



# Awareness and response to domestic violence

## A state of play analysis among housing providers and homeless services in Europe

Safe at Home Project

Including Housing Providers in Tackling Domestic Violence

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## 1. Introduction to project and context of the report

The European project 'Safe at Home- Including Housing Providers in Tackling DV' aims to strengthen the vital role that housing providers can play in responding to DV. The project is funded by the Rights, Equality and Citizenship (REC) Programme of the European Union.

The main activities and outputs of the project are

- A training toolkit on domestic violence (DV) targeting housing providers staff which will be delivered to at least 1000 frontline staff in the UK and the NL;
- A baseline survey with participating housing providers to measure the effect of the training;
- A snapshot study on the current state of play of awareness of DV among housing providers at EU-level, including an assessment of services' capacity to identify and respond to cases of DV (this report);
- A best practice guide including policy recommendations targeting policy makers (EU and national level);
- 3 3-day work visits to innovative projects to foster knowledge exchange;
- Workshops with policy makers as well as a final conference.

This report uses the term 'domestic violence', which is most used in Europe to refer to violence taking place in intimate and familial relationships, knowing that in some countries (UK, Ireland) the term 'domestic abuse' is more common. The term 'domestic violence' is mostly used in its abbreviated form 'DV'. Domestic violence is deeply gendered and disproportionately affects women. Women who have experienced or are experiencing DV are referred to as 'survivors'. This term wants to emphasize women's strengths and capacity to overcome DV and lead a self-determined life (unlike the term 'victim' which conveys a passive, enduring perspective on women with experience of DV).

The report provides a state of play analysis of the current awareness of DV among housing providers at EU-level, including an assessment of services' capacity to identify and respond to cases of DV. The core of the report consists of results from an EU-wide survey conducted among social / public housing providers and homeless services with regard to their current response to DV. Initially, the survey was planned to include social and public housing providers only. As project partner FEANTSA offered access to its network of over 130 homeless service providers throughout Europe, project partners decided to include homeless services in the survey. The data analysis part of this report (chapter 6) is based on the results of the online survey among European housing providers and homeless services in May and June 2017. Complementary interviews were conducted with experts from the housing and homeless sectors as well as with DV- / Gender-Based Violence (GBV) services. This introduction (chapter 1) is followed by a short overview on the prevalence of domestic and gender-based violence in Europe, based on recent research (chapter 2). Chapter 3 gives an overview of relevant European policies on DV and violence against women and outlines recent policy developments such as the Istanbul Convention. Chapter 4 provides a detailed analysis of the relationship between DV and women's homelessness and explains why women survivors of DV are more vulnerable to homelessness. Chapter 5 describes the role housing providers can play in improving support to survivors of DV and explains the methodology and content of the 'Safe at Home' training on recognizing signs of DV. It also presents results from the follow-up evaluation of housing providers who participated in the 'Safe at Home' training. Chapter 6 provides the analysis for the data collected during the survey among housing providers and homeless services. The quantitative data analysis is complemented by findings from expert interviews and provides examples of current good practice in terms of supporting survivors of DV efficiently (chapter 6.5). Specific attention is given to the perspective of women survivors of DV and their perception of current service provision, in particular on what should be changed to improve support for survivors (chapter 6.6). Final chapter 7 presents the report's overall conclusions, scrutinizing the current state of play of



support provided to DV survivors by housing providers and homeless services and outlines what needs to be done to improve support for DV survivors in the future.

Chapter 3 on the European policy framework on domestic and gender-based violence was drafted by Clotilde Clark-Foulquier (FEANTSA). The author would also like to give credits to Thien Trang Nguyen Phan (STADV) for her substantial contribution to the data compiling and analysis of the feedback data from the participants of the SAH training which is presented in chapter 5.

## 2. Short overview on prevalence of DV & violence against women in Europe

The European Commission commissioned the Fundamental Rights Agency (FRA) with a report on the prevalence of different forms of violence against women in the EU. The FRA published the report ‘Violence Against Women: an EU-wide survey’<sup>1</sup> in 2015, based on a survey reaching out to 42,000 women in all 28 Member States. For the first time, EU-wide data on the extent, nature and consequences of violence against women in the EU is presented.

An estimated 13 million women have experienced physical violence in the course of 12 months before the survey interviews which were conducted between March and September 2012. An estimated 3.7 million women in the EU have experienced sexual violence in the course of 12 months before the survey interviews (to provide a reference, in 2012, 257.7 million women lived in the EU). The survey shows that one in three women (33%) has experienced physical and/or sexual violence since she was 15 years old and some 8% of women have experienced physical and/or sexual violence in the 12 months before the interviews.

The report also provides data on **domestic and intimate-partner violence**, which is most relevant for this report. 22% of women in the EU have experienced physical and/or sexual violence by a partner since the age of 15. One third of victims<sup>2</sup> (34%) of physical violence by a previous partner report having experienced four or more different forms of physical violence. The most common forms of physical violence involve pushing or shoving, slapping or grabbing, or pulling a woman’s hair. Whereas in most cases violence by a previous partner occurred during the relationship, one in six women (16%) who has been victimised by a previous partner experienced violence after the relationship had broken up.

Results clearly indicate that intimate partner violence is a widespread reality in the EU. Of those women who currently have or previously had a partner, just over one in five have experienced physical and/or sexual violence by a partner. The FRA report concludes that the current prevalence of intimate partner violence ‘requires a renewed political and policy focus at EU and Member State levels’.

## 3. What are the main European policy frameworks on DV and violence against women?

The European Union has addressed domestic violence and violence against women through separated pieces of legislation, funding, data collection, mutual learning and non-binding political mechanisms of ‘soft-law’. In 2017, the three main European institutions adopted the ‘Malta joint statement’ calling for all Member States to ratify and fully implement the **Council of Europe’s Convention on preventing and combating violence against women and domestic violence**.<sup>3</sup> More recently, the European Parliament adopted a Motion for a European Parliament resolution on the elimination of domestic abuse (March 2018).<sup>4</sup> Furthermore, the

<sup>1</sup> <http://fra.europa.eu/en/publication/2014/violence-against-women-eu-wide-survey-main-results-report>

<sup>2</sup> The report reproduces the wording used in the FRA report which, unlike this report, refers to ‘victims’ instead of the term ‘survivors’ which has been used throughout this report.

<sup>3</sup> <http://www.europarl.europa.eu/news/en/press-room/20170206IPR61393/malta-joint-statement-european-institutions-call-for-action>

<sup>4</sup> <http://www.europarl.europa.eu/sides/getDoc.do?type=MOTION&reference=B8-2018-0127&format=XML&language=EN>



Parliament reiterated its call on Member States to ratify the Istanbul Convention and ensure proper implementation. However, there is no comprehensive overarching European policy framework on domestic violence. Nevertheless, all Member States have signed the Istanbul Convention in 2017 as an International Organization.<sup>5</sup> There is therefore ground for a common coordinated political approach based on the Convention.

### What is the European Union doing on domestic violence and violence against women? The development of a multi-piece legislative and political framework

With the entry into force of