series of sensitivity tests.

1.5.19. Respite Room users were more likely than the matched comparison group to leave to accommodation likely to be safe or secure. They were notably less likely to continue (or start) rough sleeping or living in homeless hostels or night shelters. This very much reflects the views of project leads and project staff, who felt that the Respite Rooms were having a strong positive impact on residents.

1.5.20. **Impacts on service users**

1.5.21. Qualitative evidence suggests that many (although not all) service users experienced positive impacts from using the Respite Room services. At the most basic these included simply recognising problems rather than denying them, but could for some users include rebuilding family relationships, building a sense of self-worth and the start of a return to normal life.

1.5.22. Staff and project leads often expressed surprise at how far some service users had come, especially those who had been cycling in and out of other services for many years. This suggests that this type of intensive engagement and holistic support offers a potential avenue to engage women with multiple complex needs. Although evidence is limited, the men's Respite Rooms project (targeted at men who were vulnerable to abuse, but not with the same level of complex need) was also appreciated by service users. Staff felt it had averted a spiral of decline into harmful behaviours and exploitation which was probable had they been admitted to a men's homeless shelter or spent longer on the streets.

1.5.23. **Wider impacts**

1.5.24. The extent to which the evaluation could gather evidence of impact on other less closely associated services (e.g. police and health services) was limited. However, project leads described how the Respite Rooms helped homelessness services by offering additional beds, removing hard-to-help and disruptive service users from DA refuges and homeless hostels. Interviewees also reported that health services have also been positively affected. There have reportedly been fewer missed appointments and fewer hospital visits thanks to Respite Rooms support, as well as a positive impact on police given some of the service users would have previously been involved in large numbers of callouts.

1.5.25. **Looking forward**

1.5.26. Project leads described workshops operated by DLUHC as very helpful in implementing the Respite Rooms. The workshop carried out for this research attracted 72 additional Local Authorities not involved in the pilot, indicating substantial interest from across the sector.

1.5.27. Most Project Leads stated that they would like to continue the Respite Rooms as they fill a gap in provision, at the time of carrying out follow-up interviews (January 2023), and by the time of writing (May 2023) most (10 out of 12) had managed to secure continuing funding. Some Respite Rooms had attracted additional funding from sources such as the Rough Sleeping Initiative, charitable grants or the New Burdens Duty funding. In at least one case this included ongoing funding for the pilot phase and beyond the end of March 2023.

1.5.28. **Conclusions**

1.5.29. The Respite Rooms programme has been highly successful in providing accommodation and support to victims of DA and VAWG experiencing, or at risk of, street homelessness. The programme design enabled the 12 pilot projects to develop a variety of approaches tailored to service users in their area. It enabled vulnerable individuals, many of whom had previously failed experiences of engagement with other services, to achieve positive outcomes via local move-on destinations.

2. Introduction

2.1. Summary

2.1.1. This chapter sets the Respite Rooms programme in context and summarises the purpose of this evaluation research. In summary, there is strong evidence that Violence against Women and Girls (VAWG) and homelessness are strongly linked, and that safe accommodation is important in averting further VAWG, including Domestic Abuse (DA).

2.1.2. Recognising that these are linked issues and often experienced by the same people, the Respite Room pilot is an intervention bridging the gap between existing street homelessness and DA and VAWG provision, aiming to help individuals with needs in both areas. It provides accommodation for victims of DA and VAWG who are also experiencing street homelessness, and who have complex needs.

2.1.3. In the context of a paucity of data on this type of provision, DLUHC commissioned this evaluation to assess what constitutes good delivery of the programme and, in particular, what is effective in helping individuals to access the support they need to make choices and decisions around next steps for recovery.

2.2. Policy background

2.2.1. Policy context

2.2.2. Violence against Women and Girls (VAWG)[2] including Domestic Abuse (DA) is one of the most frequent contributors to women's homelessness. Women who experience violent victimisation are at significantly higher risk of homelessness, and this risk increases with multiple experiences of violence and abuse (Broll & Huey, 2020).

2.2.3. Leaving an abusive relationship often means having to leave home, disrupting everyday life and support networks significantly and increasing the risk of being precariously housed or homeless (Power, 2019; Rabiah-Mohammed, et al.,2019). In England in April to June 2022, DA was the second most common single reason for statutory homelessness, accounting for 17% of households owed a relief duty[3], and had substantially increased as a source of homeless acceptances by Local Authorities (LAs) since 2019[4].

2.2.4. Without Safe Accommodation, women who experience homelessness are at greater risk of violence, abuse, and exploitation (VAWG), particularly if sleeping rough or in male-dominated service settings (Batchelor & Sanders, 2021; Brott, et al.,2021; Meyers, 2016). Furthermore, for women who have experienced DA, the risk that victims will return to previously abusive partners rises (Allen, 2017), and there is no reason to assume that this applies differently to victims of DA who are rough sleeping. There is

[2] Including harassment, stalking, rape, sexual assault, murder, coercive control, domestic abuse, 'honour-based' abuse (including female genital mutilation and forced marriage and 'honour' killings), and 'revenge porn.'
[3] The relief duty on Local Authorities requires them to support all eligible homeless households to find accommodation within 56 days.
[4] DLUHC (2022). *Statutory homelessness in England: April to June 2022.* November 2022. Accessed at: https://www.gov.uk/government/statistics/statutory-homelessness-in-england-april-to-june-2022.

therefore a cyclical relationship between gender-based violence (VAWG including DA) and homelessness, with women who experience gender-based violence having increased vulnerability to homelessness, and street homeless or precariously housed women being at greater risk of violence and abuse.

2.2.5. As a result, this is a potentially highly vulnerable population, with very specific service needs, who would benefit significantly from a single-gender integrated service that draws together crisis accommodation and other targeted support[5]. Finally, within this population there is a group of victims who have no recourse to public funds (NRPF), primarily as a result of their immigration status. While relatively small in number, this group are particularly difficult to house because they cannot receive Housing Benefit regardless of need and, depending on their circumstances, may not be permitted to work.

2.2.6. **Policy rationale**

2.2.7. Respite Rooms offer an important potential solution to a significant gap in housing and service provision for those who have experienced DA or are at risk of such violence, and have particularly complex needs including: alcohol and substance misuse issues, mental health issues, people who have been victims of trafficking and people with no recourse to public funds. Individuals who cannot be accommodated in traditional 'refuge' or 'shelter' accommodation, often because of complex and intersecting needs, are commonly also too vulnerable to be accommodated in other forms of emergency shelter, or placed straight into housing with less support. These individuals can 'fall through the cracks' in housing and service provision, leaving them vulnerable to street homelessness and further violence and exploitation.

2.2.8. Respite Rooms offer a person-centred approach to meet the needs of these extremely vulnerable people who are street homeless, or at risk of, street homelessness who need specialist support to recover from the trauma of violence and abuse. This programme fits into the Government's wider work on tackling VAWG.

2.2.9. **Policy design process**

2.2.10. Policy stakeholders explained that the Respite Rooms programme was developed by DLUHC based on the Green Room project in London, operated by St. Mungo's and funded by Westminster Council, which was established in 2018/19. One stakeholder mentioned that the Green Room had itself been inspired by short-stay direct access DA refuges with communal accommodation which are widespread in Spain[6].

2.2.11. The Green Room service was introduced as communal accommodation for homeless women with multiple complex needs, including VAWG. The council and provider staff had noticed that there was a group of women who needed help with VAWG but who could not be helped by conventional DA services. DA refuges are generally not intended for high needs individuals, whose behaviour might be disruptive or distressing to other service users, particularly when they have children:

[5] One Respite Room also has provision for male victim-survivors of DA, in a single-gender space.
[6] We describe the selection of policy, charity and delivery stakeholders we interviewed in Chapter 3.

> "[The Green Room was about] meeting that gap between more mainstream refuges, who struggled to meet the needs of our women, particularly drug use, challenging behaviour, pets… We needed something… that was accessible for our client group."

2.2.12. The core design for the Respite Rooms built on this, but with some key differences, the most important being the move to self-contained accommodation:

> "They would prefer their own spaces, and for some women that is the difference between coming in and not coming in and they feel more independent."
>
> Provider Lead

2.2.13. The DLUHC programme design specified that funding was to be used for single-sex safe housing and trauma-informed support to victims of domestic abuse, rape or sexual assault, sex workers, victims of exploitation, or violence who are sleeping rough, or at risk of, rough sleeping. DLUHC invited 21 LA areas in England with high numbers of rough sleepers to bid. LAs were required to put forward proposals setting out how they would deliver the Respite Room programme in their area. There was some flexibility in the bid for LAs to design the delivery set up and wraparound support that they felt best met the needs of the local area. This variation could also help identify in the pilot which models and approaches work most effectively. LAs were also encouraged to partner with specialist DA and homeless organisations. LA bid designs varied in physical design, number of bed spaces (from four to 18), referral routes, what and how support services were offered, staffing.

2.2.14. Successful bids were chosen based on evidence of collaboration with local domestic abuse and homelessness teams (within the LA and amongst sector partners) and alignment with wider local strategies to tackle DA, VAWG and rough sleeping. The 12 successful areas taking part in the pilot were; Bournemouth, Christchurch and Poole; Birmingham; Bristol; Camden; East Sussex; Exeter; Leicester; Liverpool; Manchester; Nottingham; Portsmouth; and Westminster.

2.3. Existing knowledge

2.3.1. There is limited evidence on homelessness amongst people who have experienced DA and other forms of VAWG. This evaluation of the Respite Room programme allowed DLUHC to measure the impact of this specialist service within this context of data paucity. The literature review conducted for this evaluation found that there is no consensus around the most appropriate way of measuring the outcomes of VAWG and DA provision and related homelessness provision (see Annex A for the full review). The policy documents reviewed commonly held that there are gaps in evidence on 'what works' in DA provision due to a lack of robust data collection which in turn have resulted in very few impact evaluations being conducted.

2.3.2. Provision is often commissioned and implemented without appropriate monitoring which results in a lack of objective evidence on the effectiveness of different types of provision. The Respite Rooms programme aimed to incorporate an evaluation from the outset to show the impact of the service and provide learnings for the sector more broadly.

2.3.3. In the feasibility study for this evaluation, consideration was given to what available statistics could offer a way of monitoring the intersection of DA and homelessness. The study concluded that homelessness statistics were limited in coverage, because they were dependent on either (A) victims identifying themselves including their status as DA victims to an LA, or (B) the victims being street homeless and visible. The feasibility study noted that LAs in England, in their mandatory data gathering on statutorily homelessness included a flag of DA both as a cause of homelessness and as an incidental factor. However, this data excluded people who did not approach the LA, a key client group for Respite Rooms.

2.3.4. The study found that an evaluation of the Respite Room was viable because the Respite Room providers monitored their clients from entry; commonly collecting information on demographics, health, current housing, family, and relationships. In addition, data was sometimes held on wellbeing, mental health and risk, with ongoing monitoring continuing during contact with the service. Short-term outcomes data were also collected and shared with LAs. The feasibility study concluded by identifying specific metrics which could be used to measure the impact of the Respite Rooms.

2.4. Research questions

2.4.1. DLUHC commissioned this evaluation to assess what constitutes good delivery of the programme and, in particular, what is effective in helping individuals to access the support they need to make choices and decisions around next steps for recovery. DLUHC's research questions included:

2.4.2. **Joint working:**

- To what extent has the Respite Room programme enabled better joint working between LAs, housing providers and other support providers?

2.4.3. **Access to Respite Rooms:**

- How do Respite Rooms reach those in need of support, and would these individuals access support otherwise?

2.4.4. **Supporting vulnerable individuals:**

- To what extent has the Respite Room programme met its objectives, including supporting vulnerable individuals?
- What helped or didn't help this to happen?

2.4.5. **Additional support:**

- To what extent has the programme guided vulnerable individuals to accessing additional support?

2.4.6. **Move-on destinations:**

- To what extent have individuals leaving the Respite Room gone on to positive destinations (e.g. other forms of Safe Accommodation)?

2.4.7. **Geographical Variation:**

- What does the Respite Room model look like in different locations?
- How are LAs and partners able to tailor the model for local needs?

2.4.8. **What works:**

- What lessons have been learned about what works or doesn't work in supporting very vulnerable individuals?
- Are there specific activities that have been particularly effective?

2.4.9. **Sharing learning:**

- To what extent has learning been shared between the 12 pilot areas?
- To what extent has learning been shared with other LAs and housing providers?

2.4.10. **Future of Respite Rooms:**

- What could the future for Respite Rooms look like beyond the pilot?

2.5. Structure of this report

2.5.1. This report combines analysis from all of the research activities carried out within the evaluation under a series of thematic headings. Most sections of the report also draw on secondary data gathered by DLUHC as part of the monitoring of the pilot programme, and in various places draw on the literature review carried out as part of the feasibility study, and updated for this evaluation. The research activities which contributed to the report are described in the next chapter.

3. Research design and methodology

3.1. Summary

3.1.1. This section of the report summarises the design of the evaluation, with further detail provided in Annex C.

3.1.2. The design was originally developed through a feasibility study, carried out by IFF Research, in partnership with BPSR, and completed in January 2022. The methodology was further developed through a scoping stage for the main Respite Rooms evaluation, in August and September 2022.

3.1.3. The research included telephone interviews with stakeholders, with project leads in all 12 pilot areas, and face-to-face interviews with frontline staff and service users in six areas selected for case study. It also included a quantitative Impact Analysis based on data gathered from pilot projects specifically for the research, as well as review and analysis of monitoring data gathered by DLUHC during the pilot projects.

3.1.4. The feasibility study also included a literature review, which has been further updated since. The outputs from the literature review are provided in Annex B alongside the methodology used to produce it.

3.2. Testing the policy

3.2.1. **Intended policy outcomes**

3.2.2. The Respite Rooms pilot programme, which started operation in 12 LA areas in England in October 2021, aimed to establish short stay supported accommodation facilities for people affected by Violence against Women and Girls (VAWG) including Domestic Abuse (DA) who are rough sleeping, or at risk of, (street) homelessness. The service was targeted at those in need of a high level of support, and who might not, for various reasons, be willing, eligible, or able to use a conventional refuge. Services were expected to cater to service users with drug or alcohol dependency or mental health issues, alongside experiences of VAWG or DA.

3.2.3. The Respite Room spaces are designed for short-term stays, but with intensive trauma-informed support to enable them to make choices and decisions around next steps for recovery[7]. They are also, importantly, intended to create a base for referrals to other specialised accommodation and support.

3.2.4. The service is intended to offer a high level of support, for those who might not, for various reasons, be willing, eligible, or able to use a conventional refuge. Originally designed to span one year, the pilot programme was extended to an 18-month period and funding was increased from £3.7 million to £5.4 million, providing 121 bed spaces[8] across the 12 areas. It was initially expected that the average length of stay would be

[7] MHCLG (2021) *Respite Rooms Trial Programme: Prospectus.* May 2021.
[8] Data sourced from DLUHC, February 2023.

two weeks, and the programme was expected to support approximately 1,500 individuals over its duration.

3.2.5. **Challenges for policy design**

3.2.6. Among stakeholders and LA project leads, there was widely (although not universally) felt to be a good fit between Respite Rooms and other services, such as housing and health, with the new service sitting between homelessness and DA. This did sometimes present challenges in terms of whether the service should sit *more* in the homelessness sphere or the DA sphere. Stakeholders had differing views on this, although overall most felt that this crossover was a strength rather than a weakness of the programme:

> "There's two types of skill sets [homelessness and DA] which have often [each] worked in a bit of a silo, and now it comes together in the Respite Room model – and I think that then develops a lot of understanding."
>
> Stakeholder

> "Many years ago, [DA refuges] would also have included these kind of emergency rooms… so I'm slightly nervous about creating something new when… should we [providers] actually be reinstating [those]."
>
> Stakeholder

3.2.7. This positioning also presented organisational challenges for some LAs in working across departments or (in some areas) between district and county LAs. Relatedly, potential service delivery providers generally had expertise in homelessness or DA, but less frequently in both.

3.2.8. While there was wide agreement on intended beneficiaries for the Respite Rooms and the types of support which should be included, there were some areas of uncertainty in the design. In particular, stakeholders had widely differing views on the length of stay which was optimum for Respite Rooms, with views on this ranging from days to months. In general, provider leads felt that longer stays were appropriate, while policy and other national level stakeholders saw potential benefit in a shorter stay model.

3.2.9. **Challenges expected for policy delivery**

3.2.10. As a new type of scheme, Respite Rooms faced a number of design challenges. Firstly, the scale of need was unknown. Although many providers of DA or homelessness services were aware of the group of potential service users, there were no reliable estimates of numbers (not least as female homelessness is often hidden). While it is known that DA and VAWG is a widespread cause of homelessness among women[9], multiple stakeholders were concerned that the target group would be difficult to locate and engage. This made it hard to judge whether services would be well-used or, conversely, overwhelmed with demand.

3.2.11. Multiple stakeholders pointed out that demand being too high might result in beds being full when needed in an emergency, reducing the effectiveness of the accommodation for those in crisis. One stakeholder also made the point that overloaded services would be

[9] DLUHC (2022). *Statutory homelessness in England: April to June 2022.* November 2022. Accessed at: https://www.gov.uk/government/statistics/statutory-homelessness-in-england-april-to-june-2022.

dealing with acute demand and there would be a temptation for staff to focus too strongly on dealing with residents' immediate problems, rather than longer term concerns.

3.2.12. The pilot project was also initiated at a time when many other changes were underway to VAWG and DA provision by LAs. One policy stakeholder noted how the policy was competing for the attention of LA and provider staff with a range of other new activities, in particular the simultaneous implementation of the Duty to provide support in DA Safe Accommodation. In addition, in order to test the concept quickly, the pilot projects needed to start in a short time period, presenting significant organisational and recruitment challenges.

3.2.13. Finally, multiple stakeholders also highlighted that the new pilots were operating in a resource-poor environment with other 'neighbouring' services, both DA and homelessness, experiencing lower levels of funding. One stakeholder felt strongly that funding to existing services should be prioritised before introducing new services. A key challenge therefore was to make the case for the value of this new type of provision relative to other services competing for funding. Stakeholders also mentioned the risk that delivery, even if successful, might not have successful outcomes due to a shortage or absence of suitable move-on accommodation.

3.3. Theory of Change

3.3.1. This section describes the Theory of Change (ToC) that was developed to underpin all activities in the evaluation. A ToC sets out how a programme is intended to work, including the resources used (inputs), programme activities and outputs, and anticipated outcomes and impacts on the target groups (programme beneficiaries).

3.3.2. The ToC has an overarching rationale which sets out the problem and reasons for intervening. It identifies the scale of the issue, and the justification for the policy. For Respite Rooms, the rationale for intervention includes the scale of the issue (1 in 5 women experiencing DA in the UK will be homeless at some point) and the nature of the problem (a high proportion of street homeless women have experienced domestic abuse, sexual violence, or trauma). The justification for the policy is that there is insufficient suitable Safe Accommodation for people with multiple, complex needs. In addition, it can be difficult for these individuals to access holistic and person-centred support available even where this exists, because they do not trust government services and are unlikely to seek support through usual channels.

3.3.3. The ToC has five main elements:

- The **inputs** and resources (in terms of time and money) that are required to deliver the Respite Rooms programme.
- The **activities** are the tasks which are carried out with the resources available (inputs). The activities column provides an overview of the main tasks that are expected to be carried out as part of the Respite Rooms programme. Activities include developing new processes to reach vulnerable individuals and assessing their support needs.
- **Outputs** are the short-term or immediate results of the activities, which help to achieve the wider outcomes. They include the number of bed spaces created for

the Respite Rooms programme, and the number of people who access Respite Rooms.

- **Outcomes** are the wider changes that should occur as a result of the Respite Rooms programme development and activities. Some outcomes may be evident in the relatively short-term, but others may take several years to occur. Measuring progress against outcomes is important as it enables project funders and stakeholders to identify if the programme is having the desired effect, and to reflect on what changes might be necessary.
- **Impacts:** These are the ultimate effect of the combined outcomes and the programme's end goal. For example, it is likely that interventions will contribute to meeting impacts, rather than being their sole cause: for example, Respite Rooms on its own is unlikely to guarantee an improved response to survivors of VAWG including DA, sexual violence and trauma with complex needs, but it can make a significant contribution towards changing LA responses and disseminating best practice, thus making this impact more likely.

3.3.4. The Theory of Change is underpinned by agreed assumptions about how the programme will work and likely results of activities, including unintended ones. These assumptions are based on the evidence and literature review, as well as discussions with expert stakeholders, LA staff, and providers that took place as part of the feasibility study and during the evaluation. The full ToC and assumptions are provided in Annex C.

3.4. Designing the evaluation

3.4.1. Design process

3.4.2. The feasibility study provided DLUHC with advice on a suitable design for the evaluation of the Respite Rooms programme. It included a literature review; document review; in-depth interviews with 20 stakeholders; three case studies of individual Respite Rooms; and development of the ToC and Evaluation Framework.

3.4.3. A review of policy documents and data on the subject of measuring VAWG and DA found that there was no consensus around the most appropriate way to measure the outcomes of VAWG and DA services, and no established 'standard' methodology for this. This left the design for the evaluation very open.

3.4.4. To assess the impact of any programme, it is necessary to gather data on those using the programme, and compare this to either their previous situation, or the situation of a similar group of people who were not helped (a 'counterfactual' group). The key challenges for evaluating Respite Rooms, identified in the feasibility study, were:

- **Scale** – as a project providing support to a relatively small number of people, across 12 pilot areas, it was anticipated that impact on whole-area statistics would be weak.
- **Other activities** – most or all relevant whole-area metrics might also be affected by other, wider changes taking place, making it hard to detect the impact of the Respite Room alone.
- **Intended client group** – many of those using the service might not previously have engaged with services and thus might not appear in databases, making

tracking their situation challenging, and making it difficult to find data about similar people to compare them to.
- **Working across boundaries** – clients of services may move across LA boundaries frequently, therefore their progress over time would not be tracked by local services.
- **Long-term nature of key impacts** – the programme ultimately aims to help clients back to a 'normal' life – but interviewees believed this would take a long time, beyond the time horizon for the evaluation, making it difficult to detect the full impact.
- **Delays to provision** – Respite Room provision was delayed in some cases, presenting challenges to delivery timescales and meeting targets.
- **Disparate and incompatible monitoring systems** – beyond DLUHC data gathering, metrics and data systems were not compatible, making it difficult to find and monitor a group of people to compare Respite Room users against.

3.4.5. Research ethics

3.4.6. Undertaking research with vulnerable people raises additional ethical issues around consent, confidentiality, and tracking participants. Respite Rooms users are, by definition, highly vulnerable; as well as having experienced DA, or other forms of VAWG, they are likely to have additional support needs, including those stemming from trauma and drug or alcohol dependency. While vulnerability is a fluctuating condition, people who have experienced abuse and/or trauma are likely to remain vulnerable for a significant period of time, and talking about their experiences is likely to be difficult even after a significant period of elapsed time. The key considerations for interviews with Respite Room (former) users were maintaining confidentiality and avoiding harm. The approach to the evaluation included:

- Ensuring throughout recruitment and during interviews that all interviewees were taking part on a voluntary basis, and understood that they could withdraw at any time before, during, or after the interview.
- To minimise barriers to taking part, participants were offered the choice to take part in person, via Zoom and Teams, or over the phone.
- Informing participants of confidentiality and the disclosure policy. The participant consent guidelines ensured respondents provided explicit and informed consent.
- A dedicated interviewing team with experience and appropriate training in conducting research among vulnerable audiences.
- An agreed policy for breaking confidentiality with participants (for example, if a child was at risk of / had been harmed, or if anyone was at risk of immediate harm).

3.5. Research design

3.5.1. The suggested evaluation approach was for a comprehensive programme of data collection and analysis which did not impose undue burden or cost on providers. It included:

- Interviews with national-level stakeholders – to explore if the programme was delivering as expected, and if the objectives, aims and reason for intervention were still valid

- Review of MI returns from local areas to DLUHC – to provide a detailed indication of who was being supported and how the programme was working in practice
- Depth case studies with six areas – to help assess the programme elements that worked well and less well, the quality of support provided, and the impacts on people supported.
- Interviews with programme beneficiaries – to provide information on how the programme was working, attitudinal changes, and potential improvements to the programme.

3.5.2. The feasibility study found that a comprehensive Value for Money assessment was not appropriate because it would have underestimated programme outcomes and impacts, which were likely to take longer to materialise. But it was likely that an Impact Analysis was feasible. Additional interviews carried out from August to December 2022 with LA and provider staff confirmed that the evaluation approach was appropriate, and helped to refine the design for the Impact Analysis. The latter was also peer reviewed by an external expert (Prabhat Vaze from Belmana). Further detail on the research design is provided in Annex C.

3.5.3. **Phases**

3.5.4. The evaluation was organised into six phases running from July 2022 to March 2023.

3.5.5. **Phase 1 (inception and review of approach)** included evaluation set up, scoping interviews with DLUHC staff, a light touch data/literature review, and a review of the key feasibility study outputs (Theory of Change, logic model, and evaluation framework) and proposed evaluation approach.

3.5.6. **Phase 2 (process evaluation design)** focused on agreeing and refining the evaluation approach, including developing and signing off the key research questions, tools, ethics and data protection protocols, approach and timescales.

3.5.7. **Phase 3 (process evaluation fieldwork)** included management information (MI) analysis, stakeholder interviews, project lead interviews with LAs and providers, and six detailed case studies, each focusing on one Respite Room area.

3.5.8. **Phase 4 (Impact Analysis scoping and design)** ran in parallel with Phases 2 and 3. Measuring the impact of the Respite Room programme required longitudinal data on the outcomes of both Respite Room clients and on a suitable comparison group, to provide counterfactual outcomes data for what happens in the absence of Respite Rooms. This phase included scoping interviews with data leads, a recommendations paper on whether or not to proceed to a full impact study, and a detailed design paper for the Impact Analysis.

3.5.9. **Phase 5 (Impact Analysis fieldwork and data review)** included liaising with data leads to identify suitable groups of comparison individuals; collation of the (anonymised) comparison data; and detailed analysis and reporting.

3.5.10. **Phase 6 (reporting and dissemination)** included peer review, a dissemination workshop, and the evaluation report. DLUHC, LA and provider stakeholders were invited to the workshop which focused on key findings from the evaluation which LAs

could use for future commissioning decisions, and sharing learning and practical pointers on delivery.

3.6. Research elements

3.6.1. Stakeholder interviews

3.6.2. In order to shape the design of the evaluation and provide context for summative reporting, seven stakeholder interviews were carried out between November 2022 and January 2023. These interviews, with DLUHC and external policy stakeholders, third sector organisations and academics, provided insight into the wider context for the Respite Rooms programme. They also provided insight into the origins of the policy design, and explored challenges the Respite Rooms were likely to face.

3.6.3. The topic guide for the interviews was designed in consultation with DLUHC. Topic guides are provided in Annex D Interviewees were provided with a privacy notice and consent form regarding data protection and usage of the interview results. Where interviewees agreed, interviews were recorded for ease of analysis and quality control.

3.6.4. Interviews were subsequently analysed through the use of a bespoke analysis framework, and emerging themes and conclusions shared with DLUHC in analysis meetings in January and February 2023. Findings and quotes from these interviews are used throughout the report.

3.6.5. Project lead interviews

3.6.6. Interviews with project leads formed a core part of the evaluation. These telephone and online interviews[10] targeted LAs and Respite Room provider staff who had led on the design and implementation of each of the 12 local Respite Room pilot projects. The interviews took place in two waves, the first between October 2022 and January 2023, and the second in February 2023.

3.6.7. The first wave interviews covered the bidding process, the setup and operation of projects and support provided. They also covered short term outcomes and impacts on service users. The second wave of interviews focused more on long-term outcomes, sharing learning, and plans for the future of projects, and was also used to fill gaps in knowledge which emerged from analysis of the first round of interviews.

3.6.8. Topic guides for these interviews were developed for LAs and service providers, with questions tailored to their specific roles in the project. Both were designed in consultation with DLUHC and are provided in Annex D Interviewees were provided with a privacy notice and consent form regarding data protection and usage of the interview results. Again, where interviewees agreed, interviews were recorded for ease of analysis and quality control.

3.6.9. In total, 49 interviews were carried out over both waves of this strand, including 41 people (some individuals were interviewed twice)[11]. Several services did not have a

[10] Two interviews were carried out face-to-face during a case study visit, for practical reasons.
[11] In the first wave, a total of 27 interviews (covering 32 people due to joint interviews) took place, and in the second wave there were 22 interviews (covering 26 people due to joint interviews).

single organisation acting as lead provider, but instead consisted of an equal partnership of two or more organisations. In addition, some LA and provider staff changed between the first and second waves of interviews.

3.6.10. In the first wave of interviews, both LA and provider leads were interviewed for all 12 pilot Respite Room projects. In the second wave, LA and provider leads were interviewed for 11 of 12 projects, and a provider lead only for the remaining project.

3.6.11. Interviews were subsequently analysed through the use of a bespoke analysis framework, and review in analysis meetings with DLUHC in January and February 2023. Findings and quotes from these interviews are used throughout the report.

3.6.12. **Case studies**

3.6.13. In-depth case studies were included in the evaluation to enable more in-depth understanding and analysis of how projects operated and provided an opportunity to interview both service users and the staff working with them. Face-to-face case studies were carried out at six of the 12 pilot Respite Room projects, from November 2022 to January 2023. Each of the six case studies started with a planning interview with the project lead, and then included a target four to five interviews with service users, and interviews with two to three staff, interviewed as a group or separately.

3.6.14. Case study areas were selected purposively in consultation with DLUHC to provide a spread of LA structures and project designs. The approach taken was to select six areas, and if an area declined to be a case study to select a replacement area in consultation with DLUHC.

3.6.15. The six case study areas were:

- Exeter
- Leicester
- Liverpool
- London Borough of Camden
- Manchester
- Portsmouth

3.6.16. Interviews were carried out, where possible, face-to-face on the provider's premises. Interviewees were provided with a privacy notice and consent form regarding data protection and usage of the interview results. Service users were provided with additional information before and after the interview, covering information on where to seek help with the issues discussed, as well as data protection information.

3.6.17. Where interviewees consented, interviews were recorded for ease of analysis and quality control. For service users, additional measures were taken (detailed in Annex F) to ensure that the research was carried out in an ethically sound and trauma-informed manner, ensuring that meaningful consent was given to take part and any potential risks to service users were minimised. For example, measures were taken to avoid IFF Research at any point holding identifiable service user data such as names or contact details, primarily by organising the interviews through the service provider.

3.6.18. Interviews were subsequently analysed through the use of a bespoke analysis framework, and reviewed with DLUHC in analysis meetings in January and February 2023. Findings and quotes from these interviews are used throughout the report. Further information regarding the methodology for these interviews is provided in Annex C and the topic guides used for these interviews are included in Annex D

3.6.19. **Impact Analysis**

3.6.20. The Impact Analysis, carried out by BPSR, was included as part of the evaluation in order to provide additional quantitative rigour, ensuring that the opinions and experiences gathered through the qualitative interviewing were validated. It also enabled the impact of Respite Rooms on service users to be isolated from the impact of wider changes occurring at the same time.

3.6.21. The core of the Impact Analysis is a comparison of move-on and support referral outcomes for a group of Respite Room users (the 'treatment group') with a group of people in the same LA areas whose starting situation was similar but who did not enter a Respite Room (the 'comparison group'). This used data gathered from LAs providing Respite Rooms by IFF Research specifically for this purpose.

3.6.22. A series of interviews was carried out between October and December 2022 with staff dealing with DA, Homelessness and/or Respite Room data at all 12 LAs involved in the Respite Room pilot. In 11 cases these people were LA staff, and in one case lead provider staff (who were best placed to assist in that case due to the wide range of other provision they operated in that LA). Interviewees were provided with a privacy notice and consent form regarding data protection and usage of the interview results. Where interviewees consented, interviews were recorded for ease of analysis and quality control.

3.6.23. Data was then submitted by 11 of the 12 area in an anonymised spreadsheet, transferred via a secure file transfer system. Ultimately, nine of the 12 projects were able to provide useable data for both the 'treatment group' and 'comparison group', sufficient for the Impact Analysis to take place. The outcome of the Impact Analysis is covered in Chapter 6. of this report. Further information regarding the Impact Analysis methodology is included in Annex A, and the topic guides used for interviews regarding data availability are included in Annex D.

3.6.24. **Management Information (MI) data analysis**

3.6.25. The final element of the research was analysis of data gathered by DLUHC through the routine (monthly) monitoring of projects. The framework for monitoring was designed by DLUHC, informed by the findings of the Feasibility Study. Data regarding service users were compiled in aggregated form by providers and LAs and gathered via the pre-existing DELTA monitoring system12.

3.6.26. The data includes information on admissions, demographics, support provided, referrals to other support, and move-on destinations, as well as basic measures of service user satisfaction. This data was subjected to extensive consistency checking and corrections

[12] DELTA is the online system developed by the Department for Levelling Up, Housing and Communities (DLUHC) to streamline its processes and systems for collecting statistical data and grant administration. See DELTA | Frequently Asked Questions (communities.gov.uk)

at IFF Research and DLUHC throughout Autumn 2022 and Winter 2023, including contacting LAs for clarification where data was contradictory.

3.6.27. The data was compiled into a dataset covering all 12 pilot projects and analysed using a tabulation tool to produce totals across all projects. This dataset is the main source of quantitative data used throughout the report. Further information regarding the methodology for this analysis is available in Annex C.

4. Respite Room design

4.1. Summary

4.1.1. This chapter focuses on the design of the Respite Rooms, from the initial bid process and establishing joint working to the practicalities of the accommodation and services provided.

4.1.2. In summary, all Local Authorities (LAs) who submitted a bid had recognised an important gap in their current provision that could be met by the Respite Rooms concept. Their approaches differed depending on the local need. Some bids partnered with one, single organisation, and others involved multiple partnerships. The latter felt that they benefited from a diversity of existing skills and could draw on these to produce a more rounded and holistic service. However, the more organisations involved in a Respite Room, the more time-consuming it was (generally) to establish smooth joint working. In some cases, this caused delays in getting the Respite Room set up and running.

4.1.3. Most LAs believed they had strong relationships with providers, and providers generally stated their relationships with LAs were positive. No long-term issues were reported. Where Respite Rooms provider staff worked directly with third parties, such as the police, health services, and other housing or support providers, these relationships were generally positive. There were, however, issues with the newness of the Respite Room concept in that staff at other organisations did not always understand the nature of provision and the vulnerability of many residents, leading to misunderstandings which on occasion led to significant difficulties for individual projects.

4.1.4. Referral routes differed across projects, with some areas developing an extensive network of referral links and others working solely with the LA. The Respite Rooms areas that used multiple referral pathways felt that they were more successful in receiving appropriate referrals as a result of this. These providers recognised that the individuals who would benefit from the pilot had complex needs and complex circumstances that made them difficult to find. The best chance of finding such women was to engage with organisations (often charities) who offered support to vulnerable women but were not seen as “the authorities.” This worked best when referral organisations collectively supported a range of vulnerabilities.

4.2. Bid process and joint working

4.2.1. **Approaches to procurement**

4.2.2. The LAs which applied to take part in the Respite Rooms pilot all described an important gap in their current provision that the Respite Rooms could fill, namely supporting (predominantly) women experiencing DA/VAWG who were at risk of or currently rough sleeping, who also had complex needs such as substance misuse, trauma and mental health issues. This combination of circumstances, particularly complex needs involving substance misuse issues, meant that such women sometimes struggled to access existing provision (e.g. refuges refusing to admit women who did not engage with substance misuse services).

> "A lot of these women are the women that slip through the net. These are women, and males, we can't offer refuge to."
>
> LA Lead

4.2.3. LAs also recognised that women in such circumstances required gender-specific provision for their own safety and wellbeing, where the male perpetrator of DA could not find them.

> "There is a clear need for gender-specific provision…I'm a strong advocate of having a women's only service., because of the need for security, and safe and secure accommodation."
>
> LA Lead

4.2.4. The first step for LAs was to identify a provider(s) to partner with to deliver a Respite Room in their local area. The process for this varied somewhat, but generally involved:

- Discussion with other relevant teams within the LA (usually the Housing team, the Rough Sleeping team, and the Domestic Abuse team) about which provider(s) to approach.
- For some, discussion with the Commissioner and/or DLUHC about what support they could expect.
- Approaching local provider(s) – the exact provider depended on the specific gap(s) in their current provision that they hoped the Respite Room would fill.

4.2.5. Pilot LAs had slightly different requirements from their providers in terms of their remit, responsibilities and specialisms, but typical provider responsibilities included:

- Provision of accommodation (the physical building(s) housing the Respite Room) and security for the building(s).
- Provision of staff to run the Respite Room on a day-to-day basis and support service users.
- Provision of / liaising with specialist staff to attend the Respite Room regularly (e.g. weekly) to support service users (e.g. substance abuse specialists, counsellors, mental health specialists etc.).
- For some, providers who would lead on identifying and referring suitable service users for the Respite Room.

4.2.6. Most LAs selected providers with whom they had an existing relationship. This was both because of tight timescales, which did not allow time to put the bid out to tender, but also because the requirements were relatively specialised so few local providers could meet them. LAs provided reasons for selecting particular providers that reflected their local needs.

> "[Provider] was the perfect fit for the provision, in having a wide range of teams and projects already working with a range of women in specific vulnerable groups. They also had a building in a perfect location for the Respite Room and could make space for it in there."

> "We had a domestic abuse provider that we knew would be interested and we had a homelessness provider that we knew would be interested. And so we worked really closely with our procurement team to work out how we could work around the procurement rules."

> "This area doesn't have a large number of operators. We're not blessed with organisations with both buildings and the skills around support. So, our approach was to seek a partnership with our existing provider of services for victims of domestic abuse - they provide outreach in our two refuges. Rather than go through a competitive process, which we probably could foresee the outcome of, in that there would only really be a single provider in the market interested…we entered into direct dialogue with that provider."

> "We engaged with a contracted provider that was able to provide us with some accommodation within a larger established housing scheme…We didn't have much time to put the thing together. It made sense to reach out to providers that we had an established relationship with."

> "Our partner provider has a broader set of provision and support. They already deliver refuges in the city, temporary accommodation and [support for] substance issues such as rehab services. It's great that we've got the pathways between the established services and the pilot already."

4.2.7. Most LAs approached providers before they wrote their bid, so providers could either be named in the bid, or could write it jointly with the LA. Most of the LA Leads who had been directly involved in the procurement process acknowledged that the timescales were tight, but felt this had not generally caused issues beyond inconvenience and time-pressure. One LA felt they could have put in a joint bid with neighbouring authorities if they had been given more time to plan.

4.2.8. Only one LA felt that the tight timescales during the procurement process had led to significant ongoing issues with the Respite Room which persisted throughout the pilot. The LA lead felt that insufficient consideration had been given to security and safeguarding.

> "I felt that other people should have been involved in mapping it. Adult social care should have been involved from a safeguarding perspective. The local refuge should have been involved. I think there's quite a lot of risk in placing women *en masse* like this, and they hadn't been consulted. If you're dealing with women who are fleeing domestic abuse, just from the sheer safeguarding and risk management. I would certainly have sought advice from people who understand the likely pitfalls, which is Refuge and Adult social care."
>
> LA Lead

4.2.9. The bidding process was generally seen as well-designed, well set up, straightforward, and familiar (i.e. similar to other funding application processes). LA and Provider leads who had been involved in writing bids noted that it was detailed and thorough. The only

other issue mentioned was some initial confusion around whether the pilot would last for 12 or 18 months.

4.2.10. One provider dropped out after the funding had been won. Again, this was attributed to the speed of the procurement process. However, in this case the other provider was well-placed to set up and staff the Respite Room in its entirety.

4.2.11. **Establishment of joint working**

4.2.12. Some projects had multiple co-equal (delivery) partners involved, while others had a single lead partner organisation. There were advantages to both approaches. Projects involving multiple partnerships felt they benefited from a diversity of existing skills and could draw on these to produce a more rounded and holistic service. This may have merit given how strongly the shape and focus of individual projects was influenced by the prior background and connections of the organisations involved. However, the more organisations involved in a Respite Room, the more time-consuming it was (generally) to establish smooth joint working. In some cases, this caused delays to getting the Respite Room set up and running.

4.2.13. **Maintaining joint working**

4.2.14. LA Leads reported few enduring problems in the relationships with their providers. Most believed they had strong relationships with providers, and providers generally stated their relationships with LAs were positive. Where tensions did exist, issues raised mainly related to (perceived) inappropriate referrals, but also in two cases to staff turnover at the LA, with incoming staff perceived to be lacking knowledge or commitment to the project.

4.2.15. LAs and providers met regularly throughout the course of the project, although many reported needing fewer meetings as joint working ran more smoothly over time. In addition, some attended online workshops with DLUHC. These were run separately for LAs and providers and discussed ongoing progress and any emergent issues.

4.2.16. Ongoing long-term problems were only reported by one area, who (as described in the previous section) attributed these largely to not having enough time to properly consider all aspects of the Respite Rooms due to the speed of the procurement process. The Respite Room in this area was run by multiple LAs, and the need for collaboration was felt to have made both early decision-making and ongoing day-to-day operations less efficient.

4.2.17. Where Respite Rooms provider staff worked directly with third parties, such as the police, health services, and other housing or support providers, these relationships were generally although not universally positive. There were, however, issues with the newness of the Respite Room concept in that staff at other organisations did not always understand the nature of provision and the vulnerability of many residents, leading to misunderstandings. One provider mentioned that it was an ongoing effort with staff turnover in police forces to ensure that all the relevant people knew how to work with them.

4.2.18. **What worked for joint working**

4.2.19. Several factors influenced how well organisations worked together, and how quickly smooth joint working was established. These were:

- LAs and providers with previous strong ongoing relationships, who were used to working together.
- Working relationships between the different LA teams that delivered the combined service.
- Organisations who were proactive about recruiting key staff members quickly, and who were in an area where recruitment was generally less challenging, tended to get the Respite Rooms set up and running smoothly more quickly.
- Providers whose existing experience most closely reflected the Respite Rooms approach – for example, experience of taking a trauma-informed approach to supporting vulnerable women with complex needs who had experienced DA – tended to have fewer challenges than those whose experience was more removed (e.g. housing / homelessness specialists with less experience of DA and trauma).
- Providers who had been involved in writing the bid with the LA tended to have a more thorough understanding of the Respite Room overall, rather than just their own role and remit.

4.3. Respite Room design

4.3.1. Table 4.1 below summarises the number of Respite Rooms beds offered in each area. Further information about the Respite Rooms can be found in Annex D.

Table 4.1 Number of Respite Rooms beds offered in each area

Local Authority	Number of beds
Bournemouth, Christchurch & Poole (BCP)	12
Birmingham	4
Bristol	10
Camden	15
East Sussex	12
Exeter	9
Leicester	8*
Liverpool	8†
Manchester	18
Nottingham	5
Portsmouth	4
Westminster	16

Source: DLUHC (February 2023) *(plus 3 move-on rooms for ex-Respite Room users) †(6 female, 2 male)

4.3.2. Of the 12 Respite Rooms, nine used a single building, and three split accommodation across two buildings. Of these three, one offered accommodation and support to both men and women, so each building was same sex. The Respite Rooms were either self-contained bedsits (own kitchen and bathroom) with some communal areas in the building, or shared houses with private bedrooms but communal kitchens, bathrooms, living rooms and (sometimes) gardens.

4.3.3. Most of the Respite Rooms were in a dedicated building so that only Respite Room users (or, in Leicester's case, women who had previously used a Respite Room) and staff could access the building. However, a small number shared space with other services such as other social housing accommodation.

4.3.4. A few of the Respite Rooms mentioned deliberately designing their space to be welcoming and friendly. Examples of how this was achieved both the décor, and how accessible the staff were. Most reported an "open door policy" so that service users had full access to staff. Some had gone further, and deliberately situated their staff in the highest-traffic areas of the building – for example, staff in one Respite Room worked in the communal kitchen to foster casual interaction between residents and staff. Similarly, staff in another Respite Room worked in an office beside the front door, so they could 'catch people coming and going'.

4.3.5. One Provider lead described the thought process behind the design of her Respite Room:

> "Building secure, boundaried and safe attachments is a fundamental part of recovery from trauma. To build a relationship, you have to build a sense of safety within the space. A lot of women, when they come here, present as acutely traumatized, very very shaken, very hypervigilant. They're constantly looking for danger as a means of survival. If someone's hyper vigilant, their body is picking up on unconscious cues that they're unsafe all the time. We thought about all of that. We have the open-door policy, and the way we decorated the project is very warm. We do small things like we have plants everywhere and we put smell dispensers so that when you come in, it smells nice and it looks warm and friendly."
>
> Provider Lead

4.3.6. In addition, a small number of staff discussed the importance of ensuring that the accommodation itself was of a high standard. This was seen as important for service users' mental wellbeing.

> "Being in lovely accommodation has proven to really work. For example, it's provided a victim of domestic abuse with a safer, less chaotic and less triggering environment. It's allowed women who've never eaten at a dining table before to experience things we may take for granted."
>
> Provider Lead, follow-up interview

4.3.7. Respite Rooms also varied in terms of staffing. Some were staffed 24/7; others only during standard working hours; sometimes with security staff over evenings and weekends.

4.3.8. The locations of each Respite Room also varied. Some were very close to other emergency or temporary housing provision (e.g. a mixed sex hostel in one area). Some were in city centre locations and others were on the outskirts. Some were located close to other services while the rest required public transport to access these other services.

4.3.9. **What worked for Respite Room design**

4.3.10. Service users identified three main aspects of design / location as particularly helpful. First, being located **at a distance from other temporary or emergency accommodation was seen as beneficial.** Respite Rooms located adjacent to refuges or hostels encountered issues including:

- The location of the Respite Room not being kept private; leading to instances of:
  - Perpetrators and other non-residents gaining entry to the Respite Room
  - Women being found by the same people who previously exploited them (e.g. sex workers being pressured to return to sex work)
- Women with substance misuse issues being in close proximity to areas where they could easily access substances.
- Conflict between women in the Respite Rooms and people in the other accommodation.

4.3.11. Both staff and Respite Room service users described these as less than ideal, and some service users did not always feel safe and relaxed.

> “I do hear it kicking off sometimes and it’s not nice. Even though I know nothing is going to happen to me, I still think…. I don’t know. Some days are better than others… But the shouting and things like that, I can get really freaked out with it. I have nightmares.”
>
> Service user (living in a Respite Room very close to a mixed-sex hostel)

4.3.12. In contrast, Respite Rooms located at a distance (at least a few hundred metres) from other refuges or hostels provided an environment where women felt more removed from the kinds of problematic / exploitative people and issues they had encountered in the past. These women described feeling safer, more relaxed, and more ready to make a fresh start once they were completely removed from the people and trappings that reminded them of their previous circumstances.

> "I feel content here. I feel calm. Less anxious. Less worried. The main thing is that there is safety, it’s quiet and far away from the people I used to hang with, so I’ve got my peace of mind back. No-one can find me.”
>
> Service user

4.3.13. Secondly, a Respite Room building located **near other relevant support services** was helpful for women, particularly those who had recently moved into a Respite Room and were often still in an extremely vulnerable mental state. For some, having to walk a long distance or use public transport could act as barriers to accessing these services. This was a particular issue for women with no resource to public funds (NRPF), as they were less likely to qualify for free public transport or be able to afford fares.

> “I’m not allowed to work, and I can’t get a bus pass. I would like to use [name of service that provides practical and emotional support for women who are sex working] but it’s very far away.”
>
> Service user, NRPF

4.3.14. Thirdly, having a **private bedsit in a building that also had shared communal areas** was helpful for women, as they had complete control over whether they wanted to interact with other staff and residents. Again, this was particularly helpful for women who had recently moved into a Respite Room and were often still in an extremely vulnerable mental state. Such women described the psychological benefits to their mental health and wellbeing of having agency over whether or not they interacted with others.

> “Something about having a room with a door I can lock and take a shower whenever I want. That's what makes me feel safe and calm. I don't have to ask anyone, or wait for the shower, or make chitchat when I'm not in the mood. It's my choice. That made me feel safe.”
>
> Service user

> "I'm African, I don’t want to eat pasta every day. The fact I can go into town, get cassava, all the little ingredients I like from my culture, then come back and do my own cooking in my own kitchen. It's empowering for independence."
>
> Service user

4.3.15. When women could choose whether or not to interact in communal areas, some were positive about being able to talk to other service users. Some women who had recently arrived in a Respite Room found it particularly beneficial to talk to women who had been there longer, as it gave them a model for what they might be able to expect for themselves in a few months.

> "It's a great space for women to talk to each other. We can talk about our experiences, our situations, our kids. You can talk to other people further along the journey, they show you what you can hope for. Like, one woman now gets to take her kids out, I can hope for that too."
>
> Service user

4.3.16. In contrast, a couple of women who moved into a shared house described struggling, although this was not a universal experience. Women who struggled could find it particularly hard in their first couple of weeks, as they had to share facilities.

> “I struggled at first, in the shared house. Some of the women were still on hard drugs or drinking and they kept trying to get me to be their driver when I was cooking my food, which I found overwhelming. One woman always wanted to hang out when she was drunk. This was hard for me, I used to be a severe alcoholic and I don't like being around alcohol. I just didn’t like how, if I wanted to cook, I was forced into being around them.”
>
> Service user

4.4. Referral routes

4.4.1. There were substantial differences between pilot projects in how admissions were handled. Four of the Respite Room areas had an extensive network of referral links, which they had invested significant effort in establishing. One project had moved from initially taking primarily LA referrals to using a wider range of routes built over time. Respite Rooms staff in these five areas felt that the Respite Rooms were more successful when they could use multiple referral pathways.

4.4.2. Providers in particular noted that some of the women who the Respite Rooms were aimed at had complex needs and circumstances that made them difficult to find. For example, women who actively avoided engaging with "authority" for multiple reasons (e.g. mental health issues, engaging in sex work or drug-use, previous bad experiences with the police / courts / a local council, asylum-seekers and other people with NRPF), or women who were in danger of street homelessness but were "sofa surfing" so were not on a council's radar as at-risk. The best chance of finding such women was to engage with organisations (often charities) who offered support to vulnerable women but were not seen as "the authorities". This worked best when referral organisations collectively supported a range of vulnerabilities – either large organisations with a broad remit such as Women's Aid, or several organisations with mutual links (e.g. a domestic violence charity, a women's refuge, an organisation supporting sex workers, or a charity supporting asylum-seekers).

4.4.3. Two Respite Rooms identified the police as an important referral source. Relationships with the police were not always reported as positive across all Respite Rooms, but these areas had worked hard to build relationships and educate relevant police teams (e.g. night shift teams who interacted with rough sleepers) about the purpose of, and entry criteria for, the Respite Room. Consequently, referrals from the police became an important route into the Respite Rooms for some of the most vulnerable women (and men) who were rough sleeping, who were not always engaging with any other services. The relationship between the police and the Respite Room was seen as mutually beneficial, and consideration could be given to developing this referral route in the future.

> "It's had a massive impact on the police. They've been able to take people to the Respite Room, saving them time trying to find somewhere safe for that person, or instead of putting them in a cell."
>
> Provider

4.4.4. Another four areas operated exclusively or mainly through LA referrals. All four of these reported some stress in the referral process. Providers, in particular, worried that some vulnerable women who may have been eligible for a Respite Room were not being identified, because they did not engage with local council services. All four areas with LA-only referral were smaller towns and cities, with less developed networks of organisations that may have been able to identify more eligible women.

4.4.5. The provider that had initially only taken referrals from the LA, later expanded to take referrals from other organisations, noted that most of their referrals happened at night. However, LA staff primarily worked during office hours, and with a very reduced service

during the evening and at weekends. This meant that when referrals came solely via the LA, opportunities for referrals were initially being missed.

> "In the beginning we didn't get enough referrals from Housing – I think they were a bit dismissive. The police now make referrals as well - a lot of referrals are made at night, and Housing only work office hours apart from a skeleton helpline outside that. The Domestic Violence helpline commissioned by the LA worked too, by the time that was set up they started referring through it. But that all took time."
>
> Provider

4.4.6. Two areas had an approach somewhere in-between, taking referrals from a more limited range of routes including the LA.

4.4.7. **Inappropriate referrals and refusals**

4.4.8. One downside of having multiple referral routes was that, in some areas, this increased the number of inappropriate referrals, i.e. women who did not fit the specific criteria for entry into a Respite Room. Although providers acknowledged that this was due to other services wanting to help women, it was also frustrating and time-consuming for Respite Rooms staff and (presumably) upsetting for the women who were not given a bed. This would usually be cases where the individual would not fit admission criteria, (e.g. absence of VAWG or DA risk), or in a few cases had support needs requiring a higher staffing level than was available at that time.

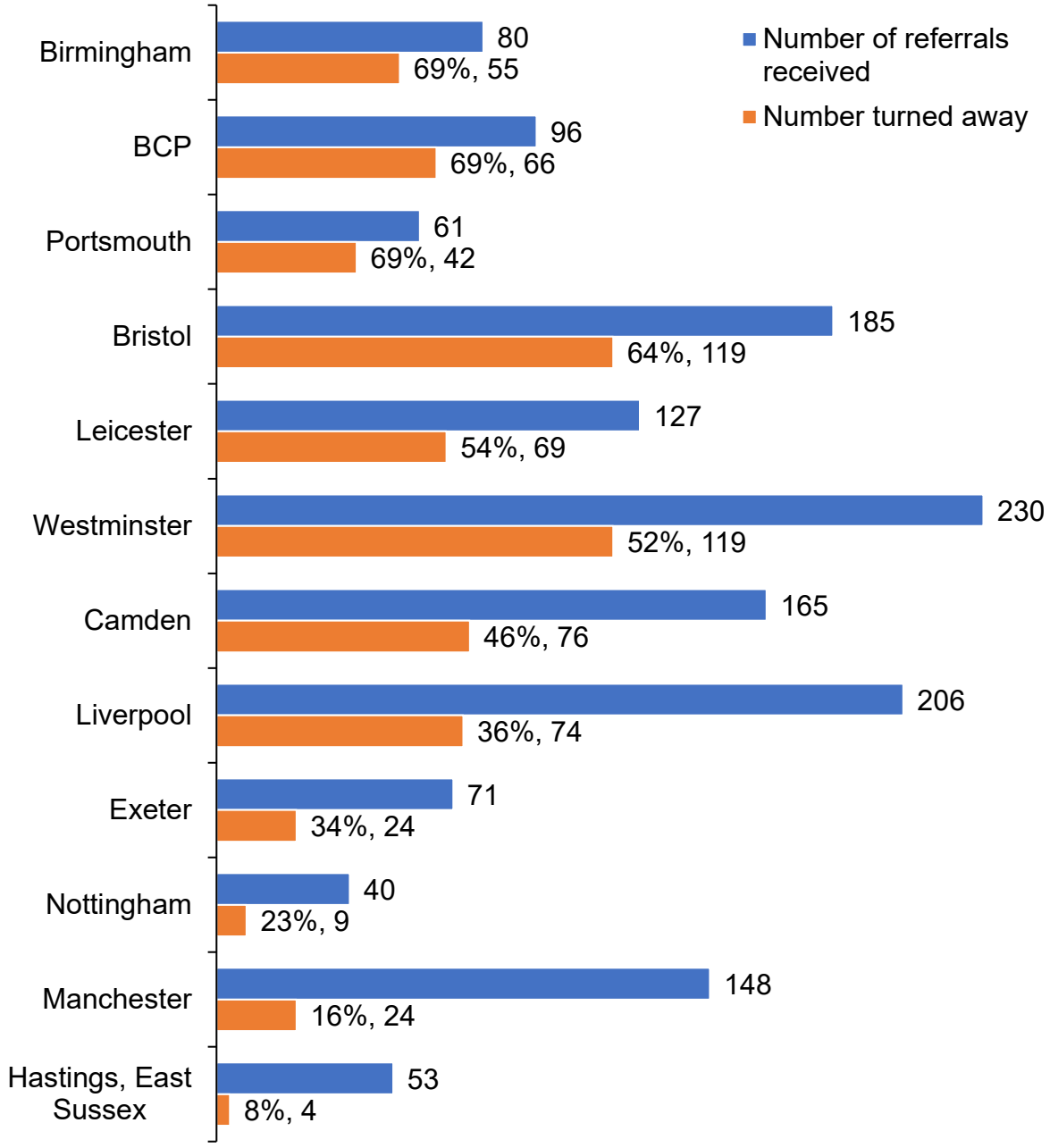
> "As we've become more established, we have seen an increase in inappropriate referrals from other services who are desperate for a bed for their clients."
>
> Provider

4.4.9. One stakeholder also noted that this was often an issue for successful services:

> "Provisions like this can get a bit inundated with demand and become a real focal point. And there's something again about kind of what's the wider system, what else is available? How does this fit in with the other types of services and provision available and how do you keep everyone informed of that to keep it all in balance and to help with continuity if the program comes to an end."
>
> Stakeholder

4.4.10. The rate at which individual Respite Rooms turned away individuals varied substantially. For example, Birmingham, Portsmouth and BCP each turned away 69% of referrals compared to only 8% in East Sussex. This partly related to the extent referral pathways continued operating when a Respite Room was known to be full, rather than the size of the Respite Room relative to demand. Figure 4.1 below shows the extent to which referrals were refused by each area.

Figure 4.1 Variations in extent to which referrals are turned away, by project



Source: DLUHC Respite Room data returns, October 2021 to January 2023. Data available in accessible form in Annex G.

4.4.11. **Service user journeys: entering the Respite Room**

4.4.12. To a large extent, where service users first heard about their local Respite Room was linked to that area's referral pathway(s). Unsurprisingly, all service users first heard either from a referral partner such as the local council, a hostel/refuge, or a Respite Room provider that offered other types of support:

> "I heard from my mental health guy – I'd been seeing him for a year. He put me in touch. At the time I was living in my car with my dog and my ex-partner and had been for over a year at that time."

> "I used to work the streets… so I'd call in to MASH. MASH staff told me about the Respite Room. I was rough sleeping at the time and using smack [heroin]."

> "There's a policewoman that comes round the streets who told me about it - the policewoman brought me here."

> "The women [staff] in [my previous supported housing] needed somewhere safer for me. It [was] independent living, but I needed more support. I was a danger to myself and to others. I couldn't be trusted."

4.4.13. Most had the service explained to them as temporary, private, single-sex accommodation, where they would have their own room, in a safe, secure location, with additional support available. Most of the women interviewed reacted positively to the idea and were eager to move into a Respite Room. The facts that it was single-sex and secure were often the most appealing aspects of the Respite Rooms.

> "[They told me it] it was a women's unit, respite for people who had been through domestic violence. I thought it would keep me safe and I would not be homeless, and I'd get the right support about other things as well. The fact of not having to worry about my ex turning up… They told me men can't come in, can't get in and out…I thought more about the safety part of it. And there would be people here who understand domestic violence [who] would help you get back into normal life."
>
> Service user

4.4.14. A few women were initially anxious (because the Respite Room was unfamiliar, and because they had previously had bad experiences in hostels), but only one woman initially rejected the offer of staying in a Respite Room.

> "I was offered it when I first came down here… I didn't want it, because of everything. …I'd been involved with Women's Aid, with MARAC [multi-agency risk assessment conference], with absolutely everything. I just wanted to get out and do it on my own. But when the council lady offered it again, I was actually really happy they offered me a second time."
>
> Service user

4.4.15. Most women noted how immediately helpful the staff were on arrival at the Respite Room, and how welcomed they felt. Many arrived at night, so had a brief discussion with staff about the basics, with initial support starting the following day.

4.4.16. Many women noted how quickly they were given choice and agency over what happened to them, and many described how their individual needs were considered from the outset. For example, some women described feeling highly anxious as a result of recent trauma, so wanted to be mostly left alone in the first few days until they were ready to engage. Staff supported this and engaged with them only to ensure their basic needs (e.g. food) were met.

> “We hold back on paperwork, meet their needs first and then show them to the rooms."
>
> Respite Rooms staff member

4.4.17. In contrast, others described how they had needed intensive support from the outset, and how the staff had supported them with this. Although service users did not use the term “trauma-informed approach”, staff confirmed that this was the approach taken.

> “It's a mixed approach when we first meet them. Some women can't even speak when they first come in. It all depends on the woman.”
>
> Respite Rooms staff member

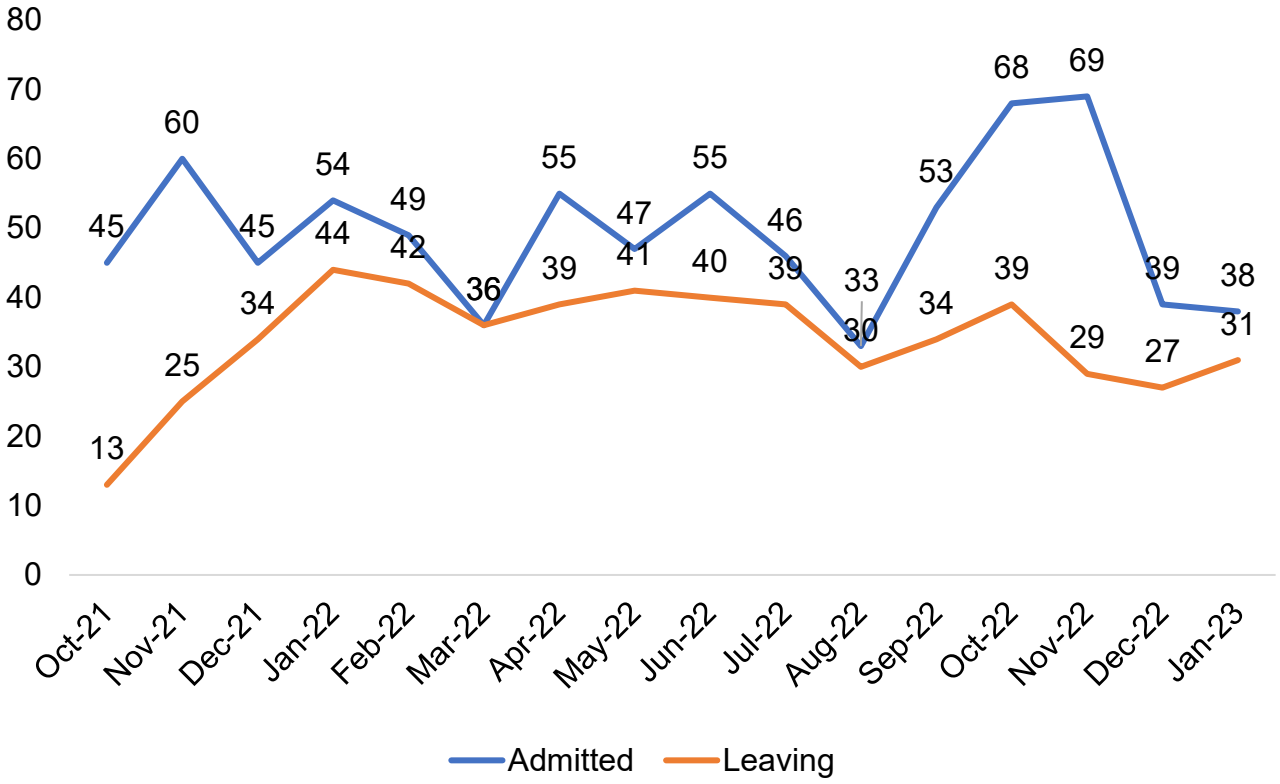
4.5. Number and profile of service users

4.5.1. The Respite Rooms pilot programme envisaged supporting 1,500 individuals at risk of DA or rough sleeping over a period of 18 months. At the final evaluation data collection point of 16 months, the programme had admitted more than half (53%) of the intended target (792 admissions).

4.5.2. More than half (52%) of all those referred (1,503) were admitted to the Respite Rooms. However, when a service is known to be full, referrals may not be made, so this may overstate the proportion of demand met. In total, 543 service users were recorded as having left the Respite Rooms.

4.5.3. Figure 4.2 identifies the number of admissions and leavers to the Respite Rooms by month. These numbers were reasonably consistent across most of the 16-month period. There was an increase in the number of admissions with no associated increase in number of leavers toward the end of the period, largely accounted for by two projects expanding in scale as they obtained additional funding.

Figure 4.2 Service users leaving Respite Rooms, compared with admissions



Source: DLUHC Respite Room data returns, October 2021 to January 2023. Data available in accessible form in Annex G.

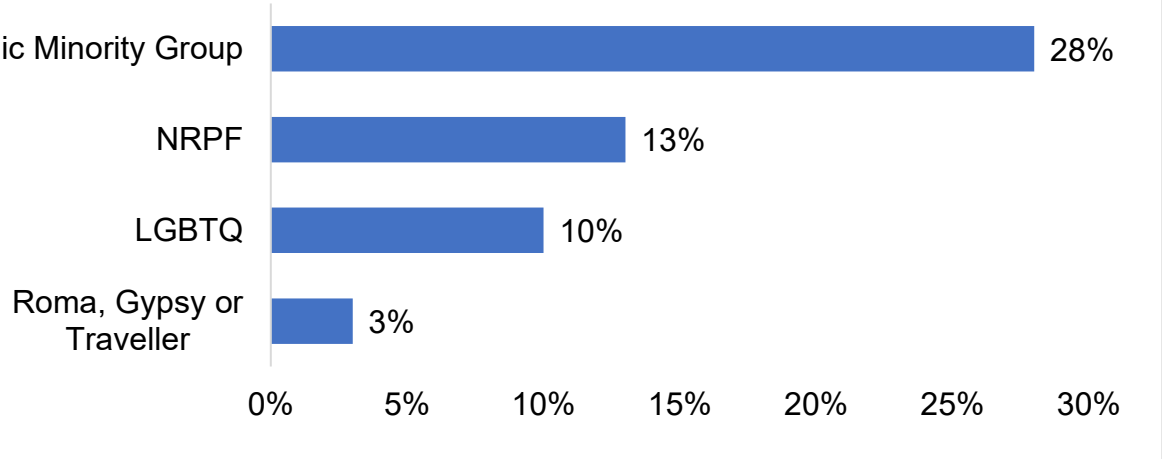
4.5.4. Most statistics for the service were collected regarding the 543 people leaving the service. From this point onward, analysis relates to this group. It was not possible to compare service user demographics to wider demographics for the intended beneficiary group, as accurate details on the size and composition of the latter group are unknown.

4.5.5. As intended, the majority of LAs provided women-only Respite Rooms which resulted in 98% of all service users being female. Liverpool City Council was the only LA to provide a male-only Respite Room (this had two bed spaces, and accounted for 1% of all service users). In a few cases gender was not recorded.

4.5.6. In terms of age, the majority of service users (439, 81%) were between the ages of 25 to 65, with 89 (25%) aged 18 to 25, and a handful (15, 3%) aged 65 plus. Given the nature of the programme, many service users had some form of disability (25%) or more commonly mental health issues (84%). In addition to this, about half of service users (58%) had addiction problems prior to entering the accommodation.

4.5.7. Looking at other demographic factors in Figure 4.3, we can see that a fair number of service users were from ethnic minority groups (28%). A total of 10% were recorded as LGBTQ, and 3% as Roma, Gypsy or Travellers. More than a tenth (13%) had no recourse to public funds (NRPF), a target group for the initiative, and a fairly high number of these (19%) were from out of the area.

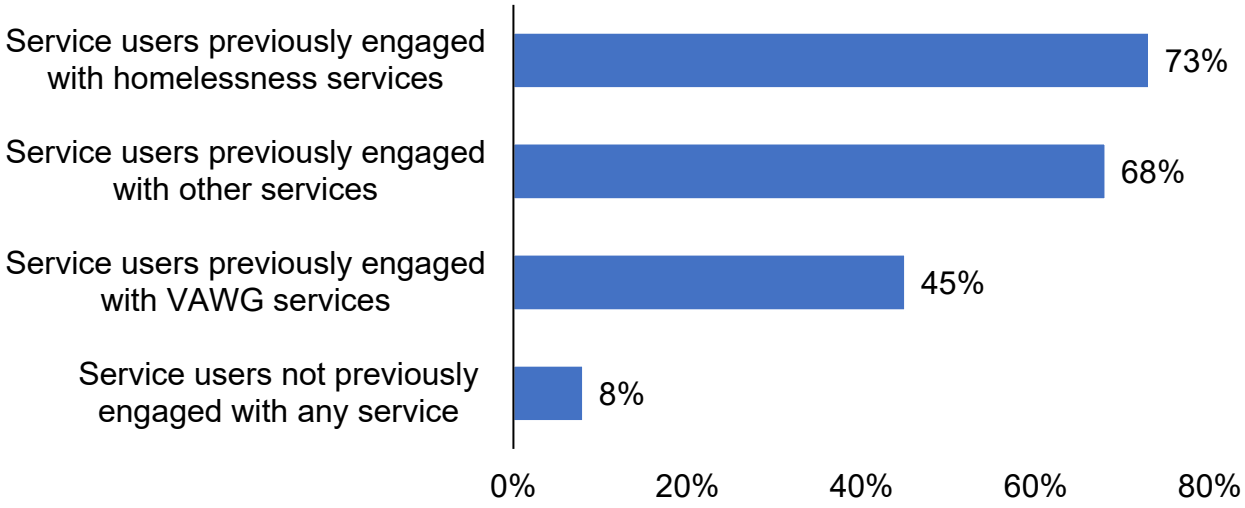
Figure 4.3 Service user demographics



Source: DLUHC Respite Room data returns, October 2021 to January 2023. Data available in accessible form in Annex G.

4.5.8. As shown in Figure 4.4, most users had engaged with other relevant services before; only 8% had never engaged with any service. This is at odds to some extent with plans for the service which had intended, in part, to target individuals who were previously resistant to engagement with services. However, previous engagement with a service includes 'unsuccessful' engagement, e.g., where a service user was evicted from a hostel, or failed to attend health appointments.

Figure 4.4 Service users' previous engagement with services



Source: DLUHC Respite Room data returns, October 2021 to January 2023. Data available in accessible form in Annex G.

4.5.9. **Local variation**

4.5.10. Individual services varied substantially in the characteristics of their intake, as shown in Annex G, Table G. 12 to Table G .15.

4.5.11. Some differences were likely to be the result of simply the location of the service; both London services had a much higher proportion of their users in ethnic minority groups than any service except Leicester. Services in large cities had a higher proportion of young residents. The proportion of out-of-area residents varied enormously, from 47% in Camden to less than 5% in several areas, many of which were areas where the LA exercised centralised control over admissions.

4.5.12. However, some elements seemed more likely to be a result of the focus of the provider, or design of the Respite Room.

4.5.13. For example, all residents in Leicester had experienced recent DA, reflecting the background of its provider as an operator of DA refuges for women from ethnic minorities. Similarly, the service in Liverpool had a high proportion of residents with addictions, reflecting the service operator's history of helping homeless people with addiction problems. It seems likely this relates to the established referral and move-on networks these organisations have.

4.5.14. In Manchester only 24% were experiencing current DA; but a high (unknown) proportion were experiencing other forms of VAWG, again a particular focus of that provider. Westminster, reflecting the background of the project in the Green Room which was less directly DA focused, had a high proportion of service users experiencing other forms of VAWG and many residents with NRPF.

5. Respite Room outcomes

5.1. Summary

5.1.1. This chapter focuses on the service users' journeys, from the support provided during their stay in the Respite Rooms to the organisation of their move-on destinations. In summary, the types of support offered in the Respite Rooms varied from practical and emotional, to formal support provided by specialists and additional wraparound support.

5.1.2. Basic needs, such as food and clothing, were met as soon as the service user entered the Respite Room, followed by a support assessment. This was the basis for a support plan that developed over time as staff built trust with the service user. Staff offered practical support by helping service users to complete forms to access benefits, apply for housing and other services. Other practical support included setting up appointments and referrals, chasing applications, and advocating for service users.

5.1.3. Formal support was offered through individual and group sessions run by specialists. Respite Rooms staff also offered more general emotional support to service users, depending on individual need. This varied from accompanying service users to appointments to having an 'open-door' policy for service users to drop into the on-site office for a chat. Service users across Respite Rooms noted that staff made a genuine effort to get to know them as people, not just in terms of their support needs.

5.1.4. In addition, Respite Rooms also offered holistic, wraparound support in the form of opportunities and activities. These were part of a trauma-informed approach, centred on individuals. They were deliberately designed to build resilience, and ultimately to help service users become self-sufficient. Project leads and Respite Rooms staff noted that the majority of service users engaged with support at some level.

5.1.5. Move-on was reported to be a major barrier to provision by most of the Respite Rooms, with most service users staying for longer than was envisaged in the design of the Respite Room policy. Difficulties included a lack of local services with low or medium support, finding housing providers who were willing to take service users with a history of rent arrears or debts, and the overall high pressure on housing stock. However, longer length of stay in services was not solely due to this; staff were keen to take a client-centred approach and supported service users until they felt they were ready. Many believed a length of stay measured in months would be more appropriate for service users with the highest level of needs.

5.2. Providing support

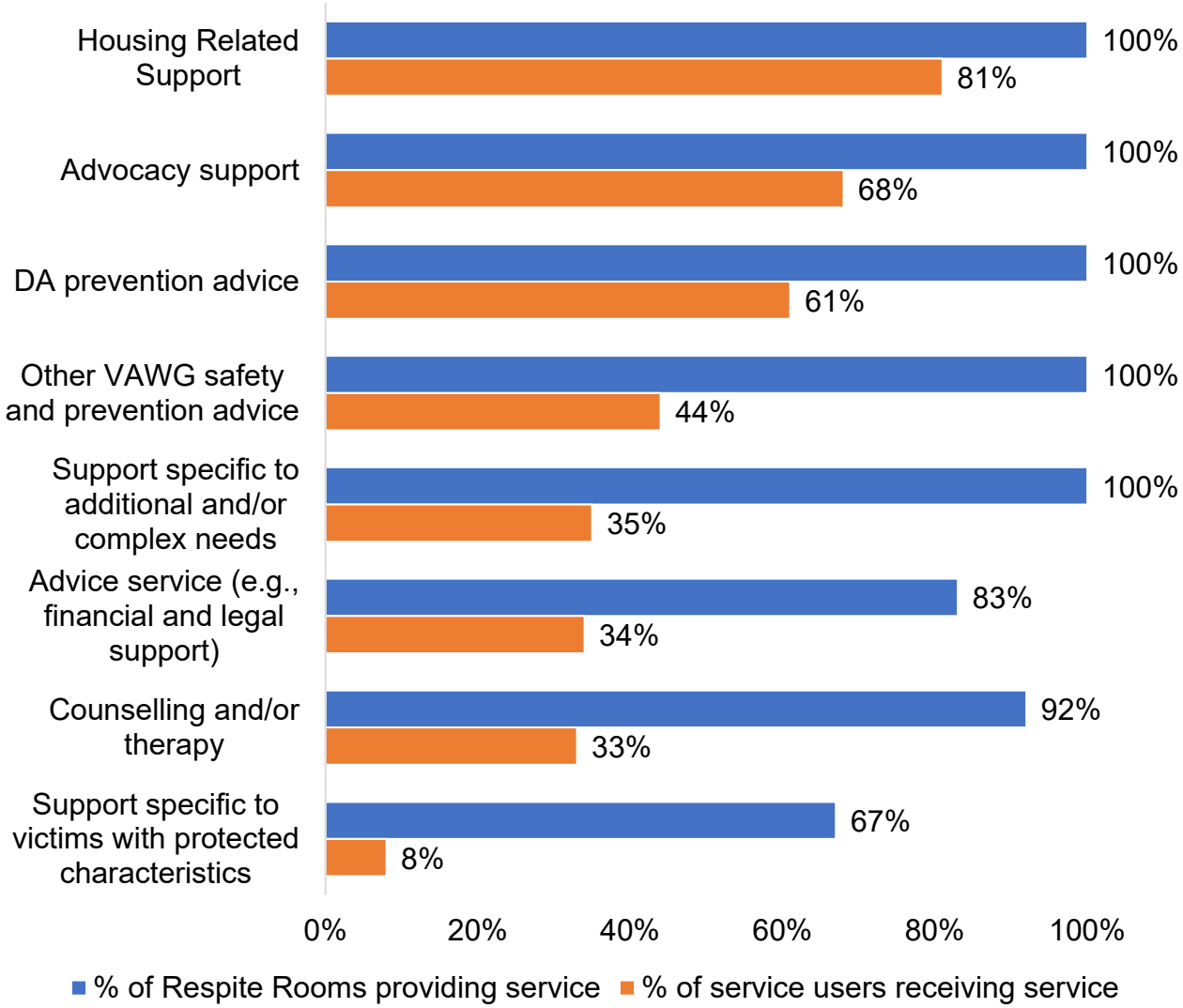
5.2.1. Women in Respite Rooms were offered a variety of support options. The choice of whether or not to engage with these was left up to individual service users, but staff strongly encouraged the women to engage as much as they felt able to. Support was provided by the Provider staff who ran the Respite Rooms, and other specialist staff such as counsellors / therapists with experiences in areas such as domestic abuse, homelessness, complex needs or substance abuse who attended the Respite Rooms to run one to one sessions with service users at set times (e.g. half a day per week).

5.2.2. As can be seen in Figure 5.1, most Respite Rooms provided all of the forms of support envisaged in at least some quantity, although around a third (33%) did not provide support specific to particular protected characteristics. However, it is unclear whether this is because service users did not require this type of support, or because it could not be supplied.

5.2.3. Support provided in Respite Rooms was most often housing related support or advocacy, which reached 81% and 68% of service users respectively. DA prevention advice was received by 61% of service users, and 44% received other VAWG support. This does broadly reflect the distribution of need; 67% of service users had experienced DA from a domestic partner (some of this group may also have experienced wider VAWG), so the other 33% were eligible for Respite Room support due to other forms of VAWG.

5.2.4. General advice (e.g. on financial or legal matters) was provided to around a third (34%) of service users, as was counselling or therapy (33%), and support specific to additional or complex needs (35%). Support for victims with protected characteristics was rarer (8%) but it may be that not all service users required this form of support.

Figure 5.1 Support provided in Respite Rooms



Source: Respite Room data returns, October 2021 to January 2023. Base: All services (12), all service leavers excluding Exeter (512). Data available in accessible form in Annex G.

5.2.5. **Local variation**

5.2.6. Provision of support varied very substantially by service (as shown in Annex G, Table G.16 to Table G.19). Some areas provided high levels of support across the board (e.g. Bristol, Camden, Leicester, Portsmouth) while others provided more targeted or limited support (e.g. Birmingham, Westminster). More often there was wide provision of support, but with some categories of support being less frequently provided compared to the average across all Respite Rooms (e.g. East Sussex for advocacy, BCP for counselling, or Manchester for housing related support, Portsmouth and Manchester for advice services such as financial or legal advice, and Liverpool for support specific to additional or complex needs).

5.2.7. There is limited information about why this variation existed; in one case a Respite Room provider mentioned the shortage of people qualified to offer particular types of support, in that case counsellors.

5.2.8. Much of the support offered by Respite Rooms staff centred as much on building trust between staff and service users as it did on offering professional services (e.g. help with substance misuse issues). Building trust was seen as central to the trauma-informed, holistic approach taken across Respite Rooms, and trust was deliberately fostered in a number of ways, always centring support around the needs of an individual service user and ensuring that support was delivered holistically.

5.2.9. Stakeholders also highlighted the importance of applying a holistic approach by supporting service users to overcome other issues or the most important issue first before moving on to supporting other needs. This was seen as a key mechanism for building trust with the service user, allowing them to settle and focus on their recovery plan. Support relationships were an important part of overcoming negative experiences of services (e.g. children taken into care), which can alienate women and make them less likely to trust public services again.

5.2.10. Inclusivity was discussed in more detail by some stakeholders, who emphasised that the specific needs of women with disabilities or women from ethnic minority backgrounds also need to be considered as part of programme design. Issues included having representative staff who understand women's experiences and additional barriers which women from some groups face when accessing support, such as stigma and discrimination from staff.

> "Somebody understanding their perspective, understanding where they've come from, understanding their experiences of discrimination and being able to better build that trust."
>
> Stakeholder

> "They value… receiving support from workers that look like them in a, you know, not just physically safe space, but emotionally safe space that protects them from racism… Workers who advocate for them."
>
> Stakeholder

5.2.11. The types of support offered in the Respite Rooms can be broadly divided into four types: practical support, emotional support, formal support provided by specialists and additional wraparound support.

5.2.12. **Practical support**

5.2.13. Respite Rooms staff (e.g. project workers, support workers and the Respite Room manager) supported the service users from the moment they arrived in the Respite Room. Many service users described how staff immediately helped and supported them, offering a 'welcome package' and ensuring that their immediate, basic needs such as food and clothing, were met.

> "There was a package [staff member] put together when we arrived, she had everything in there. Towels, teddy bears, toiletries, milk and squash, Everything you needed. If you come with absolutely nothing she'll take you out to get it. I didn't have nothing [so] she took me to get a hairdryer, clothes and underwear. You don't want for nothing. She won't go over the top and get you anything you want but she'll buy you what you need."
>
> Service user

5.2.14. After basic needs were met, the first type of support offered was usually to make a support plan – like almost all of the support provided, this was done collaboratively with service users. It usually involved a conversation about what a service user's needs and priorities were, with the subsequent plan tailored around these.

> "When the assessment is done, that's when you kind of get the full breakdown of what their needs are and how to kind of like work with them and to meet their needs and their objectives and set their goals."
>
> Respite Rooms staff member

5.2.15. Staff also acknowledged that such plans evolved over time, as women were often not ready to make disclosures (e.g. sexual abuse) in their first few days at a Respite Room when they were still highly traumatised and mistrustful.

5.2.16. Early in a service user's journey, usually in the first few days of their stay, staff next offered practical support by helping them complete whatever forms were necessary for them to access benefits, apply for housing and other services. This usually involved helping a service user to fill in the forms they needed to access services and benefits. This was not done until the service user felt ready.

> "I go and introduce myself, finding a comfortable moment for both, you know leave it a couple of days to get settled in. Sometimes when you move into an accommodation you get a lot of information, and you feel a little bit [overwhelmed]."
>
> Respite Rooms staff member

5.2.17. Staff encouraged service users to complete these themselves, as empowering women to do things for themselves was an important overall goal of providing support that ultimately led to independence. This was again tailored to an individual's needs, starting with whatever practical tasks the service user thought were the highest priority, e.g. claiming Universal Credit, applying for housing, accessing the local food bank etc.

> "When they first come in, we ask them what their priority is. 'What would make you feel best to have dealt with first? It's often money or their passport, so we do these first to get the ball rolling with what's needed. We try to do it WITH them to empower them. For example, 'Let's get on the phone to Benefits together'."
>
> Respite Rooms staff member

5.2.18. Service users who had no recourse to public funds (e.g. asylum seekers) were also helped with this – e.g. staff would investigate which charities might be able to help according to individual circumstances and help the service users to apply to these.

> "We looked into what was available for this particular lady's circumstances and we partnered her with African Support."
>
> Respite Rooms staff member

5.2.19. Although most of the "form filling" was completed in the first couple of weeks of a service user's stay in the Respite Rooms, staff continued to offer practical support on an ad-hoc basis throughout their stay. Other forms of practical support included:

- Setting up additional appointments and referrals as needed
- Chasing applications
- Advocacy with organisations such as the police, HMCTS, social services and housing services. Both service users and staff agreed that users were taken more seriously by 'authority figures' when they had a professional to speak for them.

> "Lots of the women have had terrible experiences with police and social services, so offering this [advocacy] is important – plus, services will listen more to a staff member than to one of the women."
>
> Respite Rooms staff member

5.2.20. One woman described her previous unsuccessful attempts to advocate for herself when discussing visitation rights with her child, who had been taken into foster care. She felt that she was expected to 'perform' for services in order to be taken seriously, but also that this was very difficult to do when in a highly emotional state.

> "You're in a bad way and they're meant to help. But you can't show too much emotion when you're dealing with them or you'll come across badly. People tend to dismiss you. It's not like that here [Respite Room] though."
>
> Service user

5.2.21. **Formal support**

5.2.22. More formal support was offered in the form of various individual or group sessions run by specialists from the Respite Room. These usually happened at set times, once a week, either in the Respite Room or in another venue.

5.2.23. The specifics of these varied between the different Respite Rooms. The specialists either worked directly for the Provider, or (more usually) were from an organisation that the Provider had close ties with. Examples of typical sessions included:

- Counselling with a mental health specialist, using trauma-informed approaches (e.g. a psychologist or other complex needs / domestic abuse specialist)
- Drugs counselling or group education sessions
- Alcohol counselling or group sessions
- Support for sex workers
- Advice for women whose children had been taken into care
- Rough sleeping advice and support

5.2.24. These sessions were voluntary, but women who needed them were encouraged to attend, with staff facilitating this where possible.

5.2.25. **Emotional support**

5.2.26. Staff also offered more general emotional support to service users. Again, the nature of this support depended on what an individual needed. Anecdotal examples of one-to-one emotional support from staff members ranged from going with them to the shops if they were too anxious to go themselves, accompanying them to appointments, having an 'open door' policy so that service users felt comfortable dropping in for a chat etc.

5.2.27. Service users across Respite Rooms noted that staff made a genuine effort to get to know them as people, not just in terms of their support needs. This included their likes and dislikes, their interests and their hopes for the future. This allowed staff to tailor the emotional support they offered each individual.

> "The people [staff] try to understand you, they try to really understand you and try to really help you…You can come down every time when you feel not very well. You can drink coffee with her. You can speak."
>
> Service user

5.2.28. One service user described how she used to vandalise her hostel room and how, in the Respite Room, the staff member redirected this to a positive activity:

> "She [staff member] encourages my colouring. In the other place I used to write all over the walls, I used to write psycho messages when I was in a bad mood. She's given me a white board so I can write them. She's really encouraging, she took me to The Works the other day [art shop], she bought me little canvasses, proper pens, a colouring book, papers. She notices what I like doing."
>
> Service user

5.2.29. Another service user, who was referred into the Respite Room from a local mixed-sex hostel after an altercation with another person in the hostel, describes how a Respite Room manager came to collect her from the hostel in person. This helped to set up trust between the service user and manager from the outset.

> "[Staff member] collected me from the [local hostel]. She came after hours, just to get me. Some people would be like, it's after 5pm, bye, but not her. She carried my suitcase. There are nice people in the world."
>
> Service user

5.2.30. A third service user described how, when she first arrived, she was so traumatised that she could barely function. She described how the staff helped her with her most basic needs:

> "At my worst, I couldn't even pick up a spoon, I couldn't feed myself. The staff took me shopping, they cooked meals with me, they helped me to shower."
>
> Service user

5.2.31. A fourth service user noted that sometimes staff offer emotional support by knowing when to leave her alone. This level of attention to her moods, and how / when they fluctuated, highlighted to her that the staff paid attention to small details about her, which again helped to build trust.

> "They notice things about individuals. Like, on a Monday and a Wednesday I see my daughter. They know I'm emotional on those days. They noticed that. So, they let me just sleep."
>
> Service user

5.2.32. The key themes underpinning the emotional support offered, and why it had such a powerful effect on women, were of kindness, care, compassion and genuine interest. Service users felt that the staff genuinely cared about them and were interested in them as people. For many of the women, this experience was new, and many described previous interactions with "services" or "authorities" as relatively dehumanising. One woman described how she felt she had been treated in the past, and how differently she was treated in the Respite Room.

> "In the past I've been treated like I was a problem, a nuisance, basically scum. When I got any help it wasn't because they really wanted to help me, it was because they wanted me to go away, like, they'd do whatever little they could to just make me someone else's problem. Shove me in a hostel with men sticking needles in their arms, when they know I've got a problem myself and I'm black and blue from what a man did to me, why not. Who cares about her, she's a stupid [slur for a sex worker] junkie, just make her go away. Make her invisible. But you know who cares? They [Respite Rooms staff] do. They actually treat me like a human being, not like a [expletive]"
>
> Service user

5.2.33. **Additional wraparound support**

5.2.34. In addition to the above support, Respite Rooms staff also offered holistic, wraparound support in the form of opportunities and activities for the women. These were also part of the trauma-informed approach, centred on individuals. They were deliberately designed to build resilience in women and ultimately to help them become self-sufficient when they moved on from the Respite Room. These activities had a number of purposes:

- To ensure that their experience at the Respite Rooms wasn't completely centred on support for their problems, but also included positive, fun experiences
- For some creative activities, to build self-esteem – to show women who had very low self-esteem that they could successfully take part in activities and create things.
- To offer opportunities for socialising with women with lived experience
- Another way of fostering trust between staff and residents, with shared participation.
- To show them examples of what 'normal life' could involve.

> "It's not about the crafts or arts, it's about building their confidence. Some of these women have been locked in a room for years. Coming to a crafts session, or a nails session, encouraging them. Every woman thinks they can't do that. Then they come out feeling proud and excited."
>
> Staff member

5.2.35. These activities were described to the women as fun, light-hearted, or learning opportunities. Examples included: bringing a hairdresser or masseuse to give the women treatments and massages; cookery lessons; the "Healing Together" programme, which focused on understanding emotions and how you feel in particular situations; days out (e.g. a day trip to Wales where the staff bought fish and chips); art therapy; mindfulness sessions; gardening and yoga.

5.2.36. **Engagement with support**

5.2.37. Most Project Leads and Respite Rooms staff noted that the majority of service users engaged with support at some level, with most accessing the (important) formal support offered by specialists. Service users confirmed this, noting that although they had not always engaged with all the support offered, they particularly appreciated being given the choice about whether or not to do so. Most service users confirmed that they had also engaged with some of the wraparound enrichment activities – only a very small number of service users (often those in their first few weeks at the Respite Room) had not yet taken part in activities.

5.2.38. There were some people who found it challenging to engage with support initially, but overall, both LAs and providers felt that the project had been successful in bringing in individuals who would not have been reached by conventional services. However, some service users left the Respite Rooms before engaging or, in a very small number of cases, were evicted. We were not able to speak with these people during interviews so, by definition, this section reports findings from the more engaged service users who were willing to speak with us.

5.2.39. Substance abuse and mental health issues were widely cited as barriers to engagement which had been overcome by many Respite Room users. In some locations relatively high proportions of Respite Room users were involved in (street) sex work which made them particularly vulnerable to further violence or abuse.

5.2.40. Key supporting factors included the potential in Respite Rooms for individual support, due to the high staffing ratio and small site size. In some services, the small site size enabled positive friendship groups to develop among service users, rather than the more destructive group dynamics which some interviewees reported in larger homeless shelters where some residents actively refuse support. Providers felt that if the Respite Rooms scheme were to be expanded in scale in their local area, it would be helpful to offer it on multiple, widely spaced sites, giving women the opportunity to get away from their geographical risk areas.

5.2.41. Flexibility in support was also important, with providers emphasising that some needs were unpredictable, including helping a service user to reconnect with family, providing advocacy unexpectedly, or simply helping people to deal with basic domestic tasks which they had not previously encountered. Some Respite Room providers also felt the

environment was particularly important – providing a safe and welcoming space, with enrichment activities to bring people mentally into a different space.

5.2.42. All areas had, however, achieved a slower throughput of service users than envisaged in the Respite Room design, partly due to move-on difficulties, and partly due to the need to engage with service users over a longer period than planned in order to ensure a successful move-on. Overall, this is reflected in the overall number of people served by the projects, which monitoring data indicates will be 40% lower than anticipated at c.900 rather than the planned 1,500.

5.2.43. **What worked**

5.2.44. It was clear that the physical Respite Room itself, from the day-to-day staff, to providing a safe and welcoming space, was crucial to the success of the programme. Overall, two factors were critical in why the support worked: safe, secure, quality accommodation; and wraparound, trauma-informed support delivered by staff members who considered service users as individuals. This holistic approach to support, including the enriching additional activities that staff coordinated, all encouraged engagement and also supported service users to mentally be in a more positive space.

5.2.45. Service users expressed real appreciation for the day-to-day staff who ran the Respite Rooms. With a very small number of exceptions, service users described the staff in superlatives. Those who had recently arrived in a Respite Room (e.g. within the last month at time of interview) credited the staff with helping them to feel settled, welcomed and relaxed, often for the first time in years. Those who had been there longer or moved on, credited the staff with helping to build their resilience, overcome trauma and prepare them for (in their words) “a normal life”.

> “I can sit in my room with the TV, and cook. I can do the classes they organise, or I cannot, it’s my choice, under my control. I can just be alone if I want. We’re lucky to have all this. I’m being offered privacy. I don’t have to tell everyone everything. I have my dignity back.”
>
> Service user

> “They are just so f*****g lovely! You know when you meet people and you can just tell they’re genuine, honest people, there’s no underlying motive or anything, they are just so nice, and they’ve really helped me get past [issues]. I grew up with quite domineering, aggressive women and it made me terrified of women up until working with these guys. I’m 32, it’s a long time to be scared of my own sex.”
>
> Service user

5.2.46. As a result of this trust and engagement, staff supported some service users to manage substance abuse and mental health issues, which are two widely cited barriers to engagement with services. Some also told us of the impact this support will have had on reducing costs for other public services.

5.2.47. **What worked less well**

5.2.48. Support from Respite Rooms staff worked best when dedicated staff members were available 24/7. Some locations did not offer full time staffing, and the lack of support during the night and at weekends was noted by both women and staff as less than ideal.

> "We've all said the same, the girls in the building, we'd like more evening support. It gets harder in the evenings, and at weekends. During the day you can go to [the daytime support service] or phone but at night it was quite difficult."
>
> Service user

> "The Respite Rooms have been less effective for women with very high support needs because we can't offer 24-hour support."
>
> LA Lead, follow-up interview

5.2.49. One Provider Lead noted that, although they knew that women using the Respite Rooms had complex needs, they had initially underestimated the amount of time their staff would need to provide support, and how intensive this would be. This provider also acknowledged that they would have liked more mental health support for staff as well as for the service users.

5.2.50. Both staff and women noted that there had been some challenges in housing vulnerable women with complex needs, at different stages of their progress towards move-on, in one house. Although only a few serious altercations were reported, most staff noted some tensions and disagreements between women.

> "There is a challenge and a risk of individuals and behaviours… the women who sit in the six units can get a little bit aggressive at times with each other. It's down to [their] complex needs and mental health, interaction between them can be a challenge at times."
>
> LA Lead

5.2.51. The women themselves also reported incidents where another resident had behaved erratically or aggressively.

> "She actually broke the [toilet] door… She was hitting it very hard; she was kicking it again and again… She was very angry, I don't know why."
>
> Service user

5.2.52. Although the Respite Rooms staff encouraged women not to use substances such as drugs and alcohol, this was not always prohibited. Both women and staff reported altercations between women where one or both of the women had been using substances and subsequently become aggressive.

> “There was an issue with [resident], she left last week. She was absolutely filthy. She would get drunk and was rude. She was a posh girl; she wasn’t one of us.”
>
> Service user

5.2.53. On rare occasions, such incidents resulted in a woman being asked to leave the Respite Room, which could be upsetting for other service users.

> “A physical fight broke out between two residents [A & B], last week. As a result, [A] was kicked out. I don’t think that’s right…[A] threw the first punch but there's only so much you can take from [B]… she antagonised [A], winding her up… it's [B] who should've gone.”
>
> Service user

5.3. Move-on

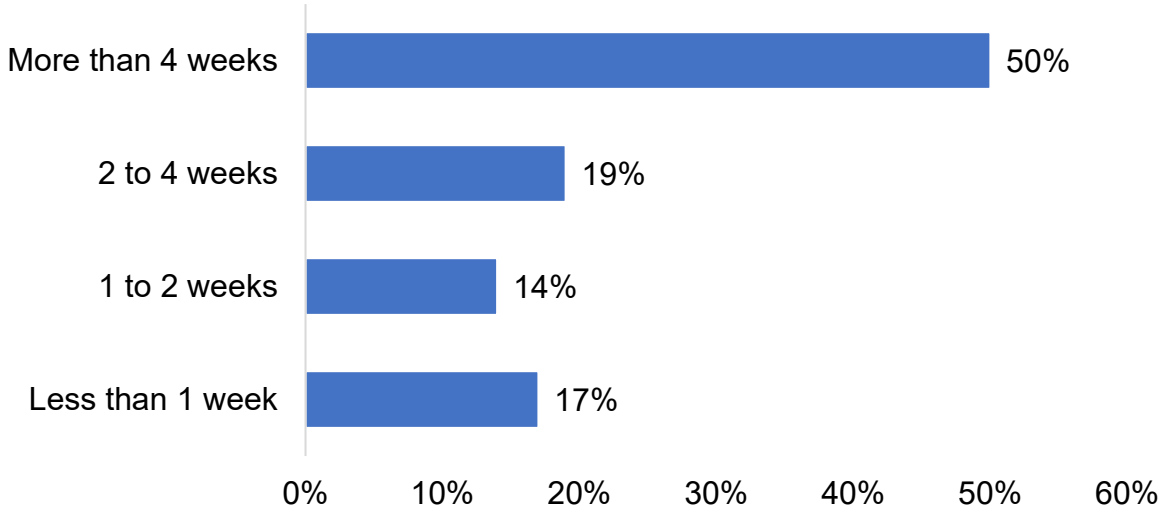
5.3.1. Arranging move-on

5.3.2. As discussed above, move-on was reported to be a major barrier to provision by many LAs, with most reporting that service users took a longer time to move-on than was envisaged in the design of the Respite Room concept.

5.3.3. Some pilot projects had expended considerable effort to building move-on pathways, but still found it a major barrier to their work.

5.3.4. As suggested by this feedback from projects, monitoring data shows that Respite Room users stayed in their accommodation for much longer than envisaged in the planning phase for the policy. Despite an intended average stay of around two weeks, half of residents (50%) stayed for more than four weeks, as shown in Figure 5.2. The data includes all stays in the Respite Room, and cannot be split in any way, for example to excluding people whose stay was unsuccessful because they left shortly after admission and before engaging with support, explaining the proportion of stays of less than one week.

Figure 5.2 Length of time in the Respite Room, % of service users



Source: DLUHC Respite Room data returns, October 2021 to January 2023. Data available in accessible form in Annex G.

5.3.5. **Move-on destinations**

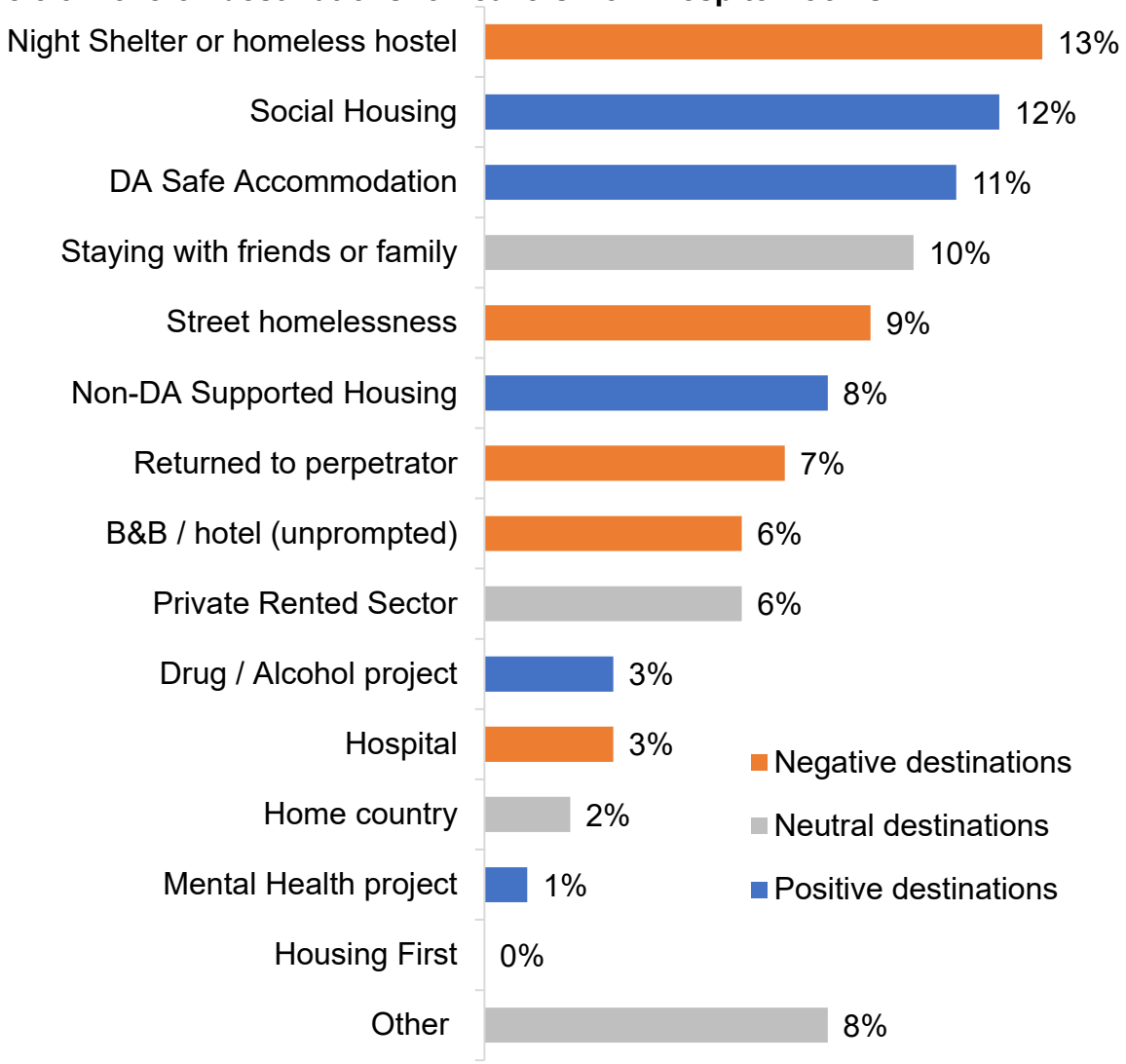
5.3.6. As shown in Figure 5.3, there was no dominant destination for people leaving Respite Rooms. These have been classified in the chart as broadly 'positive', 'neutral' or 'negative'; this classification will not hold true in every case, but is based on how project leads and staff described instances of move-on of this type in interview[13]. In general, around 35% went to destinations which could be described as broadly 'positive', while 38% went to destinations more likely to be 'negative'. Given the high needs groups catered to by the accommodation, this might be seen as a positive outcome overall.

5.3.7. Most commonly, service users moved onto night shelters or general homeless hostels (13%), to social housing (12%) or DA Safe Accommodation (11%) or non-DA supported housing (8%). A significant proportion also went to live with friends and family (10%), an outcome which for some might be positive, others negative.

5.3.8. More negatively, some service users returned to the street (9%) or back to their perpetrator (8%) after the programme. The remainder to 'Other' destinations (8%), included other self-contained emergency accommodation, or cases where the service lost track of the service user[14].

[13] Outcomes were intended to be mutually exclusive; so 'social rented' or 'private rented sector' should not generally (except in error) include those returning to an abusive partner in such accommodation. 'Social rented' has been classified as positive, while 'Private rented' is neutral due to the higher level of landlord involvement in ensuring appropriate tenants are placed in their properties.
[14] This has been classified as 'neutral' because a high proportion were in Manchester where data availability was poor due to data sharing barriers between project partners.

Figure 5.3 Move-on destinations for leavers from Respite Rooms



Source: DLUHC Respite Room data returns, October 2021 to January 2023. Data available in accessible form in Annex G.

5.3.9. To illustrate, one Respite Room had moved service users on to a wide range of locations, most frequently to accommodation owned by the provider elsewhere in the city. These included a large homeless hostel and related move-on accommodation. In addition to providing economies of scale with shared staffing, this helped service users to find a move-on destination that fit their needs.

> "We want to see more Domestic Abuse safe accommodation accepting those with additional needs and a higher level of mental health needs. So just understanding the barriers, taking in women with that level of need, the project has helped with that."
>
> LA Lead

5.3.10. They also had a high proportion of substance users among residents, so rehab and hospital were frequent immediate destinations.

5.3.11. Additionally, the Respite Room also acts as an informal drop-in centre for former residents after move-on, who drop by for informal support and a chat. This especially assisted those leaving to live more independently in social or private housing tenancies.

> "It is the kind of support that is accessible for everyone in the form of workshops, drop ins, and coffee chats which helps service users feel like help is just around the corner."
>
> LA Lead

5.3.12. Service users were also not moved into accommodation that was felt to be unsuitable for their individual needs, even if other residents had moved on to these (e.g. hostels); the Respite Room manager kept them for longer stays. Other popular move-on destinations were different forms of supported housing, such as a women's hostel or a supported studio flat operated by a housing provider.

5.3.13. In another area, most women moved either to a supported accommodation building, or to another temporary housing building (which was unsupported). A few moved to council houses or private rented accommodation (rents were not too high for a bedsit locally). A handful of women returned to the local (mixed sex) homeless hostel, but this was viewed as a negative outcome.

5.3.14. In two areas, lack of adequate move-on options for service users was a key reason for lack of move-ons. This was partly attributed to inadequate move-on facilities and partly to the timescales required.

> "The model requires move-on within 8 to 12 weeks which hasn't worked in practice due to the inadequate supply of appropriate move-on facilities such as supported housing vacancy or independent flat or bedsit. The model does not enable a sufficient period of recovery or stabilization and sometimes people are moved before they are ready to move, due to the requirement to do so which isn't person- centred."
>
> LA Lead

5.3.15. **Local variation**

5.3.16. There was substantial local variation between projects in move-on destinations, as shown in Table 5.5 to Table 5.8. In some cases, the differences in outcomes between projects were quite stark, ranging from 12% to 56% entering broadly 'positive' destinations, and from 19% to 62% leaving for broadly 'negative' destinations.

5.3.17. There are many factors which could lead to more 'negative' or 'positive' move-ons, including the level of need among the client group, and the local availability of move-on destinations, as well as the performance of the service itself. A service should not therefore be judged as 'successful' or 'unsuccessful' based simply on these statistics.

5.3.18. For example, as explored in Chapter 4. Westminster and Leicester faced particular headwinds due to more than a third of residents having NRPF, and therefore facing restricted move-on destinations. Looking at organisations achieving high 'successful' move-on rates, a key commonality seems to be the organisation either owning or having strong existing local links with potential move-on accommodation.

Table 5.1 Destinations from Respite Rooms, % of users leaving service, by location – A to B

Service	Birmingham	BCP	Bristol
Base	*18*	*33*	*58*
Night shelter or homeless hostel	0%	0%	3%
Social housing	13%	14%	5%
DA Safe Accommodation	25%	14%	10%
Staying with friends or family	6%	0%	13%
Street homelessness	6%	3%	5%
Non-DA Supported housing	6%	21%	24%
Returned to perpetrator	13%	10%	8%
B&B or Hotel (unprompted)	0%	14%	6%
Private Rented Sector	0%	3%	2%
Drug or Alcohol project	6%	7%	3%
Hospital	0%	0%	6%
Home country	13%	0%	0%
Mental health project	0%	0%	0%
Housing First	0%	0%	2%
Other	13%	14%	13%
Total: Broadly positive	**50%**	**56%**	**44%**
Total: Broadly negative	**19%**	**27%**	**28%**

Source: DLUHC Respite Room data returns, October 2021 to January 2023

Table 5.2 Destinations from Respite Rooms, % of users leaving service, by location – C to K

Service	Camden	Exeter	East Sussex
Base	*60*	*31*	*35*
Night shelter or homeless hostel	8%	22%	0%
Social housing	12%	25%	6%
DA Safe Accommodation	22%	0%	6%
Staying with friends or family	4%	9%	26%
Street homelessness	8%	3%	16%
Non-DA Supported housing	4%	9%	0%
Returned to perpetrator	8%	16%	6%
B&B or Hotel (unprompted)	12%	6%	10%
Private Rented Sector	16%	3%	13%
Drug or Alcohol project	2%	0%	0%
Hospital	2%	6%	10%
Home country	0%	0%	0%
Mental health project	2%	0%	0%
Housing First	0%	0%	0%
Other	2%	0%	6%
Total: Broadly positive	**42%**	**34%**	**12%**
Total: Broadly negative	**38%**	**53%**	**42%**

Source: DLUHC Respite Room data returns, October 2021 to January 2023

Table 5.3 Destinations from Respite Rooms, % of users leaving service, by location – L to M

Service	Leicester	Liverpool	Manchester*
Base	*44*	*61*	*37*
Night shelter or homeless hostel	15%	18%	3%
Social housing	3%	26%	5%
DA Safe Accommodation	32%	0%	0%
Staying with friends or family	12%	16%	3%
Street homelessness	0%	8%	8%
Non-DA Supported housing	3%	5%	16%
Returned to perpetrator	15%	2%	3%
B&B or Hotel (unprompted)	6%	0%	5%
Private Rented Sector	0%	5%	11%
Drug or Alcohol project	3%	10%	0%
Hospital	0%	3%	5%
Home country	6%	0%	3%
Mental health project	3%	2%	0%
Housing First	0%	0%	0%
Other	3%	5%	38%
Total: Broadly positive	**44%**	**43%**	**21%***
Total: Broadly negative	**36%**	**31%**	**24%***

Source: DLUHC Respite Room data returns, October 2021 to January 2023 *limited data recorded due to data sharing restrictions.

Table 5.4 Destinations from Respite Rooms, % of users leaving service, by location – N to Z

Service	Nottingham	Portsmouth	Westminster
Base	*21*	*17*	*128*
Night shelter or homeless hostel	14%	53%	23%
Social housing	0%	0%	18%
DA Safe Accommodation	7%	0%	16%
Staying with friends or family	17%	0%	7%
Street homelessness	31%	6%	11%
Non-DA Supported housing	3%	12%	1%
Returned to perpetrator	17%	6%	2%
B&B or Hotel (unprompted)	0%	0%	7%
Private Rented Sector	7%	6%	3%
Drug or Alcohol project	3%	12%	1%
Hospital	0%	0%	0%
Home country	0%	0%	5%
Mental health project	0%	0%	3%
Housing First	0%	0%	0%
Other	0%	6%	4%
Total: Broadly positive	**13%**	**24%**	**39%**
Total: Broadly negative	**62%**	**65%**	**43%**

Source: DLUHC Respite Room data returns, October 2021 to January 2023.

5.3.19. Some factors appeared to be associated with providers achieving more successful move-ons such as:

- The availability of a **range of locally available specialist supported services**, such as those found in larger cities. This was a particular advantage for London-based projects, and a strong disadvantage for projects located in more isolated locations (e.g. Exeter and East Sussex).
- Mainstream DA and/or homelessness **services being run by the same provider**, willing to take individuals based on their colleagues' recent experience, rather than looking at their past record. This was a particular advantage in Birmingham, Liverpool and Leicester.

5.3.20. A range of factors were cited for move-on being difficult:

- **Individuals with no recourse to public funds (NRPF)** were particularly difficult to find accommodation for. As noted previously, the proportion of these was highest in Westminster and Leicester.
- Some individuals ready for move-on were reported to have **outstanding rent arrears or other debts**, had been victims of financial exploitation by a partner, or had a record of anti-social behaviour, making it particularly difficult to find a

housing provider willing to take them. This however would have been an issue everywhere, and would not have affected move-on at one location more than any other.
- Some mentioned **overall high pressure on housing stock in their area**, due to factors affecting all lower income households (in particular in London and seaside locations).

5.3.21. There was also substantial variation by project in length of stay, as shown in Table 5.9 to Table 5.12. At some projects (e.g. BCP, Camden, Manchester, Portsmouth) a large majority of residents stayed for more than four weeks, a key factor in the lower throughput of service users than anticipated outlined in Chapter 4. At other projects (e.g. Westminster, Leicester) stays were much shorter.

5.3.22. For one Respite Room, stays were generally longer than originally anticipated, both because it took time to build trust and rapport with residents, and because suitable move-on accommodation was not immediately available.

5.3.23. In Leicester, one of the few services with a majority of stay lengths approximating the original Respite Room concept, a dedicated six-bed second stage move-on facility had been put in place, using separate funding. Even here, staff quickly realised that the women often needed to stay much longer than the two-week target. Staff felt this was not long enough to engage with the women and get them the support they needed or wanted (e.g. time taken to apply for benefits with women and have those come through). One staff member felt that a minimum of two months was more realistic.

Table 5.5 Length of stay in Respite Rooms, % of users leaving service, by location – A to B

Service	Birmingham	BCP	Bristol
Base	*18*	*33*	*58*
Less than 1 week	47%	4%	16%
1 to 2 weeks	20%	4%	8%
2 to 4 weeks	27%	7%	23%
More than 4 weeks	7%	86%	53%

Source: DLUHC Respite Room data returns, October 2021 to January 2023

Table 5.6 Length of stay in Respite Rooms, % of users leaving service, by location – C to E

Service	Camden	Exeter	East Sussex
Base	*60*	*31*	*35*
Less than 1 week	6%	3%	2%
1 to 2 weeks	2%	3%	11%
2 to 4 weeks	12%	26%	32%
More than 4 weeks	81%	68%	55%

Source: DLUHC Respite Room data returns, October 2021 to January 2023

Table 5.7 Length of stay in Respite Rooms, % of users leaving service, by location – L to M

Service	Leicester	Liverpool	Manchester
Base	*44*	*61*	*37*
Less than 1 week	38%	9%	6%
1 to 2 weeks	26%	14%	11%
2 to 4 weeks	10%	23%	8%
More than 4 weeks	26%	54%	75%

Source: DLUHC Respite Room data returns, October 2021 to January 2023

Table 5.8 Length of stay in Respite Rooms, % of users leaving service, by location – N to Z

Service	Nottingham	Portsmouth	Westminster
Base	*21*	*17*	*128*
Less than 1 week	0%	0%	46%
1 to 2 weeks	29%	6%	24%
2 to 4 weeks	55%	12%	7%
More than 4 weeks	16%	82%	23%

Source: DLUHC Respite Room data returns, October 2021 to January 2023

5.3.24. **What worked**

5.3.25. It is difficult to tease out ‘what works’ in this context, given that projects faced differing situations. Many factors were external to the projects and beyond their control. Inevitably the projects dealing with clients with the highest levels of need (as documented in section 4.5) found achieving successful outcomes for a service user more difficult. However, some projects with clients with high levels of need were, nevertheless, successful in terms of statistical outcomes.

5.3.26. A couple of projects experienced particular difficulties in achieving ‘positive’ move-ons due to specific local issues, such as organisational problems, internally or with partnership working, or close proximity to a service which caused difficulties for residents.

5.3.27. Respondents interviewed in-depth, especially staff working with service users, generally believed that successful outcomes were dependent on a substantially longer stay length than originally envisaged. It is notable that the two services with shorter stay length despite not owning move-on accommodation (Nottingham and Westminster) did have fewer move-ons to apparently ‘positive’ destinations, in both cases despite strong support provision.

5.3.28. Well-established local networks between organisations also appeared to be key. Projects that were building networks from scratch often reported slower start times, but also seem to have experienced fewer ‘positive’ move-ons, although this may relate to these projects often being in more isolated locations. It is clear, though, that projects

with established links and operating within wider organisations (e.g. Leicester, Birmingham, Liverpool) often drew on these networks and used them to good effect.

6. Respite Room impact

6.1. Summary

6.1.1. A key question that the evaluation of Respite Rooms set out to address is the extent to which Respite Room support has an impact on service users' immediate outcomes, and the advice and support they receive.

6.1.2. This chapter attempts to answer this question, comparing the short-term outcomes of Respite Room service users with those of a comparable group of people who did not go into a Respite Room.

6.1.3. Overall, Respite Rooms appear to have a large and statistically significant impact on the proportion of service users moving to safe accommodation and on the proportions receiving advice and support.

6.1.4. This is in line with the perceptions of staff and project leads, who strongly believed the Respite Rooms were having a positive impact on service users. Individual service users spoken to during the project testified to this, with many experiencing a substantial improvement in their situation. They also often praised the support they had received. Service users described the impacts of staying in the Respite Room as: making plans for the future, recognising needs for support, acknowledging addictions, caring for themselves, improved wellbeing, and rebuilding family relationships.

6.2. Impact Analysis Design

6.2.1. For this evaluation, following the approach recommended in the separate Feasibility Study, the impact of Respite Rooms has been measured using a Quasi-Experimental Design (QED). This involved comparing the outcomes of Respite Room service users against those of a matched comparison group of non-users. We controlled for observed differences in characteristics and circumstances before the Respite Room service users entered the service, to ensure that like is being compared to like, and to isolate (as best as possible) the impact of the programme from the effects of differences in underlying characteristics. The comparison group therefore aims to represent what would have happened to the Respite Room service users if they had not gone into a Respite Room. The design is summarised here, with full details described in Annex A.

6.2.2. **Variables**

6.2.3. The Impact Analyses required data about Respite Room service users and their comparators at two points in time:

- **'At baseline':** for Respite Room service users this was as they entered a Respite Room; for the comparison group it was at a point when they were deemed eligible for a Respite Room (see below).
- **'At follow up':** for Respite Room service users this was the point they left the Respite Room; for the comparison group, this was three months after baseline, to reflect a typical Respite Room stay.

6.2.4. The purpose of the baseline data was to check that the profile of the comparison group is close to that of the Respite Room service users, and to adjust for any differences in the analysis using Propensity Score Matching (PSM) (for further detail, see Appendix B). The baseline variables collected were:

- Housing situation
- Engagement with services
- Demographics and starting characteristics (gender, age, BAME, NRPF, whether disabled, whether had known mental health problems, whether had known addictions)
- Domestic abuse/violence against women and girls (DA/VAWG)

6.2.5. The purpose of the follow up data was to compare the outcomes of the Respite Room service users with those of the comparison group, having ensured that they were matched at baseline. The outcome variables collected at follow up were:

- Housing situation (so, for Respite Room service users, their move-on destination)
- Support services accessed since baseline (so, for Respite Room service users, during the Respite Room stay)

6.2.6. The findings sections below give greater detail on the definitions of these outcomes.

6.2.7. Local Authorities (LAs) provided the baseline and follow up data, populating a spreadsheet designed and provided by the evaluation team. Project teams were asked to provide data on:

- All Respite Rooms users;
- A comparison group of ideally 20, but a minimum of 10, people per LA.

6.2.8. Nearly all pilot LAs (11 of 12) provided data on their Respite Room users[15], covering between them 461 users, and nine did so for a comparison group, giving a comparison group of 153.

6.2.9. **Sources of the comparison group**

6.2.10. The identification of a comparison group was not standardised across LAs, because the majority of scoping interviews suggested that this would not be feasible for LAs to provide. Barriers included difficulties accessing data systems held by other departments or shared across multiple LAs, and wide variation in the extent to which identifiable people were ‘turned away’ from services. This variation was not purely due to differences in demand between locations, but also because in some areas no referral would be recorded if the service was already known to be full by the LA.

6.2.11. Instead, LAs were asked to use their own local data systems to identify a “group of people who would have been eligible for a place in a Respite Room, but did not enter a Respite Room for any reason”. Potential routes to identifying a comparison group the evaluation team highlighted as acceptable were as follows:

[15] One LA provided a random sample of 20 of their Respite Room users rather than all users.

- People not entering the Respite Room for capacity reasons, or due to its geographical location. This was presented by the evaluation team to LAs as the preferred source.
- People referred but turned away from Respite Room because of their level of needs, as long as the profile of this group was not very different to Respite Room users on key characteristics (e.g. information on DA, VAWG and rough sleeping or risk of rough sleeping).
- People with similar characteristics identifiable on another LA database. LAs were asked to use a database that included enough information to be able to establish similarity to Respite Room users on the same criteria outlined above.
- People with similar characteristics on a provider's own records or a LA's referral list. Again, LAs were asked to ensure similarity to Respite Room users.

6.2.12. The majority of LAs (seven) selected comparison cases from their homelessness databases, but for two LAs the comparison group was selected from women who had been through another similar service. Data on which services comparison cases used (e.g. another form of accommodation) was not always available. Where it was, this was controlled for in the Impact Analysis. The reasons given for selecting people for the comparison group are shown in Table 6.1.

Table 6.1 Reasons for selection of the comparison group

Reason for selection	Number of people selected (n)
Similar characteristics but not offered Respite Room service	38
Chose not to enter Respite Room service	23
Did not enter because Respite Room service full	20
Turned down Respite Room due to high needs/risks	20
Entered Respite Room service but refused service/left	4
Turned down Respite Room/declined due to geographical location	3
Turned down Respite Room due to low needs/risks	1
Another reason	44
Total	**153**

Source: Impact Analysis calculations (March 2023)

6.2.13. The 'baseline date' allocated to each comparison group member was a date where the LA judged the individual to have been most likely to be eligible for a Respite Room (e.g. when they presented to the LA in crisis, for example due to imminent or current rough sleeping, or due to a DA incident).

6.2.14. In addition to the baseline and follow up variables, LAs were asked to provide the following information about the comparison group members:

- The source of the data on the comparison group.
- The reason for selection per individual.

- An assessment of whether the individual is of similar, higher or lower level of need to Respite Room cases.
- Whether entered a Respite Room during the three-month follow-up period.
- Whether entered a DA refuge during the follow-up period.
- Whether engaged with services for those with additional/complex needs during the follow-up period.

6.2.15. This information was used to test the sensitivity of the impact estimates to various decisions as to who to include or exclude as valid comparators (see Appendix C).

6.2.16. The analysis presented here excludes those in the Respite Room group who were recorded as still being in a Respite Room (n=47 from 461) and those in the comparison group who were recorded as having entered a Respite Room in the three months after their baseline date (n=15 from 153). A further 18 cases were excluded from the Respite Room users group because age was not recorded, this being a key variable for the propensity score matching. The final analysis sample sizes are 396 for the Respite Room users group and 138 for the comparison group.

6.2.17. **How Impact Analysis findings are presented**

6.2.18. The sections below report separately on the impact of Respite Rooms on (a) service users' accommodation as they leave Respite Rooms and (b) the help and support they had received during their time at a Respite Room. The figures show the percentages of Respite Room service users and the propensity score matched comparison group with a 'positive' outcome at follow up. The differences between the two groups have been tested for statistical significance, with the tests taking into account the PSM weights. A p-value of less than 0.05 has been used as the threshold for significance, with significant findings denoted with an asterisk.

6.2.19. A number of sensitivity analyses have been carried to test whether the findings are sensitive to decisions about who is included or excluded in the Respite Room and comparison groups. In general, they are not sensitive to these decisions, with the exception that if the comparison group excludes the two LAs where comparison women had entered another similar service, the impacts increase in size. However, given that entry to another service is a valid counterfactual, the main analysis reported on here includes all the comparison cases.

6.2.20. The sensitivity analyses are detailed in Annex A. In summary, they cover:

- Reducing the Respite Room users group to those with outcomes recorded between two and four months, to give a better match to the outcome period for the comparison group of three months.
- Excluding those with NRPF, of whom there are 76 in the Respite Room group, but less than 10 in the comparison group.
- Restricting the comparison group to those recorded as having 'similar levels of need' to the Respite Room users.
- Reducing the comparison group to LAs that did not select their comparators from users of another similar service.
- Reducing the analysis to those LAs that gave both Respite Room user and comparison data.

6.3. Impact on immediate housing situations

6.3.1. LAs were asked to provide information about Respite Room service users' move-on destinations and about the housing situation of each comparison group member three months after baseline. The categories matched those collected as part of the standard Respite Room Monitoring Information (MI).

6.3.2. The primary outcome of interest is the percentage of Respite Room service users who leave to be in safe or secure accommodation, compared to the situations of those who had not been into a Respite Room.

6.3.3. It is recognised that immediate move-on destination can only be a general guide to the subsequent circumstances of individuals. Based on interviews with providers, individuals with these move-on destinations are more likely to have positive outcomes than those moving into other destinations (e.g. returning to the streets, to a mixed-sex homeless hostel). However, it is recognised that some moving on to these destinations will not see a sustained improvement in their situation, and indeed that a move to these locations may not be appropriate even in the short term for some individuals. However, in the absence of long-term case-by-case follow-up of individuals, it is the best indicator available of a successful outcome.

6.3.4. With this in mind, safe or secure accommodation, for the purposes of the Impact Analysis calculations only, was defined as:

- DA Safe Accommodation
- specialist accommodation/rehab (mental health, drug/alcohol, etc.)
- other supported housing (including DA supported housing)
- ordinary housing (social housing, private rented, Housing First)16
- settled with friends/family

6.3.5. The top of Figure 6.1 shows that two thirds (65%) of Respite Room service users moved to safe or secure accommodation when they left the Respite Room (the blue bar). Statistically, this was significantly more likely than the comparison group (the green bar), among whom half (48%) were in safe or secure accommodation after three months (a percentage point difference of 17, p-value <0.001).

6.3.6. Figure 6.1 also provides a breakdown of the types of accommodation that Respite Room service users and the comparison group were in at follow up, grouped into accommodation which was safe or secure and that which was not.17

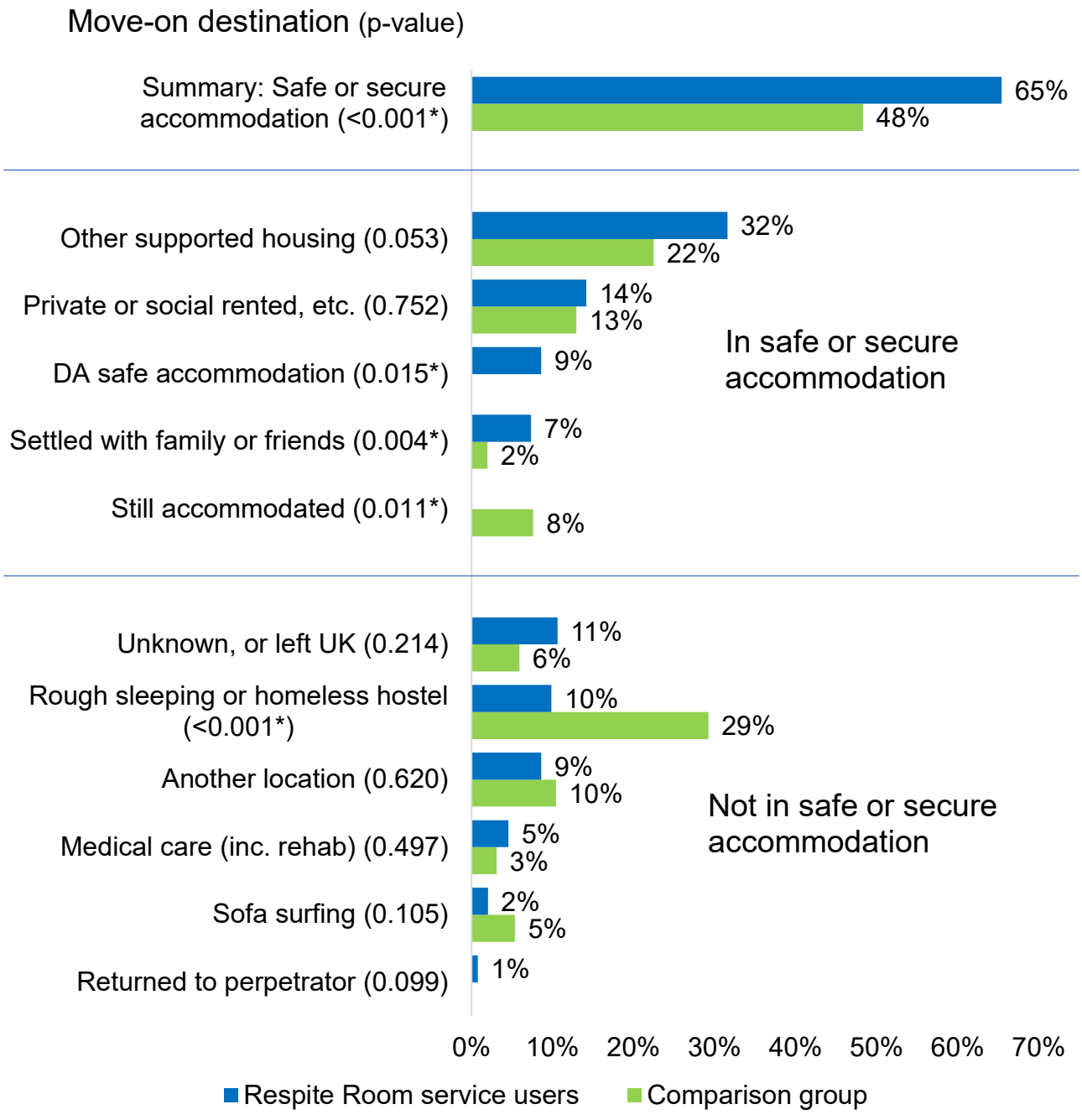
6.3.7. One in ten (9%) Respite Room service users had left a Respite Room to DA secure accommodation (this compares to fewer than three people in the comparison group, so the percentage is not shown on the chart) (p-value 0.015). Significantly more Respite Room service users (7%) had moved in with family or friends, than in the comparison group (2%) (p-value 0.004). Although more Respite Room users than the comparison

[16] It should be noted that although a move-on to ordinary housing could imply a return to perpetrator, this was a separate recording category in the MI data, and therefore should not be included.
[17] Where fewer than three people were in a particular accommodation type, percentages have not been shown, to protect anonymity.

group were in other supported housing at follow up (32% compared to 22%), this difference did not quite reach statistical significance (p-value 0.053).

6.3.8. In contrast, members of the comparison group were significantly more likely than the Respite Room service users to be rough sleeping (10% Respite Room service users; 29% comparison group, p-value <0.001) at this point.

Figure 6.1 Housing situation at follow-up



Source: LA provided data on Respite Room users (Base: 396) and comparison group (Base: 138). Data available in accessible form in Annex G.

6.4. Impact on receipt of advice and support

6.4.1. LAs were asked to provide information about the advice and support that Respite Room service users took up during their time in a Respite Room as well as the advice and support that the comparison group had had in the three months after baseline. As with the accommodation types, the categories matched those collected as part of the standard Respite Room Monitoring Information (MI), namely:

- Housing related support
- Advocacy support
- DA prevention advice
- Other VAWG safety and prevention advice
- Support for victims with additional or complex needs
- Advice services (e.g. financial and legal support)
- Counselling or therapy
- Support for victims with protected characteristics

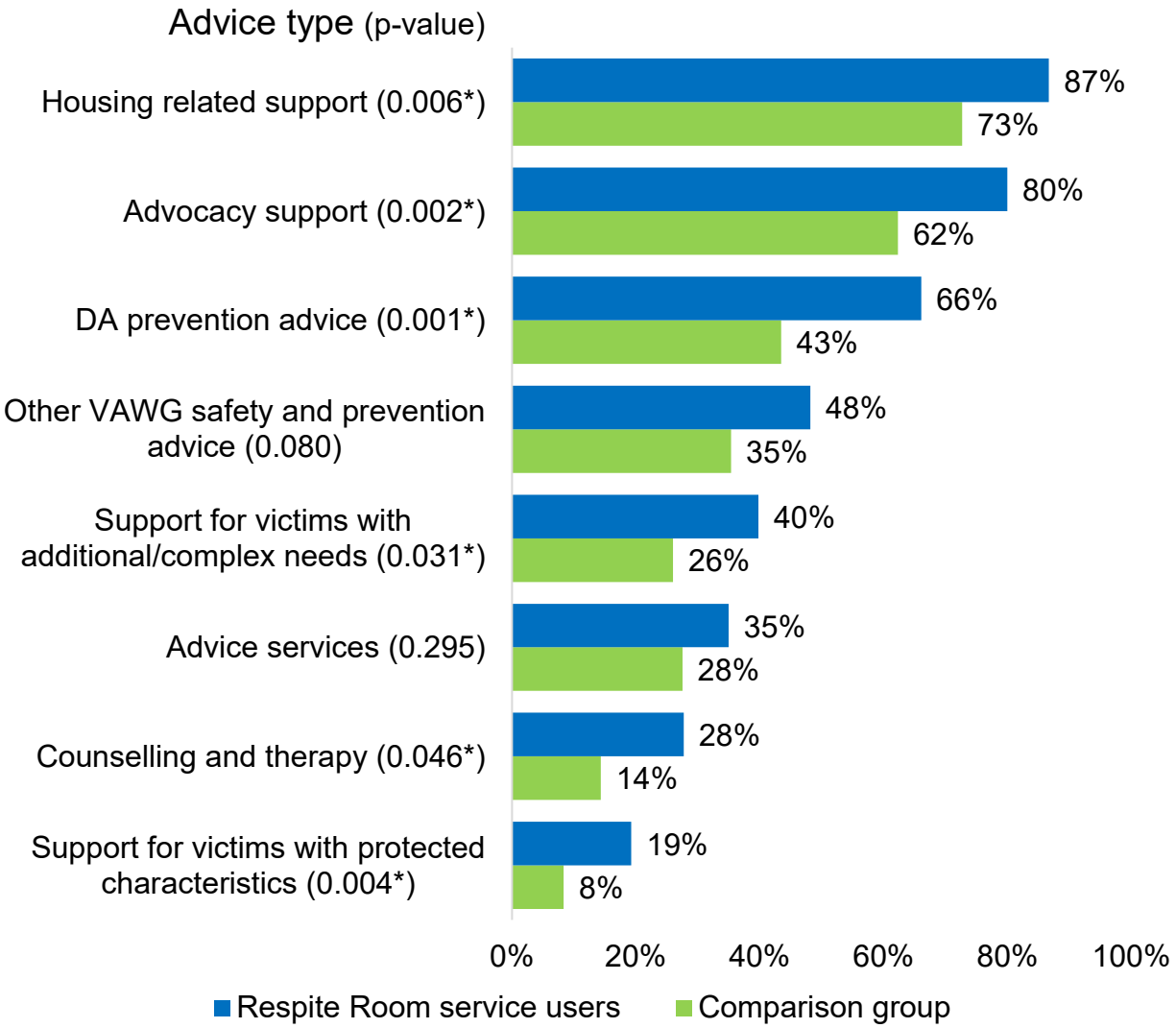
6.4.2. Figure 6.2 shows the percentage of Respite Room service users and the comparison group who had received each type of advice or support during the period, in descending order of prevalence[18]. The rank order of prevalence was almost the same among Respite Room service users and the comparison group, with the most common forms of support being housing related, advocacy, DA prevention advice and other VAWG safety and prevention advice. However, more Respite Room service users had received each type of advice or support than among the comparison group. The difference between Respite Room service users and their counterparts reached statistical significance in relation to six of the eight service types:

- Nine in ten (87%) Respite Room service users had had housing related support compared to three quarters (73%) of the comparison group (percentage point difference of 14, p-value 0.006);
- Eight in ten (80%) Respite Room service users had had advocacy support compared to six in ten (62%) of the comparison group (percentage point difference of 18, p-value 0.002);
- Two thirds (66%) of Respite Room service users had had DA prevention advice and support compared to four in ten (43%) of the comparison group (percentage point difference of 23, p-value 0.001).
- Four in ten (40%) Respite Room service users had received support for victims with complex needs compared to a quarter (26%) of the comparison group (percentage point difference of 14, p-value 0.031).
- Three in ten (28%) Respite Room service users had received counselling or therapy compared to 14% of the comparison group (percentage point difference of 13, p-value 0.046).
- One in five (19%) Respite Room service users had received support for victims with protected characteristics compared to 8% of the comparison group (percentage point difference of 11, p-value 0.004).

[18] The percentages are based on Respite Room service users or comparison group members for whom there was a ‘yes’ or ‘no’ answer in relation to receipt of the particular service.

6.4.3. Overall, Respite Room service users had received an average (mean) number of 4.03 services whilst in a Respite Room, compared to 2.53 among the comparison group (p-value <0.001).[19]

Figure 6.2 Receipt of advice and support since baseline



Source: LA provided data on Respite Room users' receipt of advice or support (Base: 369 to 390 depending on service type) and comparison group (Base: 87 to 111 depending on service type). Data available in accessible form in Annex G.

6.5. Association between receipt of advice and support and entering safe or secure housing

6.5.1. Among both Respite Room service users and their matched counterparts, those who had received advice or support were statistically significantly more likely to have been in safe or secure housing at follow-up. These findings suggest that the positive impacts of

[19] Based on Respite Room service users or comparison group members for whom there was a 'yes' or 'no' answer in relation to all services.

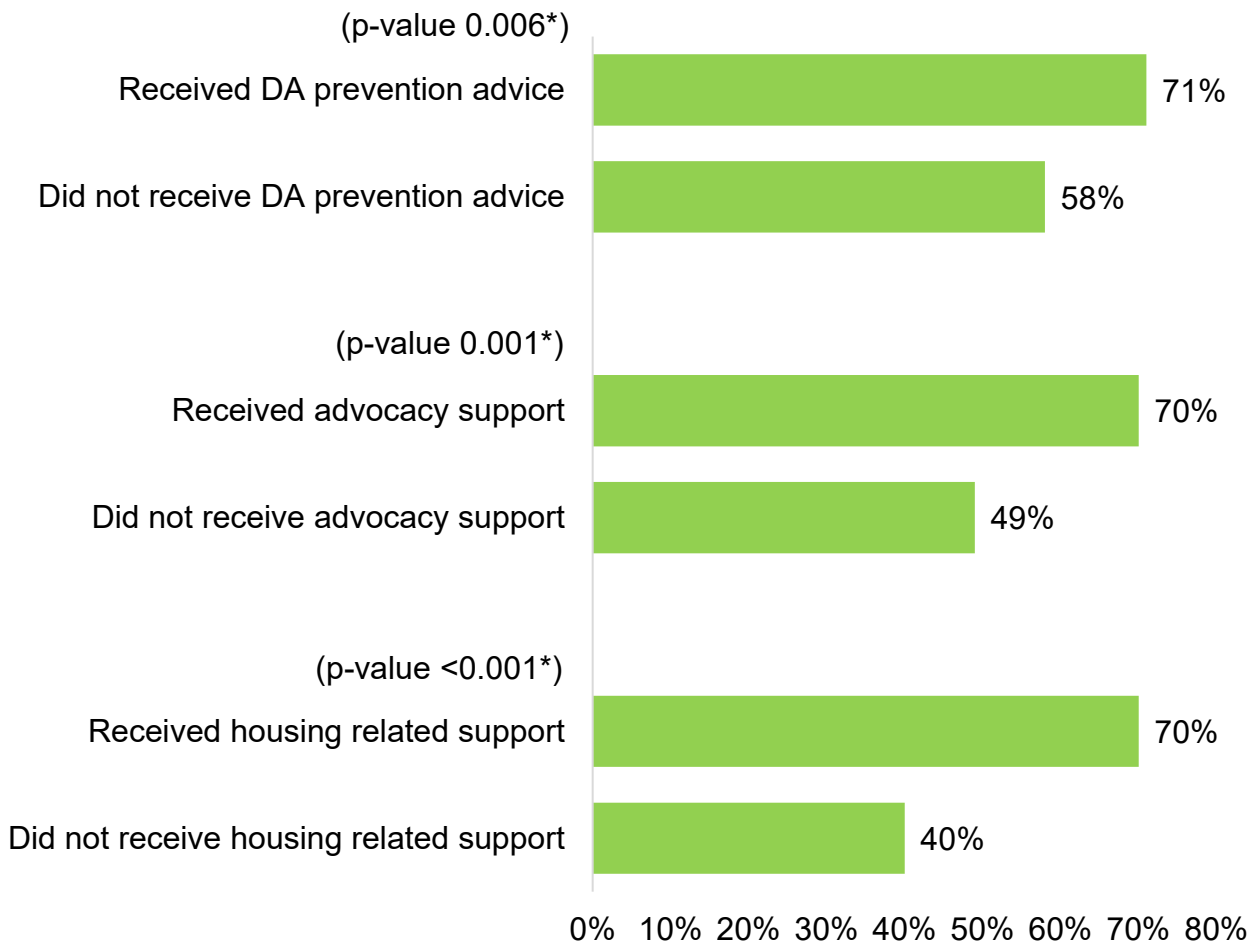
Respite Rooms (against those of the comparison group of business as usual) are at least in part due to higher levels of receipt of advice and support within Respite Rooms.

6.5.2. Figure 6.3 illustrates this point among Respite Room users20, taking as examples the three most frequently received forms of support: housing related and advocacy support, and DA prevention advice. It shows the percentage of Respite Room service users in safe or secure accommodation, split by those who had and had not received each type of advice or support. In each case, those who had received the advice were significantly more likely to be in safe or secure housing than those who had not.

6.5.3. For instance, among those who had received DA prevention advice, seven in ten (71%) left the Respite Room into safe or secure accommodation, compared to 58% of those who had not received the advice (p-value 0.006). Similarly, 70% of Respite Room service users who had received advocacy support left the Respite Room into safe and secure accommodation, compared to half (49%) of those who had not received the support (p-value 0.001). Finally, among those who had received housing related support, seven in ten (70%) had left the Respite Room for safe or secure accommodation compared to four in ten (40%) who had not received housing-related support (p-value <0.001).

[20] There was a very similar pattern among the comparison group.

Figure 6.3 Percent in safe or secure housing by receipt of advice and support



Source: LA provided data on Respite Room users in safe or secure housing who provided data on receipt of DA prevention advice (258), advocacy support (256) or housing related support (259). Data available in accessible form in Annex G.

6.6. Views on impact

6.6.1. Impact on service users

6.6.2. Wraparound support for service users was provided in many forms. This included financial support such as signing up to benefits or advice on budgeting, health care including signing up to a GP or dentist, immigration support such as applying for indefinite leave to remain, housing support including applying for social housing, and access to training or qualifications. Beyond the practical support offered, service users often focused on the importance of the emotional support they received. As one user described:

> "I've made a new family and they're really supportive. They all understand, and we've all got our own issues, but we all love each other in our own way."
>
> Service User

6.6.3. The impacts of Respite Room stays on service users were varied and wide-ranging. Service users described the impacts of staying in the Respite Room as: making plans for the future, recognising needs for support, acknowledging addictions, caring for themselves, improved wellbeing, and rebuilding family relationships.

6.6.4. Service users and staff focused on emotional impacts, including increased self-worth, self-confidence, strength, hope and independence.

> "The respite has given me self-worth. That's something I never had, and now I have that. It's odd. But nice. I've never had support before… Having people care about me had a knock-on effect. I can do boundaries now to keep myself safer. I'm less of a pushover. I have got my fight back."
>
> Service User

> "I went to Crown Court, and I stood up against him in court, I never would've been able to do that before, and I did it".
>
> Service User

> "I'm excited about life, I've got hope…I've got a life to live for, I want to get my son back… I want to get a job and be a working mum for my boy".
>
> Service User

> "I've got options now… never had that… I can say yes, or I can say no… it's my choice".
>
> Service User

6.6.5. In some cases, the Respite Room programme helped to build trust and had proven to vulnerable individuals that a service was able to help. As a result, service users had been able to access more support for multiple complex needs. As one service user put it:

> "They've stopped me from being left out to dry. They've helped me feel grounded. They've shown me that services exist to help. That people do care. I don't think many services like that exist".
>
> Service User

6.6.6. With intensive engagement and extensive holistic support, people with multiple complex needs could be successfully engaged and stay engaged with services going forward.

6.6.7. Although evidence is limited, the men's Respite Room project (targeted at men who were vulnerable to abuse, but not with the same level of complex need) also was appreciated by service users and staff felt it had averted a spiral of decline into harmful behaviours and exploitation which was probable had they been admitted to a men's homeless shelter or spent longer on the streets.

6.6.8. The monitoring data supported this; Figure 6.4 shows that more than half of users leaving the Respite Room (including those leaving without engaging) felt that the Respite Room had helped them, and two thirds felt comfortable and safe in the Respite Room.

Figure 6.4 Impact of Respite Rooms for service users, % of service users agreeing with statements on leaving

Source: DLUHC Monitoring Data (October 2021 – January 2023). Excludes Camden due to data recording issues. Data available in accessible form in Annex G.

6.6.9. **Impact on other services**

6.6.10. The Respite Room programme had a positive impact on a wide range of services. In particular, it offered alternative and specialist provision within local homelessness services and so alleviated pressures on these.

6.6.11. Project leads described how the Respite Room helped by offering extra beds where there was limited capacity, and the accommodation was better able to offer support for this particular group. Project leads also noted that other local street homelessness services appreciated having the Respite Room service. One explained that this had reduced the number of rough sleepers in their local area.

6.6.12. There were also many positive impacts on local DA services. In particular, the Respite Room programme took pressure off local refuges, as Respite Rooms were able to support people with multiple complex needs where refuges could not. One project lead described how the refuges in their area are running more smoothly:

> “It's made management of the refuges easier because it's made sure that the people in the refuge are getting their support and not being impacted by somebody who perhaps has got higher needs and not really coping there - and vice versa."
>
> LA provider

6.6.13. More broadly, Respite Rooms provision has helped DA services. For some surrounding services (e.g. homelessness services) there has been a greater awareness of the different forms of DA, which has helped vulnerable people access the help they needed. For some DA services, they have been able to add the accommodation programme as an option in their service they had not had before.

6.6.14. Interviewees reported that health services have also been positively affected. Drug and alcohol support services have connected with the Respite Room and been able to support users who might not have otherwise engaged. There have reportedly been fewer missed appointments and fewer hospital visits thanks to the Respite Room support.

6.6.15. One project lead described that the Respite Room had avoided individuals reaching crisis situations and as a result this has have avoided emergency services being called out. Additionally, in some areas, police were working with Respite Room service users and were able to refer into the Respite Room. One project lead described that the Respite Room had resulted in fewer police call outs.

6.6.16. There were also some wider impacts on the justice system and in local policy making. In one case the Respite Room had prevented a jail sentence for a service user:

> "The judge has agreed that they're really trying, and they've got that support in place so they've been given an opportunity".
>
> LA provider

6.6.17. In another area, the project lead described how they were using the data and learnings from the pilot to incorporate into the local accommodation strategy. The learnings had helped decision makers to think differently about making safe accommodation sustainable and consider how to improve access and reduce barriers for women who have multiple complex needs.

6.7. What worked

6.7.1. The Impact Analysis calculations showed that short-term impacts of Respite Rooms observed in relation to immediate move-on destinations and receipt of help and support whilst in a Respite Room were very encouraging.

6.7.2. Providers and stakeholders felt the Respite Rooms had a particularly positive impact on service users because they offered service users a sense of safety in accommodation combined with wraparound support. As a result, this often had an emotional impact on service users that built up their self-worth, self-confidence and independence. Most services reported strongly positive outcomes, although there were some variations as noted in Chapter 5.

6.7.3. The Respite Room was recognised as being effective at relieving pressure on other local services including homelessness services, Domestic Abuse services and emergency services. This is not simply in terms of reducing the net amount of people needing help from these services, but also in that those people moving from these services to Respite Rooms would typically have high needs, and be difficult to help.

6.7.4. Ideally, further evaluation work of Respite Room would allow for the estimation of longer-term outcomes, to test whether the advice and support and the immediate impacts of getting people into safe or secure accommodation lead to better outcomes over a longer period.

7. Looking forward

7.1. Summary

7.1.1. This chapter focuses on the learnings shared between Respite Rooms areas and the future of the Respite Rooms projects following the 18-month pilot.

7.1.2. DLUHC has hosted regular workshops for LAs and Providers during the pilot, where learnings and insight were shared across Respite Rooms areas. The workshops were well-attended and were considered helpful. However, only a few of the Respite Rooms leads have shared learnings with one another beyond these dedicated sessions.

7.1.3. Whilst there is no dedicated funding scheme to extend the Respite Rooms projects beyond the pilot, there are various opportunities to access other funding, such as the Rough Sleepers Initiative and utilising the LA New Burdens Duty funding for support. DLUHC note that it is for LAs to discuss at the local level what funding options are available, and how similar projects might be funded in future.

7.1.4. It has now been confirmed by DLUHC that most (10 of 12) Respite Room pilot projects have now secured funding for the next financial year.

7.2. Sharing learning

7.2.1. **Extent to which learning has been shared**

7.2.2. The main way in which learnings have been shared thus far have been at the DLUHC-facilitated online workshops. Workshops for LAs are run every month, and for Providers every other month.

7.2.3. These workshops have been described as very helpful by both LA Leads and Provider Leads, and attendance has generally been good (although with lower attendance at the Provider workshop, which tends to be attended only by Provider Leads rather than a wider range of staff).

> “Having meetings across the country with …DLUHC have been really helpful. It’s been good knowing what the other Respite Rooms teams are doing, including discussing tips, successes and challenges. That regular meeting was really valuable.”
>
> LA Lead

7.2.4. One provider described an important benefit of the workshops as showcasing the similarities between the Respite Rooms in terms of the challenges they all experienced.

> “The DLUHC meetings have been helpful. They've highlighted that the different regions are experiencing the same barriers - move-on accommodation, length of stays - and they've been able to share how they have overcome these.”
>
> Provider Lead, follow-up interview

7.2.5. Another provider described how she had taken insight gained from the workshop and applied it to her own Respite Room:

> “Listening to the other providers and how they work with partners in their areas is something I've been jumping onto… Somebody mentioned about having an IDVA (Independent Domestic Violence Advisors) in the building, which was a great idea, so we now have an IDVA who drops into us."
>
> Provider Lead, follow-up interview

7.2.6. However, aside from the DLUHC workshops, only a few of the Respite Rooms leads have shared learnings with one another. Project Leads did not report consistent ways in which they had shared learnings, although a few offered anecdotal examples. In all cases, the shared learnings were reported to be helpful. Examples included:

- Attending other Respite Rooms’ Steering Group meetings and inviting colleagues to theirs
- Presenting to partners in the local area and sharing some learning.
- Raising the profile of the Respite Rooms via visits from the Domestic Abuse Commissioner for England and Wales, the Police and Crime Commissioner and local councillors.
- Visiting the Westminster Respite Room to discuss what works well there – which reassured them that their plans reflected “what's already in Westminster and working”.
- Meeting with a Respite Room area to discuss their designated buildings model, and how they overcame challenges in affordability. This shared learning was used to build a business case for future provision.

7.2.7. Typical reasons given for not sharing learnings included time pressure – staff have been focusing on their own Respite Room and have not had time to reach out to other areas. Another reason was the elapsed time taken to fill vacancies, meaning that they did not yet have any learnings to share.

> "We've been really quite focussed on just our little area in terms of trying to get it going… We've got five Districts and Boroughs and trying to get everybody together and coordinate the different local areas… I think our focus has been on just our local provision."
>
> Provider Lead, follow-up interview

7.3. Future of Respite Rooms

7.3.1. There is no funding pot for Respite Rooms specifically following the end of the pilot. LAs have the option of utilising their New Burdens Duty funding to pay for the support element. To cover the accommodation element, DLUHC has advised pilot authorities to explore a range of different options such as Housing Benefit, existing central government funding and other internal funding options.

7.3.2. **Funding secured by projects**

7.3.3. Most Project Leads confirmed at the time of follow-up interviews (January 2023) that they would like to continue the Respite Rooms as they fill a gap in provision. At the time of writing, DLUHC have confirmed that most (10 of 12) pilot projects have found continuing funding.

7.3.4. Some Respite Rooms had attracted additional funding from sources such as the Rough Sleeping Initiative, charitable grants or the New Burdens Duty funding. In at least one case this included ongoing funding from another source beyond the pilot project. At the time of fieldwork, others hoped to continue their local Respite Room and were in the process of applying for funding, or awaiting a decision on whether their LA would allocate them part of the New Burdens Duty funding, but had yet to hear the outcome.

> "We have the New Burdens funding to assist with the implementation of the new Domestic Abuse Act. The authority is considering whether they should use some of that funding to continue the Respite Rooms. Conversations remain ongoing and no decisions have yet been made."
>
> LA Lead, follow-up interview

7.3.5. Some LA Leads were optimistic about the likelihood of securing funding:

> "A joint bid has gone to [the] County Council with [two Respite Rooms providers] to look at funding. We're waiting for the outcome, but we're quite confident we'll get it."
>
> LA Lead, follow-up interview

7.3.6. Others were more pessimistic, citing a variety of reasons why they did not think they would be able to secure finding. These included funding around homelessness already being very stretched, the difficulty of justifying prioritising funding for a very small group of people, and how to measure the actual value of the Respite Room.

> "It is just hard to build a case on nuances. Individual-level data has been really key, and it's hard to know what that means for wider provision and what we do elsewhere. How do we scale that up? Is it sustainable, it is the right priority? How you evidence the value when it's for these women only?"
>
> LA Lead, follow-up interview

7.3.7. **Future support and potential sources of funding**

7.3.8. One stakeholder suggested that DLUHC could provide more technical assistance to the programme set-up for new locations, to support these in overcoming initial challenges. In addition, an ongoing 'learning network' between Respite Room locations / programmes would allow for a sustainable Respite Room model where Respite Room providers could discuss any challenges and learn from one another. Learning opportunities have already been implemented as part of the pilot programme, for the duration of pilot funding. This stakeholder had concerns about future funding for the Respite Room programme and highlighted that LAs would struggle to fund the programme without wider partnerships and evidence of a cost-benefit analysis, which demonstrates the long-term benefits. Further, partnership funding might change the focus of the programme to become more aligned with partner organisations' purposes and lose the uniqueness of the Respite Room programme.

7.3.9. The concern around future funding possibilities was echoed by a stakeholder, who understood LAs' concerns about funding a programme similar to Respite Rooms alongside competing priorities and limited resources.

> "There's a range of different kind of potential funding sources for something like this, but it's not that straightforward and it sits alongside really high pressures in lots of areas, on homelessness and … [the] really high cost of temporary and supported accommodation support provision for a range of vulnerable groups."
>
> National Stakeholder, DLUHC

7.3.10. Another DLUHC stakeholder emphasised the need to justify funding for the Respite Rooms programme. They argued that the Respite Room pilot programme has demonstrated the need for gender-specific services, which is particularly important in ensuring women's needs are funded proportionately, and the Respite Room programme provides intensive support to a relatively small group of people at any given time.

> "We've had to make the case about why we should fund something more expensive that will meet a specific need."
>
> National Stakeholder, DLUHC

7.3.11. Another national stakeholder highlighted the difficulties of scaling up a service like this due to the complex needs of the service users and the dynamics between residents. For instance, the relatively small number of service users within each Respite Room allows the staff to provide immediate and intensive support and provides a safe and friendly environment for service users, in comparison to accommodation with a larger number of service users where there could be more social challenges.

8. Conclusions

8.1. Summary

8.1.1. The Respite Rooms programme has been successful in providing accommodation and support to victims of DA and VAWG experiencing, or at risk of, street homelessness. The local level design enabled projects to deliver tailored approaches to meet local service users' needs and enable them to move-on to positive destinations available in their area (i.e. the local discretion is a feature of success).

8.1.2. This section of the report considers each of the research questions in turn, and identifies programme successes, areas for further improvement, and learnings for those seeking to commission, manage and deliver similar projects.

8.2. Summary of findings by theme

8.2.1. **Joint working: To what extent has the Respite Room programme enabled better joint working between LAs, housing providers and other support providers?**

8.2.2. The Respite Rooms programme has helped to support better joint working between partners, although the depth and range of partnership working has been variable by area and type of partner. Given short commissioning timescales, the majority of pilot LAs commissioned service providers with whom they already had working relationships to deliver the Respite Rooms provision. In some areas, there was more than one (lead) service provider.

8.2.3. Areas typically experienced some teething problems in working with providers, but joint working between LA homelessness and DA departments and service providers, was generally effective and improved over the course of the pilot. However, in some areas these relationships were more difficult, affecting the effectiveness of some interventions.

8.2.4. There were also some challenges for service providers with different approaches and areas of expertise in working together. For example, providers who usually ran DA refuges and those who had expertise in working with people with very high and complex needs (such as active substance use issues and long-term street homelessness) sometimes took some time to develop consistent approaches to providing support. Again, these relationships strengthened and became more effective over time.

8.2.5. Joint working between Respite Rooms providers and wider services was generally good. Particularly strong relationships were forged with mental, sexual and physical health services. Relationships with the police were more mixed, but there were examples of excellent practice here too. Relationships between individuals working across different services were crucial, and consideration should be given on how best to build on individual-level links to sustain them when staff move-on.

8.2.6. **Access to Respite Rooms: How do Respite Rooms reach those in need of support, and would these individuals access support otherwise?**

8.2.7. Respite Rooms adopted a range of mechanisms to reach those in need of support. In some areas, LAs were the sole agency with referral rights. This posed some challenges

in engaging people who were mistrustful of 'authority'. In other areas, Respite Room providers built links with a variety of referring partners, such as DA support providers, local charities, and groups representing women from specific minority communities. These areas tended to be more successful in engaging people who would not otherwise known about the Respite Room.

8.2.8. Respite Room users included both people leaving situations where they were experiencing DA, and those who have experienced wider forms of VAWG. Service users demonstrated a wide range of additional support needs, both in type and nature. The majority of Respite Room users had previously engaged with at least one service, although this was often unsuccessful. Several areas noted that it could take some time to persuade service users to come to a Respite Room. Some spent several months speaking to women who had long histories of street homelessness, to persuade them to access the Respite Rooms. These individuals were particularly unlikely to have successfully engaged with other forms of support, as were those with active substance use and dependency issues.

8.2.9. **Supporting vulnerable individuals: To what extent has the Respite Rooms programme met its objectives, including supporting vulnerable individuals? And what helped or didn't help this to happen?**

8.2.10. The Respite Rooms programme has been successful in meeting its objectives overall. Interviewees noted how the programme had supported people who were previously disengaged from or not known to services; and that it provided higher levels of support than standard hostels or refuge accommodation. The programme reached a good range of service users, including those experiencing DA and VAWG, and people with a range of complex needs including substance abuse and mental health problems. In a couple of areas, substantial numbers of service users had NRPF.

8.2.11. All the forms of support envisaged by DLUHC in the design of the Respite Rooms were provided, although some with greater reach than others. Enabling factors included: funding allowing improved staffing ratios; the focus on a trauma-informed approach; provision of single rooms and private spaces for individuals; a flexible, less rulebound approach; and intensive support form a range of service providers. Barriers included: some siloed working by wider service providers; some individuals finding it difficult to engage with the support provided; some service users returning to perpetrators of abuse; and challenges in identifying suitable move-on accommodation, meaning longer than anticipated stays and consequently fewer individuals being supported across the programme duration.

8.2.12. **Additional support: To what extent has the programme guided vulnerable individuals to accessing additional support?**

8.2.13. Service users and providers gave examples of how Respite Room users were supported to access additional support, including advocacy, health and financial support. This included Respite Rooms staff supporting service users in applying for additional support (e.g. specialist counselling) as well as other providers coming to the Respite Rooms building, thereby minimising physical barriers to engagement. The type of support provided and accessed varied by Respite Rooms project.

8.2.14. **Move-on destinations: To what extent have individuals leaving the Respite Room gone on to positive destinations (e.g. other forms of Safe Accommodation)?**

8.2.15. Move-on outcomes and stay length varied substantially by Respite Rooms, and some projects were much more successful than others in achieving initially positive moves.

8.2.16. Move-on was reported to be a major barrier to provision by most of the Respite Rooms, with most service users taking a longer time to move-on than originally envisaged. Difficulties with move-on included the lack of local services with low or medium support, finding housing providers who were willing to take service users with a history of rent arrears or debts, and the overall high pressure on housing stock in the area.

8.2.17. Key factors in determining success in achieving move-ons included the level of complex needs among service users, and the proportion with No Resource to Public Funds (NRPF), but also:

- Organisational effectiveness
- A diverse range of move-on services available locally, ideally with strong links to the provider
- An environment in and around the service which enables service users to get away from their previous problems
- Sufficient stay length to enable trust to be built between staff and service users

8.2.18. The Impact Analysis calculations confirmed that the Respite Rooms pilot achieved well in this area, with those using the service appearing to be more likely than other people in similar circumstances to move-on to a destination suggestive of a positive outcome.

8.2.19. **Geographical Variation: What does the Respite Room model look like in different locations? And how are LAs and partners able to tailor the model for local needs?**

8.2.20. The Respite Room model allowed for flexibility in terms of scale, physical buildings (e.g. one large building or several smaller houses), service provider expertise, referral pathways, and mix of support provided. Service user characteristics varied by area, in part reflecting local demographics and in part the nature of referring organisations and / or the expertise of the service providers.

8.2.21. Service providers responded to local needs by developing links with a range of other support services, including those led by or aimed at supporting people from a range of minority groups.

8.2.22. **What works: What lessons have been learned about what works or doesn't work in supporting very vulnerable individuals? And are there specific activities that have been particularly effective?**

8.2.23. The Impact Analysis showed clearly that the Respite Rooms programme had a positive impact on service users. Service users showed significantly better outcomes on both move-on destinations and services accessed than other people in similar circumstances who did not use the Respite Room. The assessment strongly suggested that this difference was attributable to the programme.

8.2.24. Overall, Respite Rooms appear to have a large and statistically significant impact on the proportion of service users moving to safe accommodation and on the proportions receiving advice and support.

8.2.25. This is in line with the perceptions of staff and project leads, who strongly believed the Respite Rooms were having a positive impact on service users. Individual service users spoken to during the project testified to this, with many experiencing a substantial improvement in their situation. They also often praised the support they had received. Service users described the impacts of staying in the Respite Room as: making plans for the future, recognising needs for support, acknowledging addictions, caring for themselves, improved wellbeing, and rebuilding family relationships.

8.2.26. Respondents interviewed generally believed that successful outcomes came typically with longer stay lengths, and the data appeared to support this. Project staff felt time was needed to build relationships with hard-to-reach service users and persuade them to engage with support. Well-established local networks between organisations also appeared to be key. Projects that were building networks from scratch often reported slower start times, and also seem to have experienced fewer ‘positive’ move-ons. Projects dependent solely on Local Authorities for referrals rather than their own networks often found this difficult, with inappropriate referrals reported to be a problem.

8.2.27. Successful outcomes were also linked to good project design. Staff repeatedly stressed the importance of creating a location where service users felt safe and secure, and where informal interaction between staff and service users was encouraged by design. Project location was also a key factor; if the location was disclosed or too close to another service where perpetrators (or people abusing substances) might live or congregate, this made the work of the Respite Room much more difficult.

8.2.28. The ideal scale of Respite Room project was debatable; there was no clear advantage or disadvantage seen in outcomes data for small or large projects. Large projects typically experienced economies of scale (in being able to provide specialist support or higher levels of overnight staffing, for example) but smaller projects saw benefits in a high staff ratio allowing building constructive relationships with service users.

8.2.29. **Sharing learning: To what extent has learning been shared between the 12 pilot areas? And to what extent has learning been shared with other LAs and housing providers?**

8.2.30. Sharing of learning between pilot areas, and with other LAs and providers, has been relatively limited. DLUHC has hosted regular workshops for LAs and providers during the pilot, where learnings and insight were shared across Respite Rooms areas. The workshops were well-attended and were considered helpful. However, only a few of the Respite Rooms leads have shared learnings with one another beyond these dedicated sessions. The majority of leads noted that significant pressures in their day jobs limited the scope for sharing learning, but that they would find it useful.

8.2.31. The findings workshop held as part of this evaluation was attended by over 150 representatives from LAs and providers, suggesting strong appetite for more widespread sharing and dissemination of learning from the pilot areas.

8.2.32. **Future of Respite Rooms: What could the future for Respite Rooms look like beyond the pilot?**

8.2.33. Most Project Leads stated in follow-up interviews (in January 2023) that they would like their Respite Room project to continue, as they saw them filling an important gap in provision, and perceived them to be successful initiatives. At the time of writing (May 2023), 10 of 12 Respite Rooms had managed to secure funding to continue.

8.2.34. Some Respite Rooms had attracted additional funding from sources such as the Rough Sleeping Initiative, charitable grants or the New Burdens Duty funding. In at least one case this included ongoing funding beyond the end of March 2023.

8.2.35. The workshop carried out for this research attracted 72 additional Local Authorities not involved in the pilot, indicating substantial interest from across the sector. A small number of these areas had already set up similar schemes (sometimes without knowing about the Respite Rooms programme).

Annex A Impact Analysis

A.1. Data collection

To estimate the impact of Respite Rooms on outcomes for users, the evaluation team requested data from the 12 Respite Room Local Authorities (LAs) for two groups of people:

- All Respite Rooms users.
- A comparison group of ideally 20, but a minimum of 10, people per LA, with this comparison group being identified by the LA team.

The identification of a comparison group

The identification of a comparison group was not standardised across LAs. Instead, LAs were asked to use their own local data systems to identify a "group of people who would have been eligible for a place in a Respite Room but did not enter a Respite Room for whatever reason".

Potential routes to identifying a comparison group highlighted as acceptable were as follows (with LAs instructed that they could use multiple sources if necessary):

- People not entering the Respite Room for capacity reasons, or due to its geographical location (presented as the preferred source);
- People referred but turned away from a Respite Room because of their level of needs as long as the profile of this group was not very different to Respite Room users;
- People with similar characteristics identifiable on another LA database. This would ideally be a database that included enough information to be able to establish with some confidence that the comparison group are similar to Respite Room users on key characteristics (e.g. information on DA, VAWG and rough sleeping or risk of rough sleeping);
- People with similar characteristics on a provider's own records or a LA's referral list. Again, with enough information to be confident that they are similar to Respite Room users on key characteristics.

For everyone selected for the comparison group, LAs were instructed to assign a 'baseline date'. This is a date where the LA judged the individual to have been most likely to be eligible to enter a Respite Room. It might be when they presented to the LA in crisis, for example due to imminent or current rough sleeping, or due to a DA incident. This date would need to be no later than mid-Sept 2022 to allow for outcome data to be collected. The team instructed LAs that they could go back in time to select a comparison group but should try to avoid baseline dates that were during lockdown.

LAs were also instructed that, when identifying people for the comparison group, they should try to ignore where that person was three months later. That is, they should act as if you didn't know the future for each person. This was to avoid actively over-selecting people who at three months had poor outcomes. Having made their selection, LAs were then instructed to remove from their list anyone who had entered a Respite Room in the

three months after baseline. A few cases that were not removed were taken out at the analysis stage.

Finally, LAs were instructed to limit their selection to people for whom they had:

- Information about their situation at their 'baseline' date;
- Ideally, information about any advice and support services, and/or accommodation-based services they used over the subsequent three months.

The data fields requested

For both Respite Room users and the comparison group, longitudinal data per individual was requested, starting with entry to the Respite Room for the users and from the identified 'baseline date' for those in the comparison group. The 'end date' was leaving the Respite Room for users, and three months after baseline for the comparison group, the assumption being that this would give a broadly similar interval, on average, for the two groups. In practice, the average for Respite Room users was closer to two months.

The data collected falls into two broad categories: baseline variables and outputs/outcomes:

Baseline variables:

- Information on housing situation at the start date.
- Demographics and starting characteristics (gender, age, BAME, NRPF, whether disabled, whether had known mental health problems, whether had known addictions).
- Engagement with services prior to the start date.
- DA or VAWG at start date.

Outcomes:

- Support services accessed during the Respite Room stay (or during the three-month follow-up period for the comparison group);
- Housing situation at end date.

In addition, for the comparison group, information was requested on:

- The source of the data on the comparison group
- The reason for selection per individual
- An assessment of whether the individual was of similar, higher or lower level of need to Respite Room cases
- Whether entered a Respite Room during the three-month follow-up period
- Whether entered a DA refuge during the follow-up period
- Whether engaged with services for those with additional/complex needs during the follow-up period.

Sample numbers achieved

Of the 12 Respite Room pilot Local Authorities, 11 provided data on their Respite Room users[21], covering between them 461 users, and nine did so for a comparison group, giving a comparison group of 153 individuals. At the analysis stage the data was reduced to 396 Respite Room users, 47 being excluded because they were recorded in the data as still being in a Respite Room, and a further 18 excluded because age-group was not recorded, this being one of the planned matching variables. The comparison group was reduced to 138, 15 being excluded because they were recorded as having entered a Respite Room between baseline and three-month follow-up.

For the analysis of service receipt outcomes, the data was restricted to cases where a definitive yes/no was recorded. This varies from service to service, but broadly speaking reduces the analysis dataset to around 380 Respite Room users and 100 comparison group members.

A.2. Propensity Score Matching

To estimate impact, outcomes for Respite Room users are compared with outcomes for a matched comparison group. The matched comparison group is essentially a weighted version of the raw comparison group data, with the purpose being to generate a weighted sample that, at baseline, has a very similar profile to the Respite Room users. The matched comparison group is then assumed to give an estimate of the counterfactual for Respite Room users, with any significant difference in outcomes for the Respite Room users and matched comparison groups being evidence of impact.

The matched comparison group was generated using propensity score matching, the main steps of which were:

- The probability (or propensity) of an individual being in the Respite Room users group (rather than the comparison group) was estimated from a logistic regression model of the data. The binary outcome variable in the model was the group (1=Respite Room user; 0=control), and the predictors were all the characteristics collected at baseline.
- The comparison group was then weighted so that the distribution of propensity scores in the control group was the same as in the participant group.

The technical details of the matching undertaken were as follows:

- The logistic regression model was fitted within SPSS with all predictors being entered irrespective of significance.
- The weights for the comparison group were calculated as inverse propensity weights (i.e. p/1-p). Comparison group members that are very similar to Respite Room users, and hence have a high propensity score were given a large weight; comparison group members that are dissimilar to Respite Room users, and hence have a low propensity score were given a small weight.
- Extreme weights (below or above the 2nd and 98th percentiles) were trimmed.

[21] One LA provided a random sample of 20 of their Respite Room users rather than all users.

The matching variables included in the propensity score model were:

- Accommodation just before entering Respite Room/baseline (rough sleeping/hostel; sofa surfing; settled with family or friends, or in settled accommodation; other/unknown);
- Age-group (18-24; 25-34; 35-44; 45+);
- Whether disabled (yes; no/not recorded);
- Whether had mental health problems at baseline date (yes; no/not recorded);
- Whether had addictions at baseline (yes; no/not recorded);
- BME/BAME (yes; no/not recorded);
- Whether engaged with VAWG support services prior to baseline (yes; no/not recorded)
- Whether engaged with homelessness support services prior to baseline (yes; no/not recorded);
- Whether engaged with other support services (e.g. addiction) prior to baseline (yes; no/not recorded);
- Domestic Abuse recorded prior to baseline (yes; no/not recorded);
- Other VAWG recorded prior to baseline (yes; no/not recorded).

For most matching variables ‘not recorded’ was coded with ‘no’. In practice across all of the matching variables the category ‘no/not recorded’ is very predominantly ‘no’.

Gender and NRPF were recorded in the data but were not included in the matching. Gender was excluded because almost all cases were recorded as female (where stated); NRPF was excluded because there were very few in the comparison group. The impact of the exclusion of NRPF was tested as part of the sensitivity analysis, see A.3 below.

A reasonable test of whether the propensity score matching has generated a good, matched comparison group is simply to compare the profiles of the two groups: Respite Room users and matched comparison. The matching is judged to have been successful if there are no statistically significant differences between the two groups on any of the matching variables – which is the case. Table A.1 shows the profile of the two groups: Respite Room users and matched comparison. The comparison group prior to matching is included for completeness (central data column). Gender and NRPF are shown even though they were not matching variables.

For the analysis of service receipt outcomes, the data was restricted to cases where a definitive yes/no was recorded. A separate matched comparison group was generated for the analysis of these outcomes.

Table A.1 Baseline profile of the Respite Room users and the comparison group, before and after matching

Group of individuals within Respite Room users or comparison group	Respite Room users	Comparison group prior to matching	Matched comparison group	p-value for difference between the Respite Room and matched comparison groups
Accommodation just before baseline				0.653
Rough sleeping or homeless hostel	47%	41%	53%	
Sofa surfing	7%	9%	5%	
Housed or settled with family or friends	30%	34%	29%	
Other or unknown	16%	16%	13%	
Age group				0.580
16 to 24	16%	9%	11%	
25 to 34	26%	33%	28%	
35 to 44	35%	38%	34%	
45 or above	23%	19%	28%	
Disabled				0.556
Yes	24%	14%	21%	
No or not recorded	76%	86%	79%	
Mental health problems				0.622
Yes	72%	87%	75%	
No or not recorded	28%	13%	25%	
Addictions				0.481
Yes	53%	69%	57%	
No or not recorded	47%	31%	43%	
Ethnic minority groups				0.199
Yes	31%	16%	23%	
No or not recorded	69%	84%	77%	
Engaged with VAWG support services prior to baseline				0.622
Yes	44%	33%	41%	
No or not recorded	56%	67%	59%	

Group of individuals within Respite Room users or comparison group	Respite Room users	Comparison group prior to matching	Matched comparison group	p-value for difference between the Respite Room and matched comparison groups
Engaged with homelessness services prior to baseline				0.280
Yes	68%	86%	75%	
No or not recorded	32%	14%	25%	
Engaged with other support services prior to baseline				0.749
Yes	57%	62%	59%	
No or not recorded	43%	37%	41%	
Domestic Abuse recorded prior to baseline				0.837
Yes	78%	70%	79%	
No or not recorded	22%	30%	21%	
Other VAWG recorded prior to baseline				0.168
Yes	48%	33%	40%	
No or not recorded	52%	67%	60%	
Gender (not matched on)				<0.001
Female	99%	90%	89%	
Male	1%	3%	6%	
Other or not recorded	-	7%	5%	
NRPF (not matched on)				0.005
Yes	19%	3%	3%	
No or not recorded	81%	97%	97%	

Source: LA provided data on Respite Room users (Base: 396) and comparison group (Base: 138)

A.3. Sensitivity Analyses

The analysis of impacts makes use of almost all of the Respite Room user and comparison data supplied by the LAs, barring the exclusion of a few cases, such as the Respite Room users where age has not been recorded. Given that there may be considerable variation between, and within, LAs on the source and suitability of the comparison data, a range of sensitivity analyses have been carried out to check whether the nature and magnitude of impacts vary depending on the data used for the analysis.

This sensitivity analysis presented in here focuses on the impact on safe/secure accommodation binary outcome and on just two of the advice and support services (housing related support and DA prevention advice). Table A.2 to Table A.4 below set out the impact estimates under the scenarios listed.

The main analysis gave an impact of 17 percentage points (pp) for safe/secure accommodation (that is, 65% of Respite Room users moved to safe or secure accommodation when they left the Respite Room, compared to 48% in the matched comparison group, a difference of 17pp). This impact of 17pp does not vary greatly across the different sensitivity analyses. The single exception is an analysis where the comparison group excludes the two LAs where comparison women had entered another similar service. If the comparison group is restricted to those LAs where the comparison group is drawn more broadly from homelessness databases, the impact of Respite Rooms increases in size to 27pp. Arguably this could be interpreted as the impact of Respite Rooms when there are no similar services available in a local area.

For receipt of housing related support and DA prevention advice there is some variation in impacts across the different scenarios, but all suggest large and positive impacts on these outcomes.

The scenarios tested are as follows:

- An analysis without propensity score matching, to test whether the impact estimate is sensitive to the matching model.
- An analysis where the Respite Room user group is restricted to those who left the Respite Room within 2 and 4 months of entry. Outcomes for the comparison group were measured three months after baseline so this makes the time interval more comparable.
- An analysis that excludes all those with NRPF in the Respite Room user group. There are very small numbers with NRPF in the comparison group so the two groups cannot be matched on this variable.
- Restricting the comparison group to those described as in ‘very similar level of need’ to Respite Room users.
- Restricting the comparison group to those described as in very similar, slightly higher, or slightly lower level of need to Respite Room users.
- Excluding the comparison group from the two LAs where comparison women had entered another similar service.
- Reducing the data to the LAs that provided both Respite Room user and comparison data and controlling for LA in the PSM model.
- Including the Respite Room users where age was not recorded and excluding age from the PSM model.

Table A.2 Baseline profile of the Respite Room users and the comparison group, before and after matching, by moving into safe or secure accommodation

Scenario / Analysis	% of Respite Room users moving into safe or secure accommodation	% of matched comparison group moving into safe or secure accommodation	Impact (pp difference)
Main analysis	**65%**	**48%**	**17pp**
Without propensity score matching	65%	46%	19pp
Respite Rooms group reduced to those leaving Respite Rooms between two and four months after entry	68%	52%	16pp
Excluding those with NRPF	66%	49%	17pp
Comparison group in very similar level of need	65%	56%	9pp
Comparison group in similar level of need	65%	52%	13pp
Excluding comparison group going through a similar service	65%	38%	27pp
LA giving both Respite Room and comparison data	64%	44%	20pp
Including those with missing data on age	65%	47%	18pp

Source: LA provided data on Respite Room users (Base: varies, for main analysis 396) and comparison group (Base: varies, for main analysis 138)

Table A.3 Baseline profile of the Respite Room users and the comparison group, before and after matching, by receipt of housing related support

Scenario / Analysis	% of Respite Room users in receipt of housing related support	% of matched comparison group in receipt of housing related support	Impact (pp difference)
Main analysis	**87%**	73%	14pp
Without propensity score matching	87%	74%	13pp
Respite Rooms group reduced to those leaving Respite Rooms between two and four months after entry	99%	76%	23pp
Excluding those with NRPF	85%	71%	15pp
Comparison group in very similar level of need	87%	63%	24pp
Comparison group in similar level of need	87%	72%	14pp
Excluding comparison group going through a similar service	87%	71%	15pp
LA giving both Respite Room and comparison data	85%	67%	18pp
Including those with missing data on age	86%	71%	14pp

Source: LA provided data on Respite Room users (Base: varies, for main analysis 396) and comparison group (Base: varies, for main analysis 138)

Table A.4 Baseline profile of the Respite Room users and the comparison group, before and after matching, by receipt of DA prevention advice

Scenario / Analysis	% of Respite Room users in receipt of DA prevention advice	% of matched comparison group in receipt of DA prevention advice	Impact (pp difference)
Main analysis	66%	43%	23pp
Without propensity score matching	66%	34%	32pp
Respite Rooms group reduced to those leaving Respite Rooms between two and four months after entry	70%	50%	20pp
Excluding those with NRPF	68%	43%	25pp
Comparison group in very similar level of need	66%	43%	23pp
Comparison group in similar level of need	66%	37%	29pp
Excluding comparison group going through a similar service	66%	46%	20pp
LA giving both Respite Room and comparison data	60%	35%	25pp
Including those with missing data on age	67%	41%	26pp

Source: LA provided data on Respite Room users (Base: varies, for main analysis 396) and comparison group (Base: varies, for main analysis 138)

A.4. Scoping interviews and data gathering

Building on the feasibility study concluding in January 2022, scoping interviews were carried out by the IFF team in Autumn 2022, with support from BPSR, using an agreed checklist for information gathering. Representatives of 11 of the 12 pilot projects were interviewed between October and December 2022. Interviews were carried out via conference call, and took 30 to 60 minutes depending on the complexity of the task of collecting data for that specific Local Authority.

These scoping interviews established:

- Whether each Local Authority had a database of rough sleepers or similar that might be used as a comparison group, and if so, what data it held (e.g. starting characteristics, homeless history, outcomes, alignment with the Respite Room MI outcomes, VAWG flags).
- Whether the Local Authority believed it was possible, with guidance, to identify 10 to 20 comparison individuals from that database and share their anonymised data with the evaluation team.
- Whether it is possible to identify if individuals on the database have taken up a Respite Room place, to avoid overlap.
- Whether data could be provided at an individual level or only as aggregate counts, in which case it would not be useful for the Impact Analysis.
- Whether it would be best/easiest for Local Authorities to provide an extract of their database, or to populate a short, bespoke, database provided by the evaluation team.
- How much work it would be to identify the individuals and provide the data and how it might be done in practice (including by the evaluation team if required).
- If the work looks to be feasible, whether there were any timing or resource implications.

Feedback from these was summarised in a paper submitted to DLUHC in November 2022, which recommended that work toward an Impact Analysis should continue.

Data was gathered from Local Authorities between December 2022 and February 2023, using a bespoke data gathering spreadsheet designed by IFF Research in consultation with BPSR. Although intended to be anonymised, as a precaution data was submitted via a secure file transfer system, and stored on a secure server.

Data was checked for quality prior to analysis, including checking for consistency against DLUHC MI returns, and queries raised with Local Authorities in February 2023. Data was then merged into a single Excel file for use in the Impact Analysis calculations.

Annex B Literature Review

The Green Room was piloted in Westminster, to offer women-only emergency accommodation to homeless people who had experienced or were at risk of gender based and sexual violence. This included: domestic abuse, rape, stalking, victims of sexual exploitation, and women doing sex work. This initiative has been extended as the Respite Room initiative to 12 pilot areas across England, offering single gender spaces for victims, and integrated specialist support from organisations that offer services focused on homelessness and housing, domestic abuse and violence against women and girls. This is a population with multiple and complex needs, and services offered will therefore include support for substance misuse, migrant victims of abuse, and victims of sexual trafficking.

B.1. Contextualising Respite Rooms

Respite Rooms offer an important potential solution to a significant gap in housing and service provision for those who have experienced gender-based violence or are at risk of such violence. Individuals who cannot be accommodated in traditional ‘refuge’ or ‘shelter’ accommodation, often because of complex and intersecting needs, are often also too vulnerable to be accommodated in other forms of emergency shelter, or to be placed straight into housing with less support available. These individuals can ‘slip through the cracks’ in housing and in service provision, leaving them vulnerable to further violence and exploitation. Single gender crisis accommodation offers a stepping stone to recovery for some of the most vulnerable and at-risk homeless individuals in England (Batchelor & Sanders, 2021). It has been well established that women may avoid services that are used by homeless men (Mayock et al., 2015), and this underscores the importance of single gender service provision for women who have experienced gender-based violence and homelessness.

Crisis accommodation and transitional housing are recognised as one important component in a comprehensive long term housing system for those impacted by homelessness, who have experienced domestic abuse and other forms of violence against women and girls (Botein & Hetling, 2016). Respite Rooms offer an important targeted response to the specific and complex needs of a highly vulnerable population previously excluded from support within both the violence against women and girls and the homelessness sectors.

B.2. Violence against women and girls and risk of homelessness

Domestic abuse is one of the most frequent contributors to women’s homelessness (Bretherton, 2020; Jategaonkar & Ponic, 2011; Mayock & Bretherton, 2017). Women who experience violent victimisation are significantly more likely to experience homelessness, and this risk increases with multiple experiences of violence and abuse (Broll & Huey, 2020). Violence in the home disrupts women and children’s sense of belonging and home (Callaghan et al., 2016). Leaving an abusive relationship often means having to leave home, disrupting everyday life and support networks significantly and increasing the risk of being precariously housed or homeless (Power, 2019; Rabiah-Mohammed et al., 2019). ANROW (2018) reported that housing insecurity is experienced by approximately 60% of Australian women who leave violent partners. Without safe accommodation, the risk that victims will return to previously abusive partners rises (Allen, 2017), and women with

children may continue to live with a violent partner in order to maintain child custody (Yakubovich et al., 2022, Drabble & McInnes, 2017) Decker et al. (2022) reported that providing safe housing for women in Maryland, Baltimore who left an abusive relationship can interrupt the cycle and lead to reduced rates of further violence and housing instability.

In addition, women who experience homelessness are at greater risk of violence, abuse, and exploitation, particularly if sleeping rough or in male dominated service settings(Batchelor & Sanders, 2021; Brott et al., 2021; Meyer, 2016). This can include overt forms of violence like rape and physical assault, or more subtle coercive behaviours like ‘survival sex’, with women sleeping rough or in mixed gender crisis accommodation being more likely to exchange sex and other relational work for security, food, and other essential resources (Watson, 2011).

There is therefore a cyclical relationship between gender-based violence and homelessness, with women who experience gender-based violence having increased vulnerability to homelessness, and homeless or precariously housed women being at greater risk of violence and abuse. This makes homeless women who have experienced gender-based violence particularly vulnerable in mixed gender service contexts. It is therefore crucially important that appropriate, accessible, and responsive accommodation be provided for those who experience gender-based violence and homelessness.

The intersecting experiences of gender-based violence and homelessness are associated with higher risk of mental health difficulties (Tsai et al., 2012), physical health issues (Annor & Oudshoorn, 2019; Rollins et al., 2012), future housing instability (Daoud et al., 2016; Jategaonkar & Ponic, 2011), substance misuse (Collins et al., 2018), parenting challenges (Holtrop et al., 2015), and children’s services involvement (Bai et al., 2020). Further, women can find the experience of being in a large, mixed accommodation space psychologically triggering, especially if they have experienced domestic violence (Cooke et al., 2022). This is therefore a potentially highly vulnerable population, with very specific service needs, who would benefit significantly from a single gender integrated service that draws together crisis accommodation and other targeted support.

Risk of homelessness for those who experience gender based violence is also exacerbated by structural and systemic factors like unemployment rates, recessionary dynamics, inflation and poverty rates (Bainbridge & Carrizales, 2017; Faber, 2019), and housing market challenges (Rodriguez & Eidelman, 2017; Williams, 2020; Cooke et al., 2022). It may therefore be anticipated that the current socioeconomic conditions could intensify these challenges.

B.3. Needs and preferences

Using large scale England-wide administrative data to track the relocation journeys of women who had experienced gender-based violence, Bowstead (2019) established that this population is highly mobile, and that many women were already ‘on the move’ before the incidents that led to homelessness. Individuals typically experienced multiple moves per year, with high levels of movement across the country and across administrative boundaries. This, together with the often hidden or secret nature of the violence they were experiencing poses particular challenges in supporting this group, and in researching their engagement with services over time. In addition, much female homelessness is ‘hidden’, and often they do not directly engage with services, using informal support like sofa surfing

(Mayock & Bretherton, 2017, Yakubovich et al., 2022, Bernas et al. 2019). Whilst this may reflect a preference for using familial and friendship networks, it can also reflect problems in accessing services, or a lack of appropriate and responsive formal housing services that address the complex needs of this population(Bretherton, 2020). Homeless laws and policies can themselves act as a barrier to service access for women at risk of homelessness. Where policies require someone be homeless *before* intervention can be offered means that women, and particularly women with dependent children, will not seek formal support through local authorities for instance, preferring instead informal support that enables them to avoid the risk and precarity of rough sleeping (Bretherton, 2020; Mayock & Bretherton, 2017; Tutty et al., 2013). This kind of hidden homelessness can deny women access to needed services and support, and can also potentially further increase women's vulnerability to exploitation, violence, and abuse.

It is important to recognise that people who have experienced gender-based violence and homelessness often have complex and intersecting needs. The evidence base generally suggests that homeless survivors of gender-based violence value the provision of integrated services that draw together accommodation, health, social care, and other support. Victim/survivors of gender based violence and homelessness indicate that they need safe space, financial support, time to process what has happened to them and to adjust to accommodated life, being in a supportive environment with easy access to services to address practical and therapeutic needs, and a supportive community with shared experiences (Clark et al., 2019; Fotheringham et al., 2013). However, these studies also noted that being in this kind of accommodation involved a trade-off between 'following the rules' of the housing service that kept them safe and supported, against the shift to autonomy that was needed to be able to permanently settle in accommodation.

Health is often impacted by the intersection of homelessness and gender-based violence(Waters et al., 2005; Jagasia et al., 2022, Speirs et al., 2013), and consequently effective services need to address the physical and mental health needs of this population. In addition, health needs, and particularly mental health needs can function as a barrier to service access, making it harder for women and other homeless individuals who have experienced gender-based violence to seek out and use services they need(Jategaonkar & Ponic, 2011). Brott et al. (2021) found that transitional and emergency housing programmes that offered supported access to resources like childcare, transport, health and mental health services, and job seeking services, tended to have better overall outcomes, and retained individuals in service for longer. This suggests a proactive and integrated model of service that provides accommodation, health and social care support is required.

In addition to these identified challenges and needs, migrant women who are homeless and have experienced gender-based violence also face additional economic difficulties, lack of information about available services, language barriers, and greater economic and social marginalisation that further complexifies their service needs (Mayock et al., 2012; Mayock & Sheridan, 2012). This should be given further consideration in planning service responses.

B.4. Supporting families

Both homelessness and experiences of gender based violence are likely to increase parenting stress (Fraga Rizo et al., 2020; Kennedy et al., 2016; Kirkman et al., 2015; Zerk

et al., 2009). Being housed in crisis accommodation can also put parenting under strain (Holtrop et al., 2015). Nonetheless it is clear that homeless women who have experienced gender based violence are typically dedicated to their parenting role and highly motivated to provide their children with positive life experiences and life chances (Holtrop et al., 2015). Parents report feeling surveilled and many fear service involvement might result in children being removed (Gordon et al., 2019; Mayberry et al., 2014, Yakubovich et al., 2022). Homeless families do appear to draw disproportionate levels of child welfare involvement and the sense of being monitored may therefore not be unfounded (Bai et al., 2020; Kirkman et al., 2015). Women who experience homelessness experience significant barriers to antenatal care when pregnant. Challenging experiences often contribute to a sense of mistrust and fear of services that can impact access to antenatal support, and in qualitative research homeless women report fear that accessing support may result in them losing their children (Gordon et al., 2019). As noted previously, both homelessness and gender based violence have an impact on mental health and wellbeing, and on a sense of ontological safety (Kirkman et al., 2015). These can undermine parenting (Levendosky et al., 2018) and individuals with children may need additional support to restore this. It is important that such support be offered in an appropriate, accessible, and nonthreatening manner. This underpins the importance of ensuring that women using services like Respite Rooms have facilitated access to specialist health and social care support that makes engagement with such services less threatening. The holistic approach suggested by the Respite Room initiative is therefore particularly significant. However, it is also important that such support not be a mandated part of access to accommodation, and care should be taken to avoid any implication of coercion or conditionality in the offer of therapeutic or parenting support.

It is important that service providers enable families to maintain (or restore) as far as possible their everyday rituals and routines (Mayberry et al., 2014). This requires that accommodation offer some flexibility to allow individuals with children to maintain a sense of their own family life whilst in accommodation. Homeless parents and parents fleeing domestic abuse particularly value having a safe and homely place for their children (Kirkman et al., 2015), and children reiterate the importance of this kind of space for their sense of security, wellbeing and recovery (Callaghan et al., 2016).

B.5. An intersectional approach

In planning and evaluating the Respite Room initiative it is vital that the intersections of experiences of violence and homelessness intersect with other social factors. For example, black and ethnic minority women report particular challenges in navigating accommodation services, facing specific forms of discrimination that impact their ability to access housing (Wilson & Laughon, 2015). People with disabilities face practical barriers and discriminatory practice that result in specific housing needs that are often not well met in crisis and emergency accommodation (Shinn & Cohen, 2019). People with mental illness are disproportionately represented in the homeless population (Nishio et al., 2017), and experiences of violence and abuse are often associated with increased risk of mental health problems which can make it more challenging to make use of housing and accommodation services (O'Campo et al., 2016). Trans individuals can experience barriers to safe housing as a result of individual and structural discrimination this includes being at risk of discrimination and violence from other service users as well as the perception of trans women as aggressors (England, 2021). These kinds of factors are therefore crucial to consider in the provision of a tailored, responsive, and accessible

urgent accommodation service for people who have experienced violence and abuse, to ensure that they do not act as an additional barrier to service access. An intersectional approach that considers how different social positions may impact identity, risk, experience of services and access to services is vital to an effective service, and must feature as part of an appropriate service evaluation.

B.6. The COVID-19 pandemic and urgent housing needs

The COVID-19 pandemic produced a range of complex challenges for both the housing sector and the VAWG sector in the UK. Homeless individuals faced higher risk during the pandemic, exacerbating existing health inequalities that this group experience (Goodsmith et al., 2021). Those living with domestic abuse and other forms of gender-based violence faced particular challenges as a consequence of pandemic restrictions, that potentially further limited freedom and intensified coercive and controlling dynamics (Wood et al., 2021; Yakubovich & Maki, 2022)

Research on urgent housing during the pandemic has stressed the importance of providing rapid and appropriate housing for vulnerable women, as part of an integrated housing plan that includes a transition to more permanent housing (Goodsmith et al., 2021). Pandemic research suggests that it was important to remove administrative and bureaucratic barriers to urgent housing, by, for instance, ensuring appropriate family housing for women with children, and prioritising accommodation based on need, regardless of migration status (Goodsmith et al., 2021; Nnawulezi & Hacskaylo, 2021). Pandemic experiences also highlighted the crucial importance of an integrated approach to housing that included clear facilitated access to health, mental health and social care services (Goodsmith et al., 2021; Nnawulezi & Hacskaylo, 2021).

B.7. Literature Review Methodology

What is the purpose of this review and how was it conducted?

A scoping review was conducted to establish the state of current evidence on gender-based violence, homelessness and programmes that aim to provide crisis responsive accommodation and services for the particularly vulnerable group of individuals the Respite Room programme seeks to support. This review aims to contextualise the Respite Room programme as part of a broader response to homelessness and the housing needs of those who experience gender based and sexual violence. It is intended to support a broader evaluation of the feasibility of assessing the support offered through the initiative, including the quantification of the evaluation of Respite Rooms. In addition, it is recognised that there is a paucity of research on gender and homelessness, particularly research focused on women's trajectories and service usage (Bretherton, 2020; Mayock & Bretherton, 2017). For this reason, a scoping review was conducted to assess the state of current knowledge on policy and services for homeless women impacted by violence and abuse, including an assessment of the methodologies currently used to understand and assess these services.

Searches were conducted on Scopus and Google Scholar (in October 2021, October 2022 and March 2023) to identify key research in the area. The following search string was used:

((ALL(domestic abuse) OR TITLE-ABS-KEY(intimate partner violence) OR TITLE-ABS-KEY(domestic violence) OR TITLE-ABS-KEY(sex work*) OR TITLE-ABS-KEY(sexual violence) OR TITLE-ABS-KEY(rape) OR TITLE-ABS-KEY(stalking) AND (((homeless*))) AND ((crisis accommodation) OR (crisis housing) OR (emergency accommodation) OR (emergency housing) OR (respite room) OR (respite) OR (transitional housing)

This search initially yielded 1,552 results, for which titles and abstracts were read to make initial judgements on their relevance for the review. Studies were included in the review if they were focused on the provision of single gender accommodation services, and if those services were aimed at those who had experienced or were at risk of violence and abuse. Studies were only included if they were based on empirical evidence (either primary or secondary data). Thought pieces, service updates and other non-empirical articles and reports were excluded. Studies were excluded if they were not focused on crisis, emergency, or transitional accommodation, were not dealing with single gender provision, and did not offer a service specific to those impacted by violence and abuse. Transitional housing studies that focused only on women leaving prison, without attention to the specific risk of violence were also excluded. Based on these inclusion and exclusion criteria, 12 journal articles and two reports were included for closer reading. A systematic review of housing interventions for those impacted by homelessness and gender-based violence was also included.

Of the articles identified, one addressed the experiences of temporary accommodation for female lone parents in East London (Watt, 2018), one examined the experiences, daily routines and relationships of young mothers in crisis accommodation in Poland (Mostowska & Dębska, 2020), one explored sources of resilience and agency for homeless youth who had experienced or were at risk of gender based violence and who were in crisis accommodation, one explored experiences of women experiencing gender-based homelessness in Canada during the COVID-19 pandemic (Yakubovich & Maki, 2022); and one focused on the experiences of transitioning out of emergency shelter, in a city in North-eastern US (Stylianou & Hoge, 2021). Stylianou & Pich (2019) also examined factors associated with housing outcomes for individuals transitioning out of crisis accommodation. One article (Decker et al. 2022) conducted a quasi-experimental evaluation of on-site transitional housing and community-based rapid rehousing to meet the safety and stability needs of individuals made homeless because of IPV in Canada. One article (Cooke et al., 2022) was a qualitative case study of a local systems change approach to improving unsupported temporary accommodation for people experiencing multiple disadvantage in East Sussex. One article (Donoghue & Ang, 2016) was a descriptive account of the implementation of a crisis and transitional accommodation service in Tasmania, highlighting aspects of good practice and areas needing improvement. One article (Jagasia et al., 2022) discussed the need for community institutional partnerships in addressing the health needs of intimate partner violence survivors also examined an example of such a partnership. One article (Yakubovich et al., 2022) was a systematic review of the effects of housing interventions on the physical, psychosocial, and economic wellbeing of women experiencing IPV. One article (England 2021) explored the barriers experienced by trans people in accessing homelessness services in Wales.

The reports included did not specifically focus on the type of intervention offered by the Respite Room, but did highlight the need for such interventions (Batchelor & Sanders, 2021; Breckenridge et al., 2016). The systematic review of US research (Klein et al.,

2021)found that there was extremely limited evaluation of interventions to provide services, reduce risk of homelessness and improve safety for those impacted by domestic abuse. Breckenridge (2017) drew a similar conclusion based on their assessment of the research on specialist services in Australia, concluding that that there is a lack of evaluation of domestic abuse related housing provision across the board, and highlighting a need for more systematic, state led data collection, and investment in rigorous service evaluations.

Our review of the literature found no specific research or evaluation on the type of accommodation currently proposed under the Respite Rooms initiative. In addition, the review demonstrated a general paucity of research on single sex accommodation services and programmes for homeless people impacted by gender-based violence.

Literature Review References

Allen, N. E. (2017). Planning Livable Communities: The Family Options Study. Cityscape, 19(3), 245–254.

Annor, B. O. H., & Oudshoorn, A. (2019). The health challenges of families experiencing homelessness. Housing, Care and Support, 22(2), 93–105. https://doi.org/10.1108/HCS-12-2018-0036

Bai, R., Collins, C., Fischer, R., Groza, V., & Yang, L. (2020). Exploring the Association Between Housing Insecurity and Child Welfare Involvement: A Systematic Review. Child and Adolescent Social Work Journal. https://doi.org/10.1007/s10560-020-00722-z

Batchelor, E., & Sanders, B. (2021). Voices of Housing First: Identifying the keys to success Contents Acknowledgements. September.

Bernas K, Dunsmore R, English L, et al. (2019) Connecting the circle: a gender-based strategy to end homelessness in Winnipeg. Winnipeg, MB: West Central Women's Resource Centre

Botein, H., & Hetling, A. (2016). Home, Safe Home: Housing solutions for survivors of intimate partner violence. Rutgers University Press.

Bowstead, J. C. (2019). Women on the move: Administrative data as a safe way to research hidden domestic violence journeys. Journal of Gender-Based Violence, 3(2), 233–248. https://doi.org/10.1332/239868019X15538575149704

Breckenridge, J., Chung, D., Spinney, A., & Zufferey, C. (2016). National mapping and meta-evaluation outlining key features of effective "safe at home" programs that enhance safety and prevent homelessness for women and their children who have experienced domestic and family violence: Key findings and future direction. In Compass (Issue July).

Bretherton, J. (2020). Women's Experiences of Homelessness: A Longitudinal Study. Social Policy and Society, 19(2), 255–270. https://doi.org/10.1017/S1474746419000423

Broll, R., & Huey, L. (2020). "Every Time I Try to Get Out, I Get Pushed Back"1: The Role of Violent Victimization in Women's Experience of Multiple Episodes of Homelessness. Journal of Interpersonal Violence, 35(17–18), 3379–3404. https://doi.org/10.1177/0886260517708405

Brott, H., Kornbluh, M., Banfield, J., Boullion, A. M., & Incaudo, G. (2021). Leveraging research to inform prevention and intervention efforts: Identifying risk and protective factors for rural and urban homeless families within transitional housing programs. Journal of Community Psychology, October 2020. https://doi.org/10.1002/jcop.22663

Callaghan, J. E. M., Alexander, J. H., & Fellin, L. C. (2016). Children's embodied experiences of living with domestic violence: "I'd go into my panic, and shake, really bad." Subjectivity, 9(4), 399–419. https://doi.org/10.1057/s41286-016-0011-9

Clark, D. L., Wood, L., & Sullivan, C. M. (2019). Examining the Needs and Experiences of Domestic Violence Survivors in Transitional Housing. Journal of Family Violence, 34(4), 275–286. https://doi.org/10.1007/s10896-018-0010-4

Collins, A. B., Boyd, J., Damon, W., Czechaczek, S., Krüsi, A., Cooper, H., & McNeil, R. (2018). Surviving the housing crisis: Social violence and the production of evictions among women who use drugs in Vancouver, Canada. Health and Place, 51(March), 174–181. https://doi.org/10.1016/j.healthplace.2018.04.001

Cooke, C., Jones, K., Rieley, R. and Sylvester, S. (2022), "Approaching systems change at Fulfilling Lives South East in efforts to improve unsupported temporary accommodation: a qualitative case study", Housing, Care and Support, Vol. ahead-of-print No. ahead-of-print. https://doi.org/10.1108/HCS-12-2021-0043

Daoud, N., Matheson, F. I., Pedersen, C., Hamilton-Wright, S., Minh, A., Zhang, J., & O'Campo, P. (2016). Pathways and trajectories linking housing instability and poor health among low-income women experiencing intimate partner violence (IPV): Toward a conceptual framework. Women and Health, 56(2), 208–225. https://doi.org/10.1080/03630242.2015.1086465

Decker, M. R., Trister Grace, K., Holliday, C. N., Bevilacqua, K. G., Kaur, A., Miller, J., "Safe and Stable Housing for Intimate Partner Violence Survivors, Maryland, 2019–2020", American Journal of Public Health 112, no. 6 (June 1, 2022): pp. 865-870. https://doi.org/10.2105/AJPH.2022.306728

Donoghue, J., & Ang, Y. N. (2016). Reviewing a Homeless Program in Tasmania. Evaluation Journal of Australasia, 16(3), 35–41. https://doi.org/10.1177/1035719X1601600305

Drabble J, McInnes S. (2017) Finding her home: a gender-based analysis of the homelessness crisis in Winnipeg. Winnipeg, MB: Canadian Centre for Policy Alternatives

Fotheringham, S., Walsh, C. a., & Burrowes, A. (2013). 'A place to rest': the role of transitional housing in ending homelessness for women in Calgary, Canada. Gender, Place & Culture, May 2014, 1–20. https://doi.org/10.1080/0966369X.2013.810605

England, E. (2021) ''This is how it works here': the spatial deprioritisation of trans people within homelessness services in Wales" A Journal of Feminist Geography Volume 29 - Issue 6 836-857. https://doi.org/10.1080/0966369X.2021.1896997

Holtrop, K., Mcneil, S., & Mcwey, L. M. (2015). "It's a Struggle but I Can Do It. I'm Doing It for Me and My Kids": The Psychosocial Characteristics and Life Experiences of At-Risk

Homeless Parents in Transitional Housing. Journal of Marital and Family Therapy, 41(2), 177–191. https://doi.org/10.1111/jmft.12050

Jagasia, E., Lee, J. J., & Wilson, P. R. (2022). Promoting community institutional partnerships to improve the health of intimate partner violence survivors experiencing homelessness. Journal of Advanced Nursing, 00, 1–11. https://doi.org/10.1111/jan.15357

Jategaonkar, N., & Ponic, P. (2011). Unsafe and Unacceptable Housing: Health & Policy Implications for Women Leaving Violent Relationships. Women's Health and Urban Life, 10(1), 32–58.

Klein, L. B., Chesworth, B. R., Howland-Myers, J. R., Rizo, C. F., & Macy, R. J. (2021). Housing Interventions for Intimate Partner Violence Survivors: A Systematic Review. Trauma, Violence, and Abuse, 22(2), 249–264. https://doi.org/10.1177/1524838019836284

Mayock, P., & Bretherton, J. (2017). Women's homelessness in Europe. Women's Homelessness in Europe, 1–295. https://doi.org/10.1057/978-1-137-54516-9

Mayock, P., & Sheridan, S. (2012). Migrant Women and Homelessness: Key Findings from a Biographical Study of Homeless Women in Ireland (Issue February).

Mayock, P., Sheridan, S., & Parker, S. (2012). Migrant women and homelessness: the role of gender-based violence. European Journal of Homelessness, 6(1), 58–82. http://hdl.handle.net/10147/247814

Mayock, P., Sheridan, S., & Parker, S. (2015). 'It's just like we're going around in circles and going back to the same thing …': The Dynamics of Women's Unresolved Homelessness. Housing Studies, 30(6), 877–900. https://doi.org/10.1080/02673037.2014.991378

Meyer, S. (2016). Examining women's agency in managing intimate partner violence and the related risk of homelessness: The role of harm minimisation. Global Public Health, 11(1–2), 198–210. https://doi.org/10.1080/17441692.2015.1047390

Mostowska, M., & Dębska, K. (2020). The Conspicuous Hidden Curriculum and Young Women's Daily Lives in Polish Crisis Accommodation. The British Journal of Social Work, May, 1–17. https://doi.org/10.1093/bjsw/bcaa077

Power, E. R. (2019). Assembling the capacity to care: Caring-with precarious housing. Transactions of the Institute of British Geographers, 44(4), 763–777. https://doi.org/10.1111/tran.12306

Rabiah-Mohammed, F., Oudshoorn, A., & Forchuk, C. (2019). Gender and experiences of family homelessness. Journal of Social Distress and the Homeless, 0(0), 1–10. https://doi.org/10.1080/10530789.2019.1679420

Rodriguez, J. M., & Eidelman, T. A. (2017). Homelessness Interventions in Georgia: Rapid Re-Housing, Transitional Housing, and the Likelihood of Returning to Shelter. Housing Policy Debate, 27(6), 825–842. https://doi.org/10.1080/10511482.2017.1313292

Rollins, C., Glass, N. E., Perrin, N. A., Billhardt, K. A., Clough, A., Barnes, J., Hanson, G. C., & Bloom, T. L. (2012). Housing Instability Is as Strong a Predictor of Poor Health Outcomes as Level of Danger in an Abusive Relationship: Findings from the SHARE Study. Journal of Interpersonal Violence, 27(4), 623–643. https://doi.org/10.1177/0886260511423241

Speirs, V., Johnson, M., & Jirojwong, S. (2013). A systematic review of interventions for homeless women. Journal of Clinical Nursing, 22(7– 8), 1080–1093. https://doi.org/10.1111/jocn.12056

Stylianou, A. M., & Hoge, G. L. (2021). Transitioning Out of an Urban Domestic Violence Emergency Shelter: Voices of Survivors. Violence Against Women, 27(11), 1957–1979. https://doi.org/10.1177/1077801220954270

Stylianou, A. M., & Pich, C. (2019). Beyond Domestic Violence Shelter: Factors Associated with Housing Placements for Survivors Exiting Emergency Shelters. Journal of Interpersonal Violence. https://doi.org/10.1177/0886260519858393

Tsai, J., Rosenheck, R. A., & McGuire, J. F. (2012). Comparison of outcomes of homeless female and male veterans in transitional housing. Community Mental Health Journal, 48(6), 705–710. https://doi.org/10.1007/s10597-012-9482-5

Tutty, L. M., Ogden, C., Giurgiu, B., & Weaver-Dunlop, G. (2013). I Built My House of Hope: Abused Women and Pathways into Homelessness. Violence Against Women, 19(12), 1498–1517. https://doi.org/10.1177/1077801213517514

Waters, H. R., Hyder, A. A., Rajkotia, Y., Basu, S., & Butchart, A. (2005). The costs of interpersonal violence--an international review. Health Policy (Amsterdam, Netherlands), 73(3), 303–315. https://doi.org/10.1016/j.healthpol.2004.11.022

Watson, J. (2011). Understanding survival sex: Young women, homelessness and intimate relationships. Journal of Youth Studies, 14(6), 639–655. https://doi.org/10.1080/13676261.2011.588945

Watt, P. (2018). Gendering the right to housing in the city: Homeless female lone parents in post-Olympics, austerity East London. Cities, 76(April 2017), 43–51. https://doi.org/10.1016/j.cities.2017.04.005

Williams, I. L. (2020). A reappraisal of contemporary homelessness policy: the new role for transitional housing programmes. International Journal of Housing Policy, 20(4), 578–587. https://doi.org/10.1080/19491247.2019.1663070

Yakubovich, A. R., Bartsch, A., Metheny, N., Gesink, D., O'Campo, P. (2022). Housing interventions for women experiencing intimate partner violence: a systematic review. Lancet Public Health 2022; 7: e23–35. https://doi.org/10.1016/S2468-2667(21)00234-6

Yakubovich, A. R., & Maki, K. (2022). Preventing Gender-Based Homelessness in Canada During the COVID-19 Pandemic and Beyond: The Need to Account for Violence Against Women. Violence Against Women, 28(10), 2587–2599. https://doi.org/10.1177/10778012211034202

Annex C Design and Methodology: additional detail

C.1. Designing the evaluation

Methodological options

The evaluation feasibility study provided the Department for Levelling Up, Housing and Communities (DLUHC) with advice on a suitable design for a proposed evaluation of the Respite Rooms pilot programme.

The feasibility study included several core elements:

- Literature review, covering a range of academic literature on Respite Rooms, other similar initiatives, and their potential role in providing appropriate accommodation and support to vulnerable groups.
- Document review, covering a range of policy documents and data sources, as well as funding applications for Respite Rooms funding from DLUHC by LAs.
- In-depth interviews with 20 stakeholders, from across the charitable sector, VAWG support provision sector, LAs and DLUHC staff in both policy design and implementation- related roles.
- Three case studies of individual Respite Rooms, each including 4 to 5 interviews with LA staff and providers.
- Development of a Theory of Change, exploring the policy's design and likely outcomes, outputs, and impacts, for the purposes of developing an evaluation design.
- Development of an Evaluation Framework describing how the evaluation could be feasibly carried out, with additional detail around the proposed Impact Analysis and Value for Money Assessment.

The feasibility study explored a number of methodological options (see Table C.1).

Table C.1 Methodological options – Respite Rooms programme evaluation

Method	Pros	Cons
Interviews with national-level stakeholders	Provide a high-level overview of the programme Allow detailed exploration of issues and themes	Stakeholders may not have much insight into the day-to-day running of the different Respite Rooms projects
Review of Management Information (MI) returns from local areas to DLUHC	Provide a detailed indication of who is being supported and how the programme is working in practice Data is being collected for monitoring in any case Data is standardised across areas Not expensive	Some indicators may not be collected by local areas Potential delays in reporting/ analysing returns Does not collect depth qualitative measures/ explore reasons for varying experiences
Depth case studies	Qualitative work will help identify what particular elements have worked well, the quality of support provided, and the impacts on people supported. Case studies will provide views from a number of organisations/individuals Can explore experiences and issues in depth	Can be time-consuming for participants Can be relatively costly (depending on number of interviews / level of detailed qualitative analysis required)
Survey of LAs / providers	Survey can collect additional quantitative data as needed, and open questions can allow some qualitative views to be gathered Usually fairly cost-effective	LAs are already providing MI to DLUHC so a survey may not provide much additional evidence Need to be relatively short to maximise response rates Low response rates make mean data is not representative Online surveys do not allow additional probing of views
Interviews with programme beneficiaries	Can provide information about how programme is working and attitudinal changes, and provide insight into potential improvements to programme.	Significant ethical implications to interviewing vulnerable people. (could be mitigated by ensuring support available during and after interview). It may be very difficult to track down programme beneficiaries after they leave the Respite Rooms projects
Secondary data analysis	Not expensive Allows comparison between areas	Group(s) of interest may not be identifiable in secondary data Data not granular enough

Implementing the evaluation

The suggested evaluation approach aimed to provide a comprehensive programme for data collection and analysis which did not impose undue burden or cost.

It included case studies rather than a survey of Respite Rooms areas (LAs and providers) as LAs were already providing MI to DLUHC. It did not suggest a programme of secondary data analysis as this was unlikely to be granular enough to provide insights on the groups of interest.

Table C.2 Suggested evaluation approach for Respite Rooms programme

Method	Rationale	Suggested timing
Interviews with national-level stakeholders	These interviews will explore if the programme is delivering as expected, and if the objectives, aims and reason for intervention are still valid	6-month mark and 12-month mark
Review of MI returns from local areas to DLUHC	Will provide a detailed indication of who is being supported and how the programme is working in practice	Quarterly
Depth case studies with 5-6 LA pilot areas	Many of the programme objectives will require qualitative work to identify what particular elements have worked well, the quality of support provided, and the impacts on people supported. The case studies would include depth interviews with LA leads, lead providers, and other support organisations.	Two waves: 6-to-7-month mark and after the 12 month mark
Interviews with programme beneficiaries	Interviews with programme beneficiaries would provide a wealth of information about how the programme is working and on attitudinal changes, as well as provide insight into potential improvements to the programme.	At end of programme, and potentially during the programme; the feasibility of this will need to be investigated with service providers.
Impact evaluation element: contemporaneous comparison group from within each of the 12 Respite Room areas	A comparison group of individuals who are similar to those who enter the Respite Rooms, but do not do so themselves, will allow an assessment of the difference made by the Respite Rooms. LAs will be asked to provide a combination of existing case-level data held by themselves (in particular gathered through LA Homelessness teams and recorded on H-CLIC, or alternatively through any records of individuals turned away from provision which may be held by Respite Room providers), and existing case level data held by providers.	Throughout programme, with data analysis at end

The feasibility study found that it was unlikely that a comprehensive Value for Money assessment could be carried out in the short to medium term (as it would inevitably undercount the outcomes and impacts), but that an Impact Analysis was likely to be feasible.

Table C.3 sets out the key research questions for the evaluation, and identifies which research elements addressed each.

Table C.3 Addressing the research questions

Key research questions	Document review	Stakeholder interviews	Interviews with project leads	Interviews with Respite Room service users	MI review	IA
Geographical Variation: What does the Respite Room model look like in different locations? How are LAs and partners able to tailor the model for local needs?	X		X		X	
Access to Respite Rooms: How does Respite Room reach those at need of this support, and would these individuals access support otherwise?	X	X	X	X		
Supporting vulnerable individuals: To what extent has the Respite Room programme met its objectives, including supporting vulnerable individuals? What helped/didn't help this to happen?	X	X	X	X	X	X

Key research questions	Document review	Stakeholder interviews	Interviews with project leads	Interviews with Respite Room service users	MI review	IA
Joint working: To what extent has it enabled better joint working between LAs, housing providers and other support providers?	X		X			
Additional support: To what extent has the programme guided vulnerable individuals to accessing additional support?			X	X		X
Move-on destinations: To what extent have individuals leaving the Respite Room gone on to positive destinations (e.g. other forms of Safe Accommodation)?			X	X	X	X

Key research questions	Document review	Stakeholder interviews	Interviews with project leads	Interviews with Respite Room service users	MI review	IA
What works: What lessons have been learnt about what works/doesn't work in supporting very vulnerable individuals? Are there specific activities that have been particularly effective?		X	X	X	X	X
Sharing learning: To what extent has learning been shared between the 12 pilot areas? And with other LAs and housing providers?	X		X			
Future of Respite Rooms: What could the future for Respite Room look like beyond the pilot?	X	X	X	X		X

Theory of Change

A theory of change (ToC) sets out how a programme is intended to work, including the resources used (inputs), programme activities and outputs, and anticipated outcomes and impacts on the target groups (programme beneficiaries). The ToC sets out a visual representation of the issues, rationale for intervening, and anticipated outputs, outcomes, and impacts.

The rationale for Respite Rooms sets out the problem and reasons for intervening. It identifies the scale of the issue, and the justification for the policy. For Respite Rooms, the rationale for intervention includes the scale of the issue (1 in 5 women experiencing DA in

the UK will be homeless at some point) and the nature of the problem (a high proportion of homeless women have experienced domestic abuse, sexual violence, or trauma). The justification for the policy is that there is insufficient suitable Safe Accommodation for people with multiple, complex needs. In addition, it can be difficult for these individuals to access holistic and person-centred support available even where this exists, because they do not trust government services and are unlikely to seek support through usual channels.

The ToC is based around a logic model, which identifies the different elements of a programme and show how each element builds on the last (see Table C.4).

Table C.4 Logic model structure

Category	Description	Covered by
Inputs	Resources used	Process evaluation
Activities	Tasks carried out with those resources	Process evaluation
Outputs	The immediate results of those tasks carried out	Process evaluation
Outcomes (short-term)	The short-term changes resulting from the short-term outcomes	Impact evaluation
Outcomes (mid-term)	The mid-term changes resulting from the short-term outcomes	Impact evaluation
Impacts	Ultimate effect of the combined outcomes – your end goal	Impact evaluation

The logic model for Respite Rooms is structured around inputs, activities, outputs, outcomes and impacts as follows:

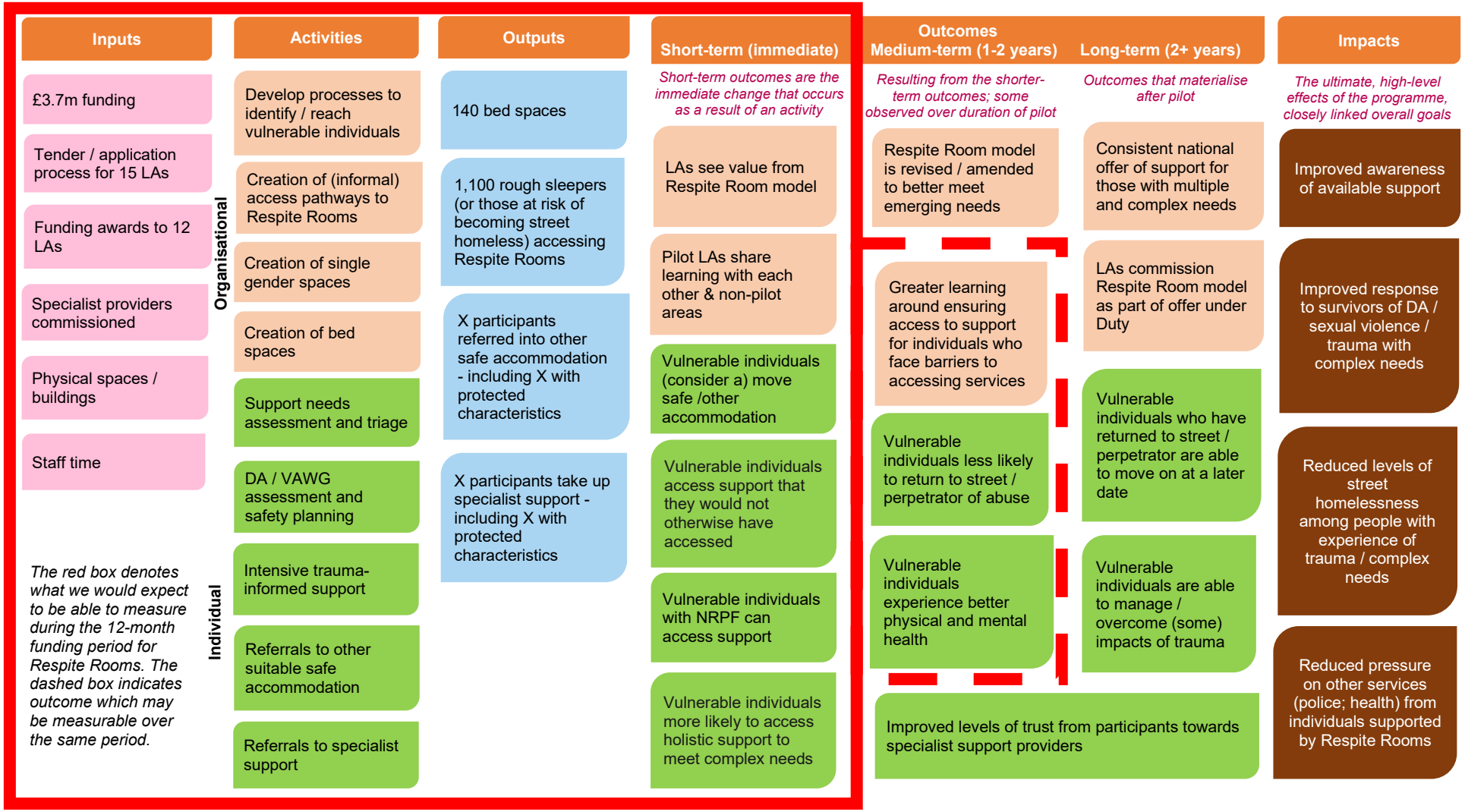
- **Inputs:** The inputs are the resources (often time or money) that have been invested in the Respite Rooms programme, as well as the programme design and application processes.
- **Activities**: The activities are the tasks which are carried out with the resources available (inputs). The activities column provides an overview of the main tasks that are expected to be carried out as part of the Respite Rooms programme. Activities include developing new processes to reach vulnerable individuals, and assessing their support needs.
- **Outputs:** These are the short-term or immediate results of the activities, which help to achieve the wider outcomes. They include the number of bed spaces created for the Respite Rooms programme, and the number of people who access Respite Rooms.
- **Outcomes:** These are the wider changes that should occur as a result of the Respite Rooms programme development and activities. Some outcomes may be evident in the relatively short-term, but others may take several years to occur. Measuring progress against outcomes is important as it enables project funders and stakeholders to identify if the programme is having the desired effect, and to reflect on what changes might be necessary.
- **Impacts:** These are the ultimate effect of the combined outcomes and the programme's end goal. For example, it is likely that interventions will contribute to meeting impacts, rather than being their sole cause: for example, Respite Rooms

on its own is unlikely to guarantee an improved response to survivors of VAWG including DA, sexual violence and trauma with complex needs, but it can make a significant contribution towards changing LA responses and disseminating best practice, thus making this impact more likely.

The theory of change for the Respite Rooms programme is provided below in Figure C.1. The red box identifies the outcomes and impacts which it will be feasible to measure during the pilot evaluation. The green-shaded boxes relate to individuals, (i.e. those participating in Respite Rooms), and the orange-shaded boxes relate to organisational changes, (i.e. change in systems, infrastructure, and policy).

Figure C.1 Respite Rooms Theory of Change

Rationale: 1 in 5 women experiencing domestic abuse in the UK will be homeless at some point. A significant % of homeless women have experienced domestic abuse, sexual violence, or trauma. For those with multiple, complex needs who are (at risk of) rough sleeping there are not always suitable safe accommodation options, nor suitable holistic and person-centred support available. Many of these individuals do not trust state or government services and are unlikely to seek support through usual channels.



The Theory of Change is underpinned by assumptions about how the programme will work and likely results of activities. These assumptions are based on the evidence and literature review, as well as discussions with expert stakeholders, LA staff, and providers:

Theory of Change: Assumptions

- Sufficient specialist provision available in Respite Room pilot areas – particularly for groups with certain protected characteristics
- Staff with appropriate skills are recruited to deliver Respite Rooms programme
- Enough self-contained rooms are available to meet the needs of vulnerable people during Covid restrictions
- Vulnerable individuals are willing/able to move into Respite Room accommodation and/or take up support offer
- If services provide better/more relevant support, people will be more willing to move into them
- Funding formula makes use of the right factors to accurately assess need
- Funding levels are sufficient to meet needs of very vulnerable client group with complex needs
- Enough suitable bed spaces/rooms are available with the Respite Room
- Word-of-mouth will increase demand for Respite Room
- LAs can commission and manage services successfully
- Individuals move from the Respite Room to a high-quality service which provides the support they need
- Service providers and pilot LAs are given opportunities and time to share their learning

Theory of Change: Unintended consequences

- Experiences/process of accessing support result in reliving trauma/mental health crises
- Individuals move from other areas to access Respite Room, potentially removing them from existing sources of support
- Increased bed volumes mean Respite Room support is offered to people who should/are able to access refuge accommodation and do not require such intensive support, or conversely existing services start to refuse access to high-needs clients on the basis of Respite Room availability.

Evaluation Framework

The Evaluation Framework draws on the evidence and data review, consultations with stakeholders, and a teach-in provided by DLUHC staff during the feasibility study. The Evaluation Framework for the Respite Rooms programme provides detail on the indicators and associated data sources for each element of the Theory of Change. The aim was to be proportionate and not place undue burden on leads or providers.

The Evaluation Framework set out a clear framework on which to base the evaluation of the Respite Rooms programme. It identified the key indicators that had to be collected to monitor and evaluate the Respite Rooms programme, assess how successful it has been at meeting its objectives, identify outcomes, and identify how the programme could be

improved. It focused on inputs, activities, outputs and the short- to medium-term outcomes (up to about two years).

Supporting the evaluation framework was detailed consideration of the feasibility of carrying out an Impact Analysis and Value for Money Assessment as part of the evaluation; in particular, the scope for a robust counter-factual to be constructed.

A summary of evaluation indicators and sources is provided in Table C.5.

Table C.5 Key source(s) for evaluation indicators to 2022/23

Category	Indicator	DLUHC	Respite Rooms MI	Project lead interviews	Staff interviews	Service user interviews
Inputs	Annual funding from DLUHC to 12 Respite Room areas	X				
Inputs	Additional funding provided by LAs to support Respite Rooms programme			X	X	
Inputs	Staff time: DLUHC, LAs, providers	X	X		X	
Inputs	Providers commissioned	X	X	X		
Inputs	Physical spaces used (number of rooms and nights used)		X			
Inputs	Number of DLUHC staff days used for Respite Rooms programme development, procurement and management	X				
Inputs	Number of staff days used for bidding process, set-up and programme management	X	X		X	

Category	Indicator	DLUHC	Respite Rooms MI	Project lead interviews	Staff interviews	Service user interviews
Inputs	Number of rooms used for Respite Rooms programme (split by bedrooms / support delivery locations)		X	X	X	
Inputs	LAs and service providers understand what Respite Room funding is intended to cover and use it for that purpose only			X	X	
Activities	New processes developed to identify vulnerable individuals			X	X	
Activities	Creation of access pathways (number and type)				X	
Activities	Creation of single gender spaces (number)		X		X	
Activities	Creation of bed spaces/rooms (number)		X		X	
Activities	Number of individuals receiving support needs assessment		X	X		

Category	Indicator	DLUHC	Respite Rooms MI	Project lead interviews	Staff interviews	Service user interviews
Activities	Number of individuals receiving DA / VAWG assessment and safety planning		X	X		
Activities	Number of individuals receiving trauma–informed support to meet needs		X	X	X	X
Activities	Types of support available		X	X	X	
Activities	Referrals to specialist support		X		X	
Activities	Referrals to suitable Safe Accommodation		X		X	
Outputs	Bed spaces/rooms	X	X			
Outputs	Number of referrals received (inc. turned away)		X	X	X	
Outputs	Number of people supported		X		X	
Outputs	Number referred to positive onward destination		X		X	

Category	Indicator	DLUHC	Respite Rooms MI	Project lead interviews	Staff interviews	Service user interviews
Outputs	Number of participants referred into other Safe Accommodation		X		X	
Outputs	Number of participants who take up specialist support within the Respite Room (ideally by type of support)		X		X	
Outcomes	Vulnerable individuals (consider a) move into Safe Accommodation / other accommodation				X	X
Outcomes	Vulnerable individuals access support that they would not otherwise have accessed (number, type)				X	X
Outcomes	Vulnerable individuals with NRPF can access support		X		X	X
Outcomes	Vulnerable individuals more likely to access holistic support to meet complex needs				X	X

Category	Indicator	DLUHC	Respite Rooms MI	Project lead interviews	Staff interviews	Service user interviews
Outcomes	Vulnerable individuals less likely to return to street / perpetrator of abuse (numbers returning; repeat Respite Room stays)				X	X
Outcomes	Vulnerable individuals experience better physical and mental health				X	X
Outcomes	LAs see value from Respite Room model in improving support for vulnerable individuals	X		X	X	
Outcomes	Pilot LAs share learning with each other & non-pilot areas	X		X	X	
Outcomes	Greater learning around ensuring access to support for individuals who face barriers to accessing services	X		X	X	

C.2. Stakeholder interviews

To better understand the wider sector context around the 12 pilot programmes, the evaluation included 30-60 minute in depth interviews with a variety of national stakeholders, including key individuals from DLUHC and other government agencies vital

to understanding the design and delivery of the Respite Room programme; and experts in VAWG and domestic abuse issues, research and delivery, including support providers with national reach, refuge providers and charities.

A dedicated IFF Research recruiter contacted potential participants by email, inviting them to take part in the study. The length of interview varied from 30 to 60 minutes depending on the participant's availability. The interviews were carried out with an IFF researcher via video call.

All stakeholder interviews were carried out using one topic guide designed in collaboration with DLUHC. This was designed to probe around the following areas of questioning:

- Familiarity with the Respite Rooms programme
- How well the programme's concept fits in with other initiatives or schemes relating to VAWG, DA and Homelessness
- Extent to which service users' needs are being met
- Barriers to the programme's success
- Other challenges facing service users and the programme
- Potential changes to the programme
- Future of the programme beyond the pilot

The full topic guide can be found in Annex D.

Analysis and quotes from these interviews are included throughout the report.

C.3. Project lead interviews

It was important to speak with the staff who led on different parts of the Respite Room delivery, from the key person overseeing the programme at the local authority, to the individual staff leading the programme at the provider organisations. In the first wave of interviews, one lead staff member from each local authority and the lead staff from each provider involved in delivering the programme were invited to take part. A second wave of interviews was included, designed to ensure an understanding of the future plans of projects and fill evidence gaps after interim analysis.

More interviews were carried out than planned in this strand. Initially, it was envisaged that 24 interviews would take place in the first wave, and 12 in the second. However, in a number of locations, a single lead to interview could not be identified due to the nature of the project's organisation as a partnership, either between multiple external providers, or between multiple Local Authorities or departments within one Local Authority.

In total, 28 interviews with 32 people were carried out in the first wave, across all 12 Respite Room pilot projects. In the second wave, a further 11 project leads were interviewed, at all but one pilot project. Interviews took place in two waves, the first between October and December 2022, and the second in January and February 2023.

A dedicated IFF Research recruiter contacted potential participants by email, inviting them to take part in the study. The length of interview varied from 30 to 60 minutes depending on the participant's availability. The interviews were carried out with an IFF researcher via video call.

Three topic guides were designed in collaboration with DLUHC (one topic guide for local authority leads and one for provider leads, and a final topic guide for the second wave of interviews). The topic guides were designed to probe around the following areas of questioning:

- The process of bidding for funding.
- Design of the Respite Room, including:
    - partnership arrangements;
    - admissions and referrals processes; and
    - fit with other initiatives.

- Service user engagement.
- Barriers and contributors to successful outcomes.
- Move-on arrangements.
- Challenges to practical implementation
- Data gathering process
- Views on the pilot project and prospects for the future

The full topic guides can be found in Annex E.

Analysis and quotes from these interviews are included throughout the report, and been combined with case study interviews where available to enhance insight.

C.4. Case studies

As well as speaking to project leads, it was important to get a wider perspective on the projects, by speaking to service users and the staff who directly work with them.

Six of the Respite Rooms areas were selected for more detailed case study research. The selection was made purposively. The key aims in selection were to cover a range of different models, LA types and Respite Rooms designs. The case studies included Liverpool, which was the only area to allow male victims of DV to use Respite Rooms.

The case studies involved in-person face to face interviews, carried out by one or two IFF researchers per location. Most interviews were carried out at the Respite Room premises. These comprised:

- 1 or 2 interviews with Respite Rroom members of staff.
- 4 to 5 same-sex interviews with service users, who were initially invited to take part by the Respite Room staff members.

Two topic guides were used for case studies (see Annex E) – one for staff and one for service users (see Annex F). The topic guide for Respite Rooms staff was based on emergent findings from Project Lead Provider interviews, and covered:

- Design of the Respite Room project.
- How the pilot is being delivered.
- How partners are working together.
- Ways in which potential Respite Room users are identified and/or access the programme (the referral process).

- Any local issues affecting delivery.
- Whether the Respite Room provision is meeting its objectives.
- Any evidence of outcomes.
- Key challenges to local delivery and how these are being addressed.
- Lessons learned by staff.
- Any sharing of good practice/lessons learned with other Respite Room pilots.
- Future plans for the Respite Room.

In advance of interviews with vulnerable service users, a full risk register and Disclosure of Harm procedure were developed. All interviewers undertook dedicated training, which included how to report a disclosure of harm, the types of disclosures that people who have experienced domestic violence might make, how to encourage openness in interviews and make interview participants feel safe and comfortable, and interviewer self-care following potentially distressing interviews.

The topic guide for service users was written with all of the above in mind, and included scripts for interviewers to read out, both about the Disclosure of Harms process, and a script to reassure participants about aspects such as anonymity, confidentiality, the right to terminate the interview at any point, and that they would not be asked questions about their past or personal circumstances.

The topic guide covered:

- How and why service users engaged with the Respite Rooms offering (including referral processes).
- Views on the types of support offered and accessed.
- (If relevant) Where they moved on to; how that process happened.
- Any changes experienced since engaging with the Respite Room.

In addition, two handouts were developed for service users. One, given to them by staff, explained the research (incusing reassurances as above) and invited them to take part. The other was a support leaflet for them to take away after the interview, with details of various support organisations and their contact details, as well as contact details for IFF should they wish to withdraw their data.

Overall, the following interviews took place:

Table C.6 Case studies carried out

Location	Date	Interview details
Liverpool	Nov 2022	Three staff, three female service users, and one male service user. Included results from.
Leicester	Dec 2022	Two staff, and five female service users.
Camden	Dec 2022	Four staff, and four female service users.
Exeter	Dec 2022	Two staff, and five service users.
Portsmouth	Jan 2023	Two staff, and four service users.
Manchester	Jan 2023	Three staff, and three service users.

Analysis and quotes from the case studies are included throughout the report, and have been combined with interviews with relevant project leads to enhance insight.

C.5. MI Analysis

MI analysis was carried out based on aggregated data gathered by DLUHC between the start of the projects and February 2022. Data was compiled by project staff and LAs, and transferred to DLUHC via the DELTA data gathering system. Data was gathered regarding:

- Number of referrals, admissions and people turned away, and reasons for non-admission
- Demographics of service users
- Background of service users, in terms of prior need and experience of DA / VAWG
- Support services received while in the Respite Room
- Length of stay
- Destinations on departure from the Respite Room, and whether departures were planned or unplanned
- Service user satisfaction

Data was transferred to IFF Research using a secure email service, to ensure no data was disclosed, and stored on a secure server.

On receipt, IFF Research inspected the data, and carried out an extensive data cleaning process, including consultation with the individual services where necessary to clarify data submitted. New or revised data returns were requested where any misunderstandings were detected in how the forms had been completed.

Destinations data included ‘other’ options; a coding process was carried out to classify these destinations, to better enable data analysis. In a number of cases, data was corrected, for example where clear typographical errors had been made (e.g. ‘11’ for ‘1’ in a case where a row reported only on one service user). Data was compiled into a spreadsheet for analysis, using a pivot table.

There is no error margin on this data; it was compiled as a census of all service users and therefore there is no imputation or estimation involved, beyond the data corrections explained above.

Annex D Summary of projects

D.1. Summary of projects

Table D.1 below summarises the Respite Room pilot projects found across England. Six of these (with names highlighted in bold) were case studies for this project. The population of the local authority is included to give a broad idea of the size of area served, although many services in reality also catered to significant out-of-area demand.

Table D.1 Key information regarding Respite Room pilot projects

Local Authority	Beds	Target stay length	Locations	Population of LA	Lead Partners of LA
BCP**	12	12 weeks	3	400,300	BCHA
Birmingham	4	8 weeks	1	1,144,900	Trident Reach
Bristol	10	6-8 weeks	1	472,400	Next Link
Camden, London	15	4 weeks	1	210,100	Single Homeless Project
Exeter	9	6 weeks	2	130,800	CoLab Exeter
East Sussex*	12	8 weeks	4	545,800***	Change Grow Live
Leicester	8	1-2 weeks	2 (1 accom.)	368,600	Panahghar
Liverpool	8	5 weeks	2	486,100	YMCA
Manchester	18	12 weeks	2 (1 accom.)	552,000	MASH, Manchester Women's Aid, Riverside Housing
Nottingham	5	8-12 weeks	1	323,700	Juno Women's Aid
Portsmouth	4	6 weeks	1	208,100	Stop Domestic Abuse, Two Saints
Westminster, London	16	12 weeks	1	204,300	St. Mungo's

Source: DLUHC (February 2023). Population from ONS Census (2021). *Centred on the town of Hastings. **Bournemouth, Christchurch and Poole. ***Split sites in several towns throughout the county of East Sussex (Hastings, Eastbourne, Bexhill and Hailsham).

Annex E Topic guides and materials

E.1. Stakeholder topic guide

Introduction
Thank you for agreeing to take part in this research project that the DLUHC (Department for Levelling Up, Housing and Communities) have asked us, IFF Research, to carry out for them.

Background
DLUHC have asked us to carry out an evaluation of the Respite Rooms programme. This evaluation will provide DLUHC with a greater understanding of the impact of the pilot projects and the most effective ways to provide support for individuals through the Respite Rooms programme. It will also identify and share learning from across the pilot areas with DLUHC, commissioners, and service providers.

Interview
The interview will take around 45-60 minutes, depending on what you have to say. Do let me know if you're pressed for time.

Confidentiality

Confirm receipt, signing and return of consent form.

IFF Research is an independent market research company, and we are members of the Market Research Society, and must follow its Code of Conduct. The information we collect will be used only for the purposes of this research project. You will not be identified by name, but your organisation would be, unless you ask us not to. However, it may be possible for an informed reader to identify you from your knowledge or opinions. You will therefore be given an opportunity before publication to review the write-up of your interview. Your personal data would be stored securely by IFF Research for a period of six months after the conclusion of the research, which is expected to be in July 2023.

Under GDPR legislation, you have the right to have a copy of your data, change your data or withdraw from the research at any point. If you'd like to do this, please ask, or you can consult the IFF Research website, or give us a call.

Is this OK? Interviewer – select box if "Yes" – if not, record details of issue below:☐

FURTHER DETAILS IF ASKED: www.iffresearch.com/gdpr – 020 7250 3035 – IFF Research, 5th Floor, St. Magnus House, 3 Lower Thames Street, London, EC3R 6HD. Market Research Society – www.mrs.org.uk – 0800 975 9596. Information Commissioner's Office (ICO) – https://ico.org.uk – 0303 123 1113.

We would like to record the conversation today so that we can accurately capture your views, and so we can write up the interview without taking too many notes while you're speaking. Only the research team will have access to the recordings. It is up to you whether we record the conversation today.

Interviewer – select box if "Yes" – if not, do not record but instead take notes:☐

Any questions/concerns before we start?

Start recording: acknowledge consent for being audio recorded.

A Respondent background (5 mins)

Interviewer: explain that we want to start by understanding a bit more about the respondent's specific role at their organisation.

A1 **Roles and responsibilities**

- Role and responsibilities in general
    - Team(s) or department(s) worked for

B Design (20 mins)

I'd like to ask you some questions about your knowledge and experience of the Respite Rooms programme so far.

B1 **How familiar are you with the Respite Rooms programme?**

- Have you been engaged with the programme from the beginning?
    - If not, then when did you first hear about the Respite Rooms programme?
- Have you been personally involved with its implementation at all?
- Are you familiar with any specific individual Respite Room projects?

B2 **When you first heard about Respite Rooms, did you think the concept made sense?**

- Did you have any reservations about it?
- In your opinion, how important is the support element of the Respite Room, as opposed to access to the accommodation itself, in achieving a successful outcome?

B3 **In your opinion, what *should* the Respite Rooms model look like?**

- How, if at all, do the Respite Rooms actually created differ from this? Why?

B4 **How well does the Respite Rooms concept fit in with other initiatives or schemes relating to VAWG, DA and Homelessness?**

- How well does it fit with other recent changes, for example around the Duty to provide support to people living in Safe Accommodation?

C Implementation (20 mins)

C1 **To what extent do you feel that the pilot projects are meeting service users' needs?**

- How? Is there anything they are particularly good at / less good at?
- Are there any particular groups it is not meeting the needs of? Any particular types of VAWG?

C2 **Has the implementation of the Respite Rooms differed from what was originally intended by DLUHC? How?**

- What has been the impact of those differences?
- Have there been any unintended outcomes?

C3 **In your opinion, have some Respite Room projects been more successful than others? How?**

- How do they differ from each other?
- Are they tailored to local needs?
- To what extent do you think learning has been shared from the pilot?

C4 **What would you believe to be the key barriers to people leaving Respite Rooms with a positive outcome? By this we mean leaving the provision in a planned way, to broadly suitable accommodation, without returning to the perpetrator of DA.**

C5 **Conversely, what needs to be put in place to enable a positive outcome for service users?**

- To what extent do you think positive outcomes for those leaving initially successfully will be sustained in the medium to longer term?

C6 **Thinking more generally, what overall impact do you think the Respite Rooms programme has had so far on the vulnerable individuals they are intended to serve?**

- How long do you think it is likely to be before the full impact of the Respite Rooms programme is seen for service users?
- Has there been any wider impact of this programme on the wider issues of homelessness and VAWG? Would there be, if it were continued?

C7 **Do you think the Respite Rooms programme will have any knock-on effects on any other services?**

- Which / why?
- Are these impacts positive or negative? Why do you say that?

D Summing up (15 mins)

D1 **To what extent would you say the Respite Rooms initiative has so far been a success?**

- Do you think there is a solution/service option for the Respite Rooms cohort that would provide better value for money?
- To what extent, if at all, might the funding ‘pay for itself,’ from the perspective of savings for other services? (e.g. police, healthcare)

D2 **What changes, if any, would you recommend for the Respite Rooms programme if local authorities choose to continue it?**

- Would you recommend that it continues in its current form beyond the pilot projects?
- What lessons would you say should be learned from the programme so far?

D3 **What would you say are the prospects for Respite Rooms going forward, as a concept?**

- What are the barriers to success?
- What could help it be more successful?

D4 **Is there anything else related to what we have been talking about today that you'd like to add?**

Before you go, just for the recording, I need to state that this interview has been carried out under IFF instructions and within the rules of the MRS Code of Conduct.

On behalf of the team at IFF Research and DLUHC, thank you very much for taking the time to help us with our research. If you haven't yet sent us the consent form, please do send it over by email after the interview.

E.2. Local Authority project lead topic guide

Introduction (5 minutes)

Introduction
Thank you for agreeing to take part in this research project that the DLUHC (Department for Levelling Up, Housing and Communities) have asked us, IFF Research, to carry out for them.

Background
DLUHC have asked us to carry out an evaluation of the Respite Rooms programme. This evaluation will provide DLUHC with a greater understanding of the impact of the pilot projects and the most effective ways to provide support for individuals through the Respite Rooms programme. It will also identify and share learning from across the pilot areas with DLUHC, commissioners, and service providers.

Interview
The interview will take around 45-60 minutes, depending on what you have to say. Do let me know if you're pressed for time.

Confidentiality

Confirm receipt, signing and return of consent form.

IFF Research is an independent market research company, and we are members of the Market Research Society, and must follow its Code of Conduct. The information we collect will be used only for the purposes of this research project. You will not be identified by name, but your organisation would be, unless you ask us not to. However, it may be possible for an informed reader to identify you from your knowledge or opinions. You will therefore be given an opportunity before publication to review the write-up of your interview. Your personal data would be stored securely by IFF Research for a period of six months after the conclusion of the research, which is expected to be in July 2023.

Under GDPR legislation, you have the right to have a copy of your data, change your data or withdraw from the research at any point. If you'd like to do this, please ask, or you can consult the IFF Research website, or give us a call.

Is this OK? Interviewer – select box if "Yes" – if not, record details of issue below:☐

FURTHER DETAILS IF ASKED: www.iffresearch.com/gdpr – 020 7250 3035 – IFF Research, 5th Floor, St. Magnus House, 3 Lower Thames Street, London, EC3R 6HD. Market Research Society – www.mrs.org.uk – 0800 975 9596. Information Commissioner's Office (ICO) – https://ico.org.uk – 0303 123 1113.

We would like to record the conversation today so that we can accurately capture your views, and so we can write up the interview without taking too many notes while you're speaking. Only the research team will have access to the recordings. It is up to you whether we record the conversation today.

Interviewer – select box if "Yes" – if not, do not record but instead take notes:☐

Any questions/concerns before we start?

Start recording: acknowledge consent for being audio recorded.

A Respondent background (5 mins)

Interviewer: explain that we want to start by understanding a bit more about the respondent's specific role at the Local Authority.

A1 **Roles and responsibilities**

- Role and responsibilities in general
    - Team(s) or department(s) worked for
- Role and responsibilities in relation to Respite Rooms programme.
- Roughly how many people have left the Respite Room so far?
- What rough proportion of these were local residents before they entered the Respite Room?

A2 **Feasibility study**

- Did you take part in the feasibility study that we carried out in January 2022?

B Respite Rooms: Understanding and Implementation (15 mins)

B1 **When did you first become aware of the Respite Rooms programme?**

- What drove the decision to take part in this programme?

B2 **How did you find the application process?**

- Was there anything that could have been improved about it?

B3 **How did you go about finding an organisation to operate the Respite Room?**

- Was there anything you'd do differently with hindsight in that process?

B4 **Can you talk me through your organisation's role now in the Respite Room programme locally?**

- Where does the Respite Room sit within the LA in terms of departmental responsibility?

B5 **Who else, if anyone, does your organisation work with to deliver the Respite Room?** (e.g. DLUHC, provider, other partners, sub-contractors)

For each of the above:

- What is their involvement?
- Were there any gaps in the support provided by DLUHC?

B6 **How do service users access the Respite Room?**

- As an organisation, what is your involvement in decision-making regarding admission of individuals to the service? (e.g. setting criteria, making individual decisions)
- *If any involvement in criteria:* What are the criteria for admission to the Respite Room in your area?

Types of potential service users:

  - *Street homeless vs. at risk of street homelessness*
  - *Victims / survivors of DA vs. victims of other types of sexual violence & exploitation*
  - *Victims / survivors with characteristics that may require specialist support (e.g. LGBT+ victims, victims of honour-based violence etc.)*
  - *Victims / survivors with insecure immigration status / NRPF (no recourse to public funds)*

- *If make individual decisions:* How does that work?
- *If make individual decisions:* Do you need to prioritise when the Respite Room provision is full? How do you do that?

C Impacts (15 mins)

Now I'd like to ask you some questions about what the Respite Rooms programme is changing for service users.

C1 **What typically happens after service users leave the Respite Room?**

- How involved are you, as an organisation, in helping service users after they leave?
    - What teams and/or departments provide this support?
- What are the typical destination(s) for service users after using this service, in terms of types of accommodation?
    - Do people often leave the Local Authority area on departure?
    - Does that vary by type of service user?
    - How about those with NRPF (no recourse to public funds)?
- How long do they stay? Was that in line with your expectations?
- If no, how and why did this differ from your expectations?

C2 **What are the key barriers to people leaving the Respite Room with a positive outcome? By this we mean leaving the provision in a planned way, to broadly suitable accommodation, without returning to the perpetrator of any DA.**

C3 **What are the key enablers?**

- To what extent do you think positive outcomes for those leaving initially successfully will be sustained in the medium to longer term?
- In your opinion, how important is the support element of the Respite Room, as opposed to access to the accommodation itself, in achieving a successful outcome?

C4 **Thinking more generally, what overall impact do you think the Respite Rooms programme has had so far on the vulnerable individuals they are intended to serve?**

- How long do you think it is likely to be before the full impact of the Respite Rooms programme is seen for service users?
- Has there been any wider impact of this programme on the challenges your local area faces relating to homelessness and VAWG? Would there be, if it were continued?

C5 **How well does the Respite Room fit in with other local initiatives or schemes relating to VAWG, DA and Homelessness?**

- Just briefly, has the wider offer in terms of VAWG or DA services changed recently, for example in response to the Duty to provide support in Safe Accommodation? How substantially has it changed?
- Has the Respite Rooms programme itself had any knock-on effects on any of these services?
    - Which / why?
    - Have these impacts will be positive or negative? Why do you say that?

D Challenges and solutions (20 mins)

D1 **Did you encounter any unexpected challenges in setting up or operating the Respite Room?**

- *IF YES:* How were these tackled?
- Have there been any unwanted or unintended impacts of the Respite Room locally? (e.g. have services become less willing to accept people they feel should be in the Respite Room)

D2 **How well have the organisations involved directly in delivering the Respite Room worked together to deliver the service?**

- Is there anything which could be improved about those relationships? How?
- How about working with other services, such as Police and healthcare services?

D3 **The Respite Rooms service combines elements of Homelessness and DA or VAWG provision, often dealt with in different Local Authority departments. How well have these links worked?**

D4 **How have you found gathering and submitting monitoring data for DLUHC? Is there anything which could be improved?**

D5 **To what extent is the type and level support originally planned being delivered within the Respite Room? In what ways is it different?**

D6 **To what extent is it helping the group of people you expected it to? In what ways is it different?**

D7 **Has your implementation of the Respite Room otherwise differed from what was originally intended? How?**

E Final questions (5 mins)

E1 **To what extent would you say the Respite Room has been a success?**

- Do you think there would be more cost-effective uses of the funds made available for Respite Rooms, in the context of other possible uses of the funds within VAWG or Homelessness services?
- To what extent, if at all, might the funding 'pay for itself', from the perspective of savings for the Local Authority, or local services more widely? (e.g. police, healthcare)

E2 **What changes, if any, would you recommend for the Respite Rooms programme if it is continued?**

- Would you recommend that it continues in its current form beyond the pilot project?

E3 **Is there anything else related to what we have been talking about today that you'd like to add?**

Before you go, just for the recording, I need to state that this interview has been carried out under IFF instructions and within the rules of the MRS Code of Conduct.

On behalf of the team at IFF Research and DLUHC, thank you very much for taking the time to help us with our research. If you haven't yet sent us the consent form, please do send it over by email after the interview.

E.3. Provider project lead topic guide

Introduction
Thank you for agreeing to take part in this research project that the DLUHC (Department for Levelling Up, Housing and Communities) have asked us, IFF Research, to carry out for them.

Background
DLUHC have asked us to carry out an evaluation of the Respite Rooms programme. This evaluation will provide DLUHC with a greater understanding of the impact of the pilot projects and the most effective ways to provide support for individuals through the Respite Rooms programme. It will also identify and share learning from across the pilot areas with DLUHC, commissioners, and service providers.

Interview
The interview will take around 45-60 minutes, depending on what you have to say. Do let me know if you're pressed for time.

Confidentiality

Confirm receipt, signing and return of consent form.

IFF Research is an independent market research company, and we are members of the Market Research Society, and must follow its Code of Conduct. The information we collect will be used only for the purposes of this research project. You will not be identified by name, but your organisation would be, unless you ask us not to. However, it may be possible for an informed reader to identify you from your knowledge or opinions. You will therefore be given an opportunity before publication to review the write-up of your interview. Your personal data would be stored securely by IFF Research for a period of six months after the conclusion of the research, which is expected to be in July 2023.

Under GDPR legislation, you have the right to have a copy of your data, change your data or withdraw from the research at any point. If you'd like to do this, please ask, or you can consult the IFF Research website, or give us a call.

Is this OK? Interviewer – select box if "Yes" – if not, record details of issue below:☐

FURTHER DETAILS IF ASKED: www.iffresearch.com/gdpr – 020 7250 3035 – IFF Research, 5th Floor, St. Magnus House, 3 Lower Thames Street, London, EC3R 6HD. Market Research Society – www.mrs.org.uk – 0800 975 9596. Information Commissioner's Office (ICO) – https://ico.org.uk – 0303 123 1113.

We would like to record the conversation today so that we can accurately capture your views, and so we can write up the interview without taking too many notes while you're speaking. Only the research team will have access to the recordings. It is up to you whether or not we record the conversation today.

Interviewer – select box if "Yes" – if not, do not record but instead take notes:☐

Any questions/concerns before we start?

Start recording: acknowledge consent for being audio recorded.

A Respondent background (5 mins)

Interviewer: explain that we want to start by understanding a bit more about the respondent's specific role at the Provider organisation.

A1 Your organisation

- Roughly how many employees nationally.
- Roughly how many employees in this Local Authority.
- Briefly, what other services delivered locally.
- How long operating in this Local Authority.

A2 Roles and responsibilities

- Role and responsibilities in general
    - Team(s) or department(s) worked for
- Role and responsibilities in relation to Respite Rooms programme.
- Roughly how many people have left the Respite Room so far?
    - What rough proportion of these were local residents before they entered the Respite Room?

A3 Feasibility study

- Did you take part in the feasibility study that we carried out in January 2022?

B Respite Rooms: Understanding and Implementation (15 mins)

B1 When did you first become aware of the Respite Rooms programme?

- What input did your organisation have, if any, to the Local Authority's initial bid for funds from the programme?
- What drove your decision to become involved in it?

B2 How did your organisation initially become involved?

- How did you find the process?
- Was there anything that could be improved?

B3 Can you talk me through your organisation's role now in the Respite Room programme locally?

- What services do you provide?
- Are there any services you would like to provide as part of the Respite Room but are unable to? And why?

B4 Who else, if anyone, does your organisation work with to deliver the Respite Room? (e.g. DLUHC, provider, other partners, sub-contractors). *For each of the above:*

- What is their involvement?

B5 **How do service users access the Respite Room?**

- As an organisation, what is your involvement in decision-making regarding admission of individuals to the service? (e.g. setting criteria, making individual decisions)
- *If set criteria:* What are the criteria for admission to the Respite Room in your area?
    - Types of potential service users:
        - Street homeless vs. at risk of street homelessness
        - Victims / survivors of DA vs. victims of other types of sexual violence & exploitation
        - Victims / survivors with characteristics that may require specialist support (e.g. LGBT+ victims, victims of honour-based violence etc.)
        - Victims / survivors with insecure immigration status / NRPF (no recourse to public funds)
    - *If make individual decisions:* How does that work in practice?
    - *If make individual decisions:* Do you need to prioritise when the Respite Room provision is full? How do you do that?

B6 **Are service users generally willing to engage with the support offered?**

- Have you developed any successful strategies for engagement you would like to share?
- What effect does previous engagement of services by the service user have to their engagement in the Respite Room?

C Impacts (20 mins)

Now I'd like to ask you some questions about what the Respite Rooms programme is changing for service users.

C1 **What typically happens after service users leave the Respite Room?**

- How involved are you, as an organisation, in helping service users after they leave?
- What are the typical destination(s) for service users after using this service, in terms of types of accommodation?
    - Do people often leave the Local Authority area on departure?
    - Does that vary by type of service user?
    - How about those with NRPF (no recourse to public funds)?
- How long do they stay? Was that in line with your expectations?
    - If no, how and why did this differ from your expectations?

C1 **What are the key barriers to people leaving the Respite Room with a positive outcome? By this we mean leaving the provision in a planned way, to broadly suitable accommodation, without returning to the perpetrator of any DA.**

C2 **What are the key enablers?**

- In your opinion, how important is the support element of the Respite Room, as opposed to access to the accommodation itself, in achieving a successful outcome?
- Are there any components/type of support that appear to be more effective than others?

C3 **Thinking more generally, what overall impact do you think the Respite Rooms programme has had so far on the vulnerable individuals they are intended to serve?**

- How long is it likely to be before the full impact of the Respite Rooms programme is seen for service users?

C4 **How well does the Respite Room fit in with any other initiatives or schemes your organisation runs or is planning relating to VAWG, DA or Homelessness?**

- Has the Respite Rooms programme had any knock-on effects on any of these?
    - Which / why?
- Have these impacts will be positive or negative? Why do you say that?

C5 **Is there anything else related to what we have been talking about today that you'd like to add?**

D Challenges and solutions (15 mins)

D1 **Did you encounter any unexpected challenges in setting up or operating the Respite Room?**

- IF YES: How were these tackled?
- Have there been any unwanted or unintended impacts of the Respite Room locally? (e.g. have other services become less willing to accept people they feel should be in the Respite Room)

D2 **How well have the organisations involved directly in delivering the Respite Room worked together to deliver the service?**

- Is there anything which could be improved about those relationships? How?
- How about working with other services, such as Police and healthcare services?

D1 **How have you found gathering and submitting monitoring data for the Local Authority and/or DLUHC? Is t**here anything which could be improved?

D2 **To what extent is the type and level support originally planned being delivered within the Respite Room? In what ways is it different?**

- Why?
- Are there any important types of support you've been unable to offer, but you think should have been provided?

D3 **To what extent is it helping the group of people you expected it to? In what ways is it different?**

- Are there any specific groups of people the Respite Room is not reaching which you think it should have been able to? Why not? (e.g. NRPF, ethnic minorities)

D4 **Has your implementation of the Respite Room otherwise differed from what was originally intended? How?**

E Final questions (5 mins)

E1 **To what extent would you say the Respite Room has been a success?**

- Do you think spending on Respite Rooms is the best value use of funding, in the context of other possible uses of the funds within VAWG or Homelessness services?

E2 **What changes, if any, would you recommend for the Respite Rooms programme if it is continued?**

- Would you recommend that it continues in its current form beyond the pilot project?

E3 **Is there anything else related to what we have been talking about today that you'd like to add?**

Before you go, just for the recording, I need to state that this interview has been carried out under IFF instructions and within the rules of the MRS Code of Conduct.

On behalf of the team at IFF Research and DLUHC, thank you very much for taking the time to help us with our research. If you haven't yet sent us the consent form, please do send it over by email after the interview.

E.4. Project lead follow-up topic guide

Introduction
Thank you for agreeing to take part in this follow-up interview for the Respite Rooms project that IFF Research are doing on behalf of DLUHC. This interview is very short and focused on your thoughts about the future of the Respite Rooms.

Background
DLUHC have asked us to carry out an evaluation of the Respite Rooms programme. This evaluation will provide DLUHC with a greater understanding of the impact of the pilot projects and the most effective ways to provide support for individuals through the Respite Rooms programme. It will also identify and share learning from across the pilot areas with DLUHC, commissioners, and service providers.

Interview
The interview will take around 15 minutes, depending on what you have to say. Do let me know if you're pressed for time.

Confidentiality

IFF Research is an independent market research company, and we are members of the Market Research Society, and must follow its Code of Conduct. The information we collect will be used only for the purposes of this research project. You will not be identified by name, but your organisation would be, unless you ask us not to.

However, it may be possible for an informed reader to identify you from your knowledge or opinions. You will therefore be given an opportunity before publication to review the write-up of your interview. Your personal data would be stored securely by IFF Research for a period of six months after the conclusion of the research, which is expected to be in July 2023.

Under GDPR legislation, you have the right to have a copy of your data, change your data or withdraw from the research at any point. If you'd like to do this, please ask, or you can consult the IFF Research website, or give us a call.

Is this OK? Interviewer – select box if "Yes" – if not, record details of issue below:☐

FURTHER DETAILS IF ASKED: www.iffresearch.com/gdpr – 020 7250 3035 – IFF Research, 5th Floor, St. Magnus House, 3 Lower Thames Street, London, EC3R 6HD. Market Research Society – www.mrs.org.uk – 0800 975 9596. Information Commissioner's Office (ICO) – https://ico.org.uk – 0303 123 1113.

We would like to record the conversation today so that we can accurately capture your views, and so we can write up the interview without taking too many notes while you're speaking. Only the research team will have access to the recordings. It is up to you whether or not we record the conversation today.

Interviewer – select box if "Yes" – if not, do not record but instead take notes:☐

Any questions/concerns before we start?

Start recording: acknowledge consent for being audio recorded.

*Interviewer: Respondents are unlikely to be able to answer every question; reassure them that this is fine. Ask all questions in **bold**; use the bullets and follow-up questions as prompts.*

A Recap / changes (5 mins)

For those previously interviewed:

- **Quickly recap their role and responsibilities; who they work with to deliver the Respite Room.**

Ask new interviewees

- **Can you briefly summarise your experience with the Respite Room?**
  - **Key challenges / key successes?**
  - **Experience of working with providers / LA?**

Ask all (note slightly different wording for re-interviews / new interviews)

- **Has anything about the Respite Room changed since we last spoke / since the Respite Room started?**
  - e.g. new processes, new funding, new referral partners, new move-on accommodation, new pathways
  - *For any changes:* What prompted this change?

B Impacts and learnings (5 mins)

- **We discussed the impact of the Respite Room on service users last time we spoke to you (or, person previously in the role), but have any new, perhaps longer term, impacts come to light since then?**
  - **ASK PROVIDER LEADS ONLY: Can you think of any women who have left the Respite Rooms, who are a good example of [the above impact]?**

- **How effective have the Respite Rooms been overall, for the women who've used them?**
- **What overall impact do you think the Respite Room has had so far on other services?**
  - VAWG (violence against women and girls) services?
  - Homelessness services?
  - [IF LA: On any other LA departments?]
  - On outside organisations such as the Police or health services?
- IF LA: Has it caused any wider changes of policy or changes to pathways?
- How well have the referral pathways worked? What have been their key impacts?
- When service users are moved on into ordinary social or Private Rented Sector tenancies, to what extent do they get referred to onward support?

Ask Provider leads only

- **In your view, how important is the physical scale and design of the service for creating a positive space for service users?**
    - What elements? (E.g. décor, furniture, colour-schemes, room layouts etc.)

Ask all (but LA leads probably better positioned to answer)

So far, have you exchanged learning about Respite Rooms with any other providers of Respite Rooms around England?

- **How about with other Local Authorities or service providers not operating Respite Rooms?**
    - Have you applied (or, do you plan to apply) any learnings from this source to your own Respite Room? Or to your wider VAWG / homelessness services?
    - Do you know if other Respite Rooms have applied what they've learned from you to their own Respite Room model?

C The future (5 mins)

- **Going forward, do you plan to continue the Respite Room project?**

If yes:

- Which factors drove this decision?
- What will the Respite Room look like going forward?
- Will you be making any changes?
    - What changes? Why / what has promoted this?
- **How will this be funded?**

If no, or if Respite Room smaller or offering less support going forward:

- **What drove the decision [not to continue with / to reduce the scale of] the Respite Room?**
    - *If related to funding:* Where did you seek funding from?
- **Is there anything else related to what we have been talking about today that you'd like to add?**

Before you go, just for the recording, I need to state that this interview has been carried out under IFF instructions and within the rules of the MRS Code of Conduct. On behalf of the team at IFF Research and DLUHC, thank you very much for taking the time to help us with our research.

E.5. Case study topic guide: staff

Introduction
Thank you for agreeing to take part in this research project that the DLUHC (Department for Levelling Up, Housing and Communities) have asked us, IFF Research, to carry out for them.

Background
DLUHC have asked us to carry out an evaluation of the Respite Rooms programme. This evaluation will provide DLUHC with a greater understanding of the impact of the pilot projects and the most effective ways to provide support for individuals through the Respite Rooms programme. It will also identify and share learning from across the pilot areas with DLUHC, commissioners, and service providers. As part of this, we are doing some case studies with some of the staff and service users who took part in the Respite Rooms pilot – we are doing these in 6 different areas. We have already interviewed [Project lead] as part of the [local area] case study.

Interview
The interview will take around 60 minutes, depending on what you have to say. Do let me know if you're pressed for time.

Confidentiality

Confirm receipt, signing and return of consent form.

IFF Research is an independent market research company, and we are members of the Market Research Society, and must follow its Code of Conduct. The information we collect will be used only for the purposes of this research project. You will not be identified by name, but your organisation would be, unless you ask us not to. However, it may be possible for an informed reader to identify you from your knowledge or opinions. You will therefore be given an opportunity before publication to review the write-up of your interview. Your personal data would be stored securely by IFF Research for a period of six months after the conclusion of the research, which is expected to be in July 2023.

Under GDPR legislation, you have the right to have a copy of your data, change your data or withdraw from the research at any point. If you'd like to do this, please ask, or you can consult the IFF Research website, or give us a call.

Is this OK? Interviewer – select box if "Yes" – if not, record details of issue below:☐

FURTHER DETAILS IF ASKED: www.iffresearch.com/gdpr – 020 7250 3035 – IFF Research, 5th Floor, St. Magnus House, 3 Lower Thames Street, London, EC3R 6HD. Market Research Society – www.mrs.org.uk – 0800 975 9596. Information Commissioner's Office (ICO) – https://ico.org.uk – 0303 123 1113.

We would like to record the conversation today so that we can accurately capture your views, and so we can write up the interview without taking too many notes while you're speaking. Only the research team will have access to the recordings. It is up to you whether or not we record the conversation today.

Interviewer – select box if "Yes" – if not, do not record but instead take notes:☐

Any questions/concerns before we start?

Start recording: acknowledge consent for being audio recorded.

*Interviewer: Respondents are unlikely to be able to answer every question; reassure them that this is fine. Ask all questions in **bold**; use the bullets and follow-up questions as prompts.*

A Respondent background and involvement with Respite Rooms (10 mins)

Interviewer: explain that we want to start by understanding a bit more about the respondent's specific role at the Provider organisation.

A1 **Roles and responsibilities**

- Role and responsibilities in general
    - Team(s) or department(s) worked for
- Role and responsibilities in relation to Respite Rooms programme
    - What support / services they provide

A2 **Who else, if anyone, does your organisation work with to deliver the Respite Room?** (e.g. LA, provider, other partners, sub-contractors). *For each of the above:*

- What is their involvement?
- How do you and [LA / other providers] work together – what are each of your roles and responsibilities?
- How well does that relationship work? What's working well / less well?

B Impacts (35 mins)

Now I'd like to ask you some questions about what the Respite Rooms programme is changing for service users.

B1 **Can you tell me about a typical service user of Respite Rooms?**

- What kind of situations have they been in?
- What kind of needs do they have?
- How long have they been rough sleeping (if applicable)?
- Are the people who come to the Respite Room typically already known to you/your immediate colleagues?
    - If yes – where have you previously met them?
- What other kinds of provision or support have they tried to access (both housing and wider support – e.g. substance abuse/counselling? Why have these not had positive outcomes / not been appropriate?

B2 **Details of the support or service they offer**

- What happens when people first arrive?
- How is a support plan developed? Who is involved in this? What is your role in this? How quickly does this happen?
- In your view, how well does this work? What improvements could be made?
- How do you deliver the support? (What is the format, how often do sessions happen, how are outcomes determined?)

- Are service users generally willing to engage with the support you offer? Does this change over time? Are there differences by type of support?
- Have you developed any successful strategies for engagement you would like to share?
- What other different types of support are offered, overall?
    - In your opinion, are these the right kinds of support? Why / why not? Is anything missing?
- What effect does previous engagement with services by the service user have on their engagement with the Respite Room?
- How long do people usually stay in a Respite Room?
- Was that in line with your expectations? If no, how and why did this differ from your expectations?

B3 **What are the key barriers to people leaving the Respite Room with a positive outcome?** By this we mean leaving the provision in a planned way, to broadly suitable accommodation, without returning to the perpetrator of any DA.

B4 **What are the key enablers to people leaving the Respite Room with a positive outcome?**

- In your opinion, how important is the support element of the Respite Room, as opposed to access to the accommodation itself, in contributing to a successful outcome?
- Are there any components/type of support that appear to be more effective than others?

B5 **Thinking more generally, what overall impact do you think the Respite Rooms programme has had so far on the vulnerable individuals they are intended to serve?**

- How long is it likely to be before the full impact of the Respite Rooms programme is seen for service users?

B6 **How well does the Respite Room fit in with any other initiatives or schemes your organisation runs or is planning relating to VAWG, DA or Homelessness?**

- Has the Respite Rooms programme had any knock-on effects on any of these?
    - Which/ why?
    - Have these impacts will be positive or negative? Why do you say that?

C Challenges and solutions (10 mins)

C1 **How well have the organisations involved directly in delivering the Respite Room worked together to deliver the service?**

- Is there anything which could be improved about those relationships? How?
- How about working with other services, such as Police and healthcare services?

C2 **How have you found gathering and submitting monitoring data for the Local Authority and/or DLUHC? Is there anything which could be improved?**

C3 **To what extent is the type and level support originally planned being delivered within the Respite Room? In what ways is it different?**

- Why?

C4 **To what extent is the Respite Room helping the group of people you expected it to? Are there any specific groups of people the Respite Room is not reaching which you think it should have been able to? Why is this? (e.g. NRPF, people from specific ethnic minority backgrounds)**

C5 **Has your implementation of the Respite Room otherwise differed from what was originally intended? How?**

D Final questions (5 mins)

D1 **To what extent would you say the Respite Room has been a success?**

- Do you think spending on Respite Rooms is a good use of funding, in the context of other possible uses of the funds within VAWG or Homelessness services?

D2 **What changes, if any, would you recommend for the Respite Room/similar provision programme if it is continued?**

- Would you recommend that it continues in its current form beyond the pilot project?

D3 **Is there anything else related to what we have been talking about today that you'd like to add?**

Before you go, just for the recording, I need to state that this interview has been carried out under IFF instructions and within the rules of the MRS Code of Conduct.

On behalf of the team at IFF Research and DLUHC, thank you very much for taking the time to help us with our research. If you haven't yet sent us the consent form, please do send it over by email after the interview.

E.6. Case study topic guide: service users

Background and objectives of the overall evaluation

Respite Rooms is an 18-month **pilot programme** providing short stay single sex accommodation facilities to individuals affected by domestic abuse and other forms of violence who are rough sleeping, or at risk of, street homelessness.

The aim of the Respite Rooms is to provide stability and wraparound support for people who might not, for various reasons, be willing, eligible, or able to use conventional refuge provision.

The Department for Levelling Up, Housing and Communities (DLUHC), have commissioned us at IFF Research to **evaluate** the impact of the Respite Rooms programme across the 12 local authority areas. This evaluation will help DLUHC understand the most effective ways to provide support for individuals through the Respite Rooms programme.

This area is one of **six case studies** we have chosen to do a deep dive study on, where we are undertaking research with staff, stakeholders and service users in the Respite Rooms.

Interview purpose

This guide is for use with current and recent Respite Rooms service users: 4-5 interviews per case study.

The interviewer will need to check before the interview, whether they are current or recent service users and tailor the interview accordingly.

Interviews will take place face-to-face (in an agreed safe place for interviewee and interviewer) or online / phone. The purpose of these interviews is to:

- To understand the service user experience
- Explore early outcomes of their Respite Rooms experience, including move-on plans

Key research questions to be covered in this discussion:

- How does Respite Room reach those at need of this support, and would these individuals access support otherwise?
- To what extent has the Respite Room met its objectives, including supporting vulnerable individuals? What helped/didn't help this to happen?
- To what extent has each local Respite Room offering guided vulnerable individuals to accessing additional support?
- To what extent have individuals leaving a Respite Room gone on to positive destinations (e.g. other forms of Safe Accommodation)?
- What lessons have been learnt about what works/doesn't work in supporting very vulnerable individuals? Are there specific activities that have been particularly effective?
- What could the future for Respite Rooms look like beyond the pilot?

This guide will be used with a mix of individuals with varying characteristics and backgrounds. The guide gives guidance on the themes to be covered, and avoids using pre-set questions. This is to allow the interviewer space to respond to the participant, mirror the language (they may not call their accommodation a “Respite Room”) and be emotionally intelligent to the situation. Please use your common sense to ask follow-up questions like ‘why’ ‘when’ ‘how’.

Interview principles and safeguarding
Respite Rooms service users have experienced domestic violence and/or abuse. We do not ask about this backstory or history of violence, but if the participant wishes to share this information, it is important to allow someone to tell their story before bringing them back to the topic guide.

Respite Rooms service users are vulnerable participants. They are likely to have additional support needs, including those stemming from trauma and drug or alcohol dependency. It is not your job to solve anyone’s problems in an interview, but you do have a duty of care to be kind and if necessary to signpost to professional support. Alongside this topic guide, please use the *Guide on Handling Disclosures of Harm* to understand how to look after yourself and how to look after your participants:

- **Recognise…**when a participant says someone is being harmed, or at risk of, harm – or they disclose criminal activity that may cause significant and immediate harm to others.
- **Respond…**appropriately (stay calm, listen, explain that you will probably need to share this with others, ask what they would like to happen, record contact details, tell them what you will do next).**“I’m only going to tell the people I need to tell, to keep you and me safe”**
- **Report…**concerns to the Respite Rooms Staff and Project Director and as soon as possible.
- **Record…**the situation, key information and steps taken. Be accurate and comprehensive.

Please ensure you are using the buddy system to alert your buddy of your whereabouts during fieldwork / after leaving interviews and to debrief after interviews. We expect the majority of these interviews to take place in person.

Section 1: Research introduction (10 mins)	Section description
Introduction: Introduce yourself and IFF Research – independent research agency **Introduce research and purpose of interview:** research on behalf of Department for Levelling Up, Housing and Communities (DLUHC) to understand experiences of the Respite Room. **About Respite Rooms:** The Respite Rooms project is run by the local authority together with housing and/or support providers, and funded by DLUHC. It aims to provide accommodation and wraparound support for people who have experienced violence, are at risk of homelessness and may not be able to use refuge provision. **Reason for participation** – You have been selected to participate in this research because you are currently using or recently used the Respite Room. We are interested in learning more about the views and experiences of people who have used the Respite Room and how they could be better supported. We are not here to talk about your personal history. We will not ask any personal questions, although you are welcome to discuss any of your previous experiences if you wish to do so. **Reassurances**: • I have this guide for questions and topics we want to cover. These questions are designed to help us understand how the programme is running and how it could be improved in future. • You don't have to tell me anything you don't want to or anything that makes you feel uncomfortable. We can skip questions. • There are no right or wrong answers. • Participation is voluntary – you can take a break, stop at any time or withdraw from the research. If you want to withdraw your data form the study, let me know during the interview and it will be destroyed. • We will provide a leaflet at the end, with our contact details if you have any questions about the research or your data. **Duration:** Up to 45 - 60 minutes, depending on how much you have to say. **Incentive:** £30 thank you for taking part, offered as a Love2Shop multi-retailer gift card, with the option of an Amazon voucher if the participant prefers (and wishes to share their email address). [IMPORTANT] This will not impact any benefits participants may be receiving. The incentive will not be conditional on answering all	*Introduction to the research* *Ensures we gain informed consent*

questions. If the participant chooses to end the interview early, they will still receive the incentive. **Consent:** *read out form, get verbal consent, interviewer signs form with own signature to confirm verbal consent has been given* **MRS Code of Conduct and Confidentiality:** IFF Research is an independent market research company, operating under the strict guidelines of the Market Research Society's Code of Conduct. The information you provide will be stored anonymously and reported anonymously so no-one will know which answers came from you. **Disclosure policy:** If we see or hear something which causes concern about your physical safety, we have a duty to act to make sure you are protected; for example, if you tell us something may cause significant harm to you or another person. If this was to happen, we would talk to you about what to do first – e.g. we would encourage you to talk to someone who can help, or agree that we would talk to the Respite Room staff on your behalf. That is the only exception. Otherwise, what you say will stay confidential. **GDPR:** The data you provide to us in this discussion will be kept until three months after the end of the project, which is due be July 2023, and then it will be destroyed. Your data will be kept anonymously and will not be shared with any other organisations or with anyone else in IFF. If you would like to change the information you have provided or withdraw from the study, you will need to tell me during the interview. If you have any questions after the interview, you can contact me at respiteroomsresearch@iffresearch.com. You can find out more information about your rights under the data protection regulations by going to iffresearch.com/gdpr. 1. **Please can you confirm that you understand the research and that you are happy to take part in this discussion today?** 2. **Do you have any questions before we begin?** **Permission to record:** It would really help me to record this interview, so I don't have to make too many notes during the interview. The recording is encrypted, it will be stored anonymously, only until three months after the end of the evaluation (due to be July 2023), and then securely destroyed. Only I will have access to it. 3. **Would you be willing for me to record this discussion for research purposes only?** START RECORDING	

IF NO, you will need to take extensive notes and try to capture quotes.	

Section 2: Participant introduction (15 mins)	
This Respite Room project is run by the local authority and [PROVIDER(S)]. A Respite Room gives single sex accommodation and support for people who have experienced domestic abuse / violence, are at risk of homelessness and may not be able to use a refuge. **When did you arrive in the Respite Room?** • How long in Respite Room? • [IF EXITED] How long since left Respite Room? How long was their stay? *Participant may decide to share their backstory / context to arriving in the Respite Room. Give space for this, thank for sharing.* **Moving on I'm going to ask you specific questions about the Respite Room accommodation and support.** **Are you happy to continue?**	*Participant and interviewer warm up to the tone of the discussion* *Understand their current circumstances in relation to Respite Room*

Section 2 – Initial awareness (5 mins)	**Section description**
Think about when you first learned about Respite Rooms. **How did you first hear about the Respite Room?** • Who did you hear from? • When? • What was going on at the time? **How was the Respite Room explained to you?** **How did you think the Respite Room might be able to help you?** **What made you decide to stay in the Respite Room?** **Were you receiving any other support at the time?** • Previous accommodation • Health • Mental health • *If any support:* Where from?	*To explore the profile of customers and their journey into the programme.* *Research questions to explore:* • *How does Respite Room reach those in need of this support, and would these individuals access support otherwise?*

Section 3: Experience of Respite Room (10 mins)	**Section description**

Are you ok to continue? *Here we can take a pause if needed.*
 	
Next, I would like to ask you about your experience in the Respite Room.
 	
If necessary: Just to remind you, you don't have to tell me anything you don't want to or anything that makes you feel uncomfortable.
 	
How have you found your Respite Room experience? Good bits / bad bits?
 	
How about the staff? Good / bad?
 	
And the other [women / residents] living here?
 	
What support did you receive when you first started your stay in the Respite Room? e.g. in the first 2 weeks
Listen for and explore:
• Accommodation
• Wraparound support: health, mental health, financial
  ○ Who do you get this from?
  ○ How often?
  ○ Where does this take place?
 	
How have you found this support? Good bits / bad bits?
 	
How well did the support you were offered fit with what you needed at the time?
• Did you feel that people were listening to you?
 	
Have you received any further support?
 	
Was there any support offered to you that you chose not to take?
• What support offered?
• Why not taken?
 	
If participant is finding it hard to describe their experience of the Respite Room, read out the fictional example below and discuss.
 	
Vignette 1: Laura had left her abusive partner, and was sofa-surfing with friends. She was feeling anxious and low. She contacted the council to see if they could help. A staff member listened to her experiences, and told her about the Respite Room service.
	Research questions to explore:
	• *To what extent has the local Respite Rooms project met its objectives, including supporting vulnerable individuals? What helped/didn't help this to happen?*
	
	• *To what extent has the programme guided vulnerable individuals to accessing additional support?*

Laura was given accommodation in the local Respite Room programme. She had her own space and once she started to feel a bit settled, she agreed to meet with a mental health worker. The mental health worker is nice. She's also enjoyed speaking with other women who are going through similar experiences. Overall, Laura feels glad she has this space to feel secure and wonders if she would have met the mental health worker if she hadn't been in the Respite Room programme. • Discuss Laura's experience of the Respite Room • What support did she get? • How do you think it made her feel? • Reflect on the similarities / differences with their own experience. ALL: **In your experience, what was the best thing about the Respite Room accommodation and support?** **What was the most difficult or challenging thing about your experience of the Respite Room accommodation and support?** **Is there anything else about the Respite Room you've found helpful?** **Have you been offered any other support as a result of being in the Respite Room? e.g. a place to move into, financial advice, help getting benefits**	

Section 4: Outcomes (10 mins)	**Section description**
Are you ok to continue? *Here we can take a pause if needed.* **Next, I would like to ask you about your experience during / after the Respite Room (**'during' for those still in the Respite Room) **How has being in the Respite Room affected you?** *Explore:* • Describe the effect • How Respite Room helped *Listen for intended service user outcomes:*	*Research questions to explore:* ○ *To what extent have individuals leaving the Respite Room gone on to positive destinations (e.g. other forms of safe accommodation)?*

- *they are more likely to access holistic support to meet complex needs* - *they access support that they would not otherwise have accessed* - *they experience better physical and mental health* - *they are able to manage/ overcome (some) impacts of trauma* - *individuals with NRPF can access support* - *they (consider a) move safe /other accommodation* - *they are less likely to return to street / perpetrator of abuse, or are able to move-on at a later date* - *improved levels of trust from participants towards specialist support providers* If participant is finding it hard to describe their experience of Respite Room, read out the fictional example below and discuss. **Vignette**: Zahra has just left the Respite Room, and has moved to women's sheltered accommodation. She thinks that her time in the Respite Room meant she didn't have to worry about finding a place to stay, and the possibility of going back to living with her abusive partner Overall, she's glad that once she was in the programme, she could also get help with her debt. This has helped her feel less anxious. She wonders how she would have felt if the Respite Room hadn't been there to support her. • Discuss Zahra's views • Why do you think having Respite Rooms accommodation helped her to get support for her debt and anxiety? • Reflect on the similarities / differences with their own experience **How are you feeling about life now, compared to six months ago? Why do you say that?** *IF LEFT* **What happened after you left the Respite Room?** • Where did you go after the Respite Room? **How did you find out about that? How's that going? Good/bad bits?** *IF STILL IN Respite Room* **What do you think will happen after you leave the Respite Room?** *Listen for:*	○ *To what extent has the local Respite Room project met its objectives, including supporting vulnerable individuals? What helped/didn't help this to happen?* ○ *To what extent has the project guided vulnerable individuals to accessing additional support?*

• Moving to / considering a move to other forms of safe accommodation • Returned to street homelessness • Returned perpetrator of abuse • *[IF RETURNED]* are they able to move to other forms of safe accommodation at a later date **What helped you / will help you succeed in your next steps after the Respite Room?**	

Section 5 – Reflections (5 mins)	**Section description**
Are you ok to continue? *There are my final questions to wrap up our discussion* **If you could change one thing about your experience of the Respite Room, what would it be?** **Is there anything else you would like to say about the Respite Room project that you haven't already had a chance to?** Thank you for your time today and for taking part in the research. As mentioned at the start of the discussion, any data you provide will be kept until three months after the end of the project, (due to be July 2023) and then it will be destroyed. Your data will not be shared with any other organisations. For any data not anonymised, you have the right to have a copy of your data, change your data, or withdraw from the research. You can find out more information about your rights under the new data protection regulations by going to iffresearch.com/gdpr. **Provide incentive** **Give support leaflet**	- *What lessons have been learnt about what works/doesn't work in supporting very vulnerable individuals? Are there specific activities that have been particularly effective?* - *What could the future for Respite Rooms in [local area] look like beyond the pilot?*

E.7. Information materials

Participant information leaflet


Research about the Respite Rooms

We would like to invite you to take part in a research study about Respite Rooms. Before you decide, if you want to take part, it is important that you understand why and how the research is being conducted. Please take time to read this information and discuss it with others if you wish. If anything is unclear, or if you have questions, please ask us.

What is the research about?

The Department for Levelling Up, Housing and Communities (DLUHC), a government department, have asked us at IFF Research to look at how well the Respite Rooms programme has worked.

We are interested in talking to people who have used a Respite Room, about their experiences. We're interested in what has gone well, and in anything that hasn't gone so well. We won't be asking questions about your personal circumstances – we're just interested in your experience of using a Respite Room.

We will then report back to DLUHC and offer advice about ways they might improve Respite Rooms for people in future.

What is involved in the interview?

We'd like to chat with you for about 30-45 minutes about your experience of the Respite Rooms. We can do this wherever you like, as long as it's in a safe place where you feel comfortable chatting freely where no-one else can overhear. We'd recommend a private setting, such as where you live now, or at the Respite Rooms building, but it's up to you. You can bring a female friend or family member with you if you'd like to. Or, we could have a Zoom call or phone call if you prefer.

We'll ask you if you're happy for us to record the interview on an audio recorder – this is just so we can chat without having to take notes. If you don't want to be recorded, you don't have to be.

Your interviewer would be a woman.

As a thank-you for your time, we're offering a £30 voucher to everyone who chats with us (unfortunately we're not able to offer vouchers to anyone who comes with you).

How will my privacy be protected?

We take people's privacy very seriously and have a number of steps to ensure this is protected.

1. Your interviewer won't be given your full name, just your first name. She won't ask you for any details that could identify you.
2. We do need people to give consent for the interview (agree to take part) – you can do this either verbally, or by ticking a box on a form the interviewer will give you.

3. We don't use anyone's names in our reports, and we don't report any details that could be used to identify individuals.
4. We store data, such as an audio recording, on our secure servers. Only your interviewer has access to your data. All data is destroyed after the project is over.
5. You can find out more information about your rights under the new data protection regulations by going to iffresearch.com/gdpr/

What if I change my mind?

You can stop the interview at any point. Or, if you decide afterwards that you don't want to take part, just let us know and we'll delete all your information.

Changing your mind won't affect any support you might be getting, and you can keep the £30 voucher.

To do this, you can email us on [EMAIL ADDRESS] or call us on [PHONE NUMBER] and leave a message for [NAME], or just let [RESPITE ROOM LEAD NAME] know that you've changed your mind and she will pass the message on to us.

What should I do if I have questions about taking part, or if someone close to me wants to find out more?

You can email us on [EMAIL ADDRESS], call us on [PHONE NUMBER] and leave a message for [NAME], or ask [RESPITE ROOM LEAD NAME] to pass a message on.

Participant handout

Thank you very much for your input in this research.

We know that sometimes, speaking about difficult or sensitive experiences, as you did in the research, can help -but we recognise that occasionally chats like this can leave you feeling a bit unsettled.

If that happens, we recommend that you have a chat with [RESPITE ROOM STAFF MEMBER], as she knows you already so is probably the best person to offer support and advice

However, if you'd like to talk to someone anonymously (without them knowing who you are), here is some information that you might find useful. All the links are to free, independent, confidential services.

Mental or physical health emergency? Don't wait –get some help and support.

If you have seriously harmed yourself or feel that you may be about to harm yourself, call 999 for an ambulance or go straight to A&E. Or ask someone to call 999 to take you to A&E.

If you need to talk right now, there are people ready to listen. You don't have to be suicidal to use these services –they are for anyone who's struggling.

- Call Samaritans any time for free: 116 123
- Shout also offers a free 24/7 crisis text service. Text SHOUT to 85258
- NHS helpline: visit the NHS website to speak to a professional on Mental Health Helpline for Urgent Help -NHS (www.nhs.uk)

If you don't feel you need urgent help, but things don't feel quite right either, there are other options.

- Mind helpline: call the Mind helpline where you can ask about mental health problems, where to get help near you and treatment options, on 0300 123 3393
- Gov.uk: For Government guidance for the public on mental health and wellbeing, visit Every Mind Matters -NHS (www.nhs.uk)

If you want to talk to someone about harm you've suffered in the past:

- Refuge's website has lots of information about supporting people who've suffered domestic abuse - **https://sww.nationaldahelpline.org.uk/**. They also have a free, 24-hour confidential Helpline, on 0808 2000 247
- The Men's Advice Line, run by Respect, is a confidential helpline specifically for male victims of domestic violence - 0808 801 0327
- Bright Sky is a free mobile app and website for anyone experiencing domestic abuse, or who is worried about someone else. You can find the app on your phone's app store, or visit the website for a link here - https://www.hestia.org/brightsky
- Gov.uk has a website of further resources including other helplines and live chat services - https://www.gov.uk/guidance/domestic-abuse-how-to-get-help
- Rape crisis offers both a phone helpline (0808 802 9999) and an online chat service via its website - https://rapecrisis.org.uk/

If you're struggling with alcohol or drugs:

If you need treatment for a drug or alcohol addiction, you're entitled to NHS care in the same way as anyone else who has any other health problem.

- For drug issues, the NHS website offers links to various free services, such as Frank and Adfam, as well as other ways to get help and support. https://www.nhs.uk/live-well/addiction-support/drug-addiction-getting-help/
- For alcohol issues, the NHS website offers a directory of where to find support in your local area. This includes Alcoholics Anonymous (AA) but also includes other options if AA is not right for you. https://www.nhs.uk/live-well/alcohol-advice/alcohol-support/

Annex F Ethics and data protection

This document sets out our ethics and data protection approach for the Respite Rooms Evaluation research project. Following this protocol will help to ensure we avoid harm or distress to participants, interviewers and researchers, adhere to the highest ethical standards, and ensure the project meets all MRS (Market Research Society) Code of Conduct, GSR (Government Social Research) Code of Ethics and GDPR (General Data Protection Regulation) requirements.

Our guiding principle is our duty of care to our participants. We recognise that some participants will be vulnerable, and topics covered are sensitive. It is paramount that data is protected and anonymised throughout. This protocol will be used with the *Guide on Handling Disclosures of Harm* for interviewers.

F.1. Context of the project

IFF is conducting an evaluation of the Department for Levelling Up, Housing and Communities (DLUHC) Respite Rooms programme pilot. This pilot programme provides short stay accommodation facilities for people affected by Violence against Women and Girls (VAWG) who are rough sleeping, or at risk of, street homelessness. The service targets those in need of support and who might not, for various reasons, be willing, eligible, or able to use conventional domestic abuse refuge provision.

The methods of primary research for this evaluation include: a) analysis of management information and b) qualitative interviews with providers, support staff, and current and recent Respite Room users. Respite Room users are by definition highly vulnerable, and they are likely to have additional support needs, including those stemming from trauma and drug or alcohol dependency. Undertaking research with vulnerable people raises ethical issues around consent, confidentiality, and tracking participants.

F.2. Ethical considerations

Throughout our work we apply the principles of the GSR Code of Ethics and MRS Code of Conduct. Here we highlight the key actions we are taking with the Respite Rooms evaluation project to ensure we meet these principles.

We will ensure participation in this research is based on specific and informed consent by:

- Approaching Respite Rooms users (including recent users) through Respite Room providers with whom they have built a relationship. We will never make initial contact with users directly.
- Recruiting participants who have the capacity to consent. We will work closely with the Respite Room provider and support workers to ensure we only speak to service users who are no longer in crisis. A number of potential participants will lack the capacity to consent. We will instead gain an understanding of the experience of this group of service users by analysing secondary data, and through discussions with service providers and other stakeholders such as Local Authorities.

- Consent forms will be provided before the interview. For service user interviews, the interviewer (and translator where necessary) will talk through the consent form at the start of the interview. The participant will give verbal consent, and the interviewer will sign to record on the consent form that consent has been given.
- Viewing consent as a continuous process. The interview will build in moments to pause to check the participant is happy to continue. Participants will have the right to change or withdraw their data. This can be done during the interview, and for any data provided to us which is not held anonymously (and thus cannot be attributed) by informing the research team up to three months from the point of participation. This right will be explained by the interviewer at the start of the interview and in the aftercare support leaflet.
- Providing a clear description of the project and how we will use participant data. This description will be shared in recruitment emails and calls, a participant information sheet, and a consent form.

F.3. Actions taken

We will ensure research is conducted in a manner that minimises personal and social harm to participants by:

Actions before interviews

- Working with service providers and, where relevant, other stakeholders, to ensure we do not recruit recent / current service users where case workers feel our contact would have a negative impact on the individual.
- Designing accessible and clear recruitment materials that give participants all the information they need about the research and the opportunity to opt-out at any stage. For recent / current service users, this will include reassurances that their participation will not impact current or any future support they receive.
- Briefing interviewers and recruiters on consent and the withdrawal of consent. Briefings will prioritise a duty of care at all stages. This will be supported by the Guide on Handling Disclosures of Harm.
- All researchers conducting interviews with recent / current service users will receive safeguarding and ethics training with our internal ethics advisor: [NAME] (Director, IFF).
- Ensuring all topic guides for recent / current service users are reviewed by our internal ethics advisor and also externally by our academic partner on this project. Topic guides follow the principle of minimising the burden on participants, so we only collect data relevant to the research questions.
- Designing topic guides for recent / current service users to minimise triggers, offer pauses and breaks and remind participants they do not have to answer questions they do not want to.
- Ensuring interviews with recent / current service users are accessible for those with language barriers. During recruitment, IFF will discuss with providers if there are any language requirements for the interview. If the participant would prefer an interpreter, we will source an interpreter, rather than accept an interpreter from the provider. Interpreters will be required to sign a confidentiality agreement. Any external interpreters will also be briefed on the Ethics and Data Protection Protocol, and the Guide on Handling Disclosures of Harm, and be required to view the recorded training session for interviewers.

Actions during interviews

- Conducting interviews with recent / current service users with researchers who have completed safeguarding and ethics training specific to this project. Interviewers will be of the same gender as the interviewee. All researchers will have experience of conducting qualitative research on complex topics with vulnerable groups. Briefings will prioritise a duty of care at all stages.
- Ensuring participants feel safe. For recent / current service users, participants will be given the option to conduct the interview face-to-face, by phone or video call. If face-to-face, they will be given the option to choose a safe place for the interview to take place (the place for the interview must be safe for participant and interviewer). For face-to-face interviews, all researchers will show their identify card at the start of the interview. Also, for recent / current service users, we will allow another individual to attend the interview in a support role, if desired by the interviewee. For example, a trusted friend or Respite Rooms practitioner. In these cases, interviewers will speak with the additional person before or at the start at the interview to clarify their role, and interviewers will ensure the discussion is with the service user so the additional person is not representing the voice of the service user. The visitor will be reminded everything discussed in the interview is confidential and will be required to sign a confidentiality agreement.
- Offering the option on whether the participant would allow the interview to be recorded for analysis purposes. If the participant would prefer the interview not be recorded, the interviewer will take extensive notes, which will be typed up to be securely stored, and any physical (i.e. paper) record securely destroyed (e.g. shredded).
- Abiding by the Guide on Handling Disclosures of Harm to ensure duty of care to our participants. We will keep a record of ethical issues arising during interviews and decisions made. This record will be stored securely.
- Offering a £30 voucher to recent / current service users participating in interviews, as recognition of their expertise and compensation for their time. The incentive will not be conditional on answering all questions, and this will be made clear to the respondent. These incentives will be offered as a Love2Shop multi-retailer gift card, with the option of an Amazon voucher if the participant prefers (and wishes to share their email address). This will not impact any benefits participants may be receiving.
- Reassuring recent / current service user participants that no personally identifiable data will be shared with DLUHC or any other Government body, police, court, child protection service, health service, or local authority unless stated under the Guide on Handling Disclosures of Harm. In that event, the interviewer will discuss whether the harm is significant, immediate or against a minor, and may have to break confidentiality. This interview should not have any impact on a case with any Government or other public service.

Actions after interviews

- Providing an aftercare support leaflet to all recent / current service user participants. Our leaflet will give a summary of the research to show to any concerned family/friends/support worker, IFF contact information if the participant wishes to get back in touch, and further sources of relevant support (including a Respite Room contact). To avoid stigmatising individuals, interviewers will be clear that aftercare leaflets are given to all participants.

- Allowing participants access to any data provided to us which is not held anonymously and thus cannot be attributed to them. Under GDPR legislation, the participant has the right to have a copy of their data, change their data, or withdraw from the research.
- Maintaining participant anonymity. In the report we will not attribute quotes to individuals and we will remove unique / identifying information from cases (including place names, Respite Room set up that could identify place, backstory, details about their personal life). Also, all personal data and interview responses will be stored securely (see Data Protection section below).
- Delivering rigorous mixed-methods analysis that represents the full breadth of voices and perspectives. Our analysis phase will bring together the qualitative and quantitative data, which we will discuss in our full-team analysis session to ensure all views are represented. All perspectives will be considered when reporting the findings.

We will ensure the research is conducted in a manner that does not harm or adversely affect interviewers by:

- Conducting interviews with researchers who have completed internal safeguarding and ethics training specific to this project.
- Briefing interviewers on the Guide to Disclosures of Harm, which includes the disclosure of crime. Interviewers will be clear about their duty of care, including their own safety and wellbeing.
- Implementing a buddy system. This ensures interviewers conducting in-person and virtual fieldwork are buddied with another team member. For in-person fieldwork, the buddy is responsible for tracking the location of the interviewer, keeping in regular contact, and alerting the Project Directors if the interviewer does not respond at the agreed time. For virtual (and in-person) fieldwork, the buddy is also there to debrief with the interviewer and provide a space to decompress after each interview.
- Flagging distressing interviews. We will ask interviewers and their buddies to notify the Project Directors of distressing interviews, to make sure they have the necessary support. Support includes: speaking to IFF's Mental Health first aiders or IFF's counselling service.
- Any issues arising during interviews will to be written up in the safeguarding log.

F.4. Data protection

IFF takes the issue of data security extremely seriously. We take all reasonable steps to ensure the safety and confidentiality of data. This data includes participant' records, management data provided by our clients, and survey data we collect. We fully support the aims of the General Data Protection Regulation (GDPR). IFF Research are ISO27001 and Cyber Essentials certified for data security.

We manage and store research and personal data securely. Access to IFF systems is restricted to users with an approved Active Directory account. We also have an access rights policy that restricts access to sensitive data on an authorised basis. For this evaluation [NAME] (project manager) will approve access to a secure folder on our system, which will be visible only to named project team members. All personal data,

including research responses, will be stored in this secure folder. Data relating to this project is not exported or transferred outside of the UK.

In terms of data transfers, the process that we will use for this project is as follows:

- All sensitive personal data (as defined by GDPR), including sample files, is transferred by secure electronic transfer via our Secure File Transfer Protocol system with sophisticated encryption technologies (AES-256) and Extended Validation SSL to ensure the integrity of data. File transfer sessions are fully encrypted using TLS 1.2/1.3 certificates. Access to files is restricted to authorised recipients only, who receive an email with details of the download as well as a further identity verification check.
- All files containing personal data are saved to a project-specific folder on IFF's secure network, which only the named project team are able to access. This original file is not moved, other than when it is securely deleted.
- Permission rights to secure network folders are allocated by the Project Manager [NAME]. All activity (copying, amending etc.) is recorded on the Data Asset Register and this is monitored and reviewed regularly by our IT team.
- Recordings of interviews with recent / current service users, any notes which have not been anonymised, contact details and any other information potentially disclosive of the identity of service users, will be stored in sub-folders within the main secure folder. Access to these sub-folders will be restricted to the individual researcher(s) carrying out that specific case study.
- Analysis frameworks will be designed not to show any potentially identifying information regarding service users, and researchers will be briefed not to include any such information in these, or in any other research output. The first write up from each researcher will be reviewed by the project manager for quality assurance, clarity of summary and confidentiality.
- Researchers will not be permitted to hold recordings or other potentially identifying information in other locations, such as personal devices.
- For face-to-face interviewing, we use portable secure recording devices, using AES-256 encryption, with distribution of devices and password security overseen by our IT team. Recordings can only be downloaded and decrypted by our IT team.
- For online video interviewing, we use Zoom to record to a local device, which is immediately saved to the secure folder and deleted from the device.
- When out on site or working from home, connections to our server are exclusively via secure VPN (Virtual Private Networking), to avoid any interception of data.
- All participants have a right to have a copy of their data. If a copy is requested, a voice recording of the interview will be sent via our Secure File Transfer Protocol system.

IFF Research will use the information gathered for research purposes only. We will report all individual responses in aggregate form. This means all the responses to questions are presented in a way that will not identify them. If a participant decides they want to change or withdraw their data, they can inform the interviewer during the interview, and they have up to three months from the point of participation to change or withdraw any data that is not held anonymously (and thus cannot be attributed to them). All data held by IFF will be retained for three months after the end of the evaluation, i.e. until July 2023, and then securely destroyed, including from all back-ups.

Annex G Data tables

This Annex displays the data from the charts included in the report.

Table G.1 Data for Figure 4.1 Variations in extent to which referrals are turned away, by project

Respite Room project	Number of referrals received	Number turned away	% turned away
Birmingham	80	55	69%
BCP	96	66	69%
Portsmouth	61	42	69%
Bristol	185	119	64%
Leicester	127	69	54%
Westminster	230	119	52%
Camden	165	76	46%
Liverpool	206	74	36%
Exeter	71	24	34%
Nottingham	40	9	23%
Manchester	148	24	16%
East Sussex	53	4	8%

Source: DLUHC Respite Room data returns, October 2021 to January 2023

Table G.2 Data for Figure 4.2 Service users leaving Respite Rooms, compared with admissions

Month	Number of service users admitted	Number of service users leaving
Oct-21	45	13
Nov-21	60	25
Dec-21	45	34
Jan-22	54	44
Feb-22	49	42
Mar-22	36	36
Apr-22	55	39
May-22	47	41
Jun-22	55	40
Jul-22	46	39
Aug-22	33	30
Sep-22	53	34
Oct-22	68	39
Nov-22	69	29
Dec-22	39	27
Jan-23	38	31

Source: DLUHC Respite Room data returns, October 2021 to January 2023

Table G.3 Data for Figure 4.3 Service user demographics

	% of service users
Ethnic Minority Group	28%
NRPF	13%
LGBTQ	10%
Roma, Gypsy or Traveller	3%

Source: DLUHC Respite Room data returns, October 2021 to January 2023

Table G.4 Data for Figure 4.4 Service users' previous engagement with services

	Number of service users
Service users previously engaged with homelessness services	73%
Service users previously engaged with other services	68%
Service users previously engaged with VAWG services	45%
Service users not previously engaged with any service	8%

Source: DLUHC Respite Room data returns, October 2021 to January 2023

Table G.5 Data for Figure 5.1 Support provided in Respite Rooms

	% of Respite Rooms providing service	% of service users receiving service
Housing Related Support	100%	81%
Advocacy support	100%	68%
DA prevention advice	100%	61%
Other VAWG safety and prevention advice	100%	44%
Support specific to additional and/or complex needs	100%	35%
Advice service (e.g. financial and legal support)	83%	34%
Counselling and/or therapy	92%	33%
Support specific to victims with protected characteristics	67%	8%

Source: Respite Room data returns, October 2021 to January 2023. Base: All services (12), all service leavers excluding Exeter (512).

Table G.6 Data for Figure 5.2 Length of time in the Respite Room, % of service users

	% of service users
More than 4 weeks	50%
2 to 4 weeks	19%
1 to 2 weeks	14%
Less than 1 week	17%

Source: DLUHC Respite Room data returns, October 2021 to January 2023

Table G.7 Data for Figure 5.3 Move-on destinations for leavers from Respite Rooms

	Positive destinations	Neutral destinations	Negative destinations
Night Shelter or homeless hostel	-	-	13%
Social Housing	12%	-	-
DA Safe Accommodation	11%	-	-
Staying with friends or family	-	10%	-
Street homelessness	-	-	9%
Non-DA Supported Housing	8%	-	-
Returned to perpetrator	-	-	7%
B&B / hotel (unprompted)	-	-	6%
Private Rented Sector	-	6%	-
Drug / Alcohol project	3%	-	-
Hospital	-	-	3%
Home country	-	2%	-
Mental Health project	1%	-	-
Housing First	0%	-	-
Other	-	8%	-

Source: DLUHC Respite Room data returns, October 2021 to January 2023

Table G.8 Data for Figure 6.1 Housing situation at follow-up

Housing situation at follow-up (p-value)	Comparison group	Respite Room service users
Summary: Safe or secure accommodation (<0.001*)	48%	65%
In safe or secure accommodation		
Other supported housing (0.053)	22%	32%
Private or social rented, etc. (0.752)	13%	14%
DA safe accommodation (0.015*)		9%
Settled with family or friends (0.004*)	2%	7%
Still accommodated (0.011*)	8%	
Not in safe or secure accommodation		
Unknown, or left UK (0.214)	6%	11%
Rough sleeping or homeless hostel (<0.001*)	29%	10%
Another location (0.620)	10%	9%
Medical care (inc. rehab) (0.497)	3%	5%
Sofa surfing (0.105)	5%	2%
Returned to perpetrator (0.099)		1%

Source: LA provided data on Respite Room users (Base: 396) and comparison group (Base: 138) *statistically significant finding

Table G.9 Data for Figure 6.2 Receipt of advice and support since baseline

Advice type (p-value)	Comparison group	Respite Room service users
Housing related support (0.006*)	73%	87%
Advocacy support (0.002*)	62%	80%
DA prevention advice (0.001*)	43%	66%
Other VAWG safety and prevention advice (0.080)	35%	48%
Support for victims with additional/complex needs (0.031*)	26%	40%
Advice services (0.295)	28%	35%
Counselling and therapy (0.046*)	14%	28%
Support for victims with protected characteristics (0.004*)	8%	19%

Source: LA provided data on Respite Room users' receipt of advice or support (Base: 369 to 390 depending on service type) and comparison group (Base: 87 to 111 depending on service type) *statistically significant finding

Table G.10 Data for Figure 6.3 Percent in safe or secure housing by receipt of advice and support

	% in safe or secure housing by receipt of advice and support
DA prevention advice (p-value: 0.006*)	
Received DA prevention advice	71%
Did not receive DA prevention advice	58%
Advocacy support (p-value: 0.001*)	
Received advocacy support	70%
Did not receive advocacy support	49%
Housing related support (p-value: <0.001*)	
Received housing related support	70%
Did not receive housing related support	40%

Source: LA provided data on Respite Room users in safe or secure housing who provided data on receipt of DA prevention advice (258), advocacy support (256) or housing related support (259) *statistically significant finding

Table G.11 Data for Figure 6.4 Impact of Respite Rooms for service users, % of service users agreeing with statements on leaving

Statement	% of service users agreeing
"I felt comfortable and safe in the Respite Room"	67%
"Staying in the Respite Room helped me"	60%

Source: DLUHC Monitoring Data (October 2021 – January 2023). Excludes Camden due to data recording issues.

Table G.12 Demographics of service users, % of users leaving, by location – A to B

Service	Birmingham	BCP	Bristol
Base	*18*	*33*	*58*
18 to 25	0%	6%	9%
Mental Health issues	72%	94%	83%
Addictions	33%	91%	83%
Current DA	83%	39%	52%
Current other abuse / violence	6%	48%	29%
Ethnic minorities	6%	3%	10%
NRPF	0%	3%	0%
Out of area	11%	3%	3%

Sources: Respite Room data returns, October 2021 to January 2023.

Table G.13 Demographics of service users, % of users leaving, by location – C to E

Service	Camden	Exeter*	East Sussex
Base	*60*	*31*	*35*
18 to 25	27%	n/a	6%
Mental Health issues	100%	n/a	46%
Addictions	33%	n/a	34%
Current DA	47%	n/a	86%
Current other abuse / violence	48%	n/a	3%
Ethnic minorities	65%	n/a	0%
NRPF	8%	n/a	0%
Out of area	47%	n/a	6%

Sources: Respite Room data returns, October 2021 to January 2023. *no data due to issues with data return.

Table G.14 Demographics of service users, % of users leaving, by location – L to M

Service	Leicester	Liverpool	Manchester
Base	*44*	*61*	*37*
18 to 25	18%	18%	19%
Mental Health issues	30%	90%	73%
Addictions	30%	80%	57%
Current DA	100%	80%	24%
Current other abuse / violence	64%	8%	n/a*
Ethnic minorities	80%	7%	0%
NRPF	32%	2%	3%
Out of area	0%	7%	0%

Source: Respite Room data returns, October 2021 to January 2023 *Data recording issue; this group were extensively mentioned in interviews at this provider.

Table G.15 Demographics of service users, % of users leaving, by location – N to Z

Service	Nottingham	Portsmouth	Westminster
Base	*21*	*17*	*128*
18 to 25	5%	29%	10%
Mental Health issues	95%	47%	76%
Addictions	76%	100%	37%
Current DA	71%	82%	33%
Current other abuse / violence	33%	12%	55%
Ethnic minorities	14%	6%	46%
NRPF	0%	0%	35%
Out of area	24%	0%	29%

Source: Respite Room data returns, October 2021 to January 2023

Table G.16 Support provided in Respite Rooms, % of users receiving service, by location – A to B

Service	Birmingham	BCP	Bristol
Base	*18*	*33*	*58*
Housing Related Support	72%	97%	83%
Advocacy support	6%	97%	66%
DA prevention advice	56%	79%	57%
Other VAWG advice	17%	45%	48%
Additional/complex needs support	39%	97%	43%
Advice service	0%	12%	38%
Counselling and/or therapy	0%	3%	29%
Protected characteristics support	0%	0%	5%

Sources: Respite Room data returns, October 2021 to January 2023

Table G.17 Support provided in Respite Rooms, % of users receiving service, by location – C to E

Service	Camden	Exeter	East Sussex
Base	*60*	*31*	*35*
Housing Related Support	100%	n/a	91%
Advocacy support	100%	n/a	3%
DA prevention advice	100%	n/a	66%
Other VAWG advice	100%	n/a	51%
Additional/complex needs support	48%	n/a	46%
Advice service	67%	n/a	43%
Counselling and/or therapy	73%	n/a	29%
Protected characteristics support	32%	n/a	3%

Sources: Respite Room data returns, October 2021 to January 2023

Table G.18 Support provided in Respite Rooms, % of users receiving service, by location – L to M

Service	Leicester	Liverpool	Manchester
Base	*44*	*61*	*37*
Housing Related Support	91%	93%	24%
Advocacy support	70%	82%	38%
DA prevention advice	93%	89%	24%
Other VAWG advice	57%	56%	27%
Additional/complex needs support	25%	15%	41%
Advice service	74%	32%	19%
Counselling and/or therapy	48%	66%	27%
Protected characteristics support	20%	11%	3%

Source: Respite Room data returns, October 2021 to January 2023

Table G.19 Support provided in Respite Rooms, % of users receiving service, by location – N to Z

Service	Nottingham	Portsmouth	Westminster
Base	*21*	*17*	*128*
Housing Related Support	86%	100%	68%
Advocacy support	43%	100%	73%
DA prevention advice	62%	100%	20%
Other VAWG advice	71%	24%	12%
Additional/complex needs support	62%	41%	13%
Advice service	47%	16%	34%
Counselling and/or therapy	29%	82%	3%
Protected characteristics support	0%	0%	1%

Source: Respite Room data returns, October 2021 to January 2023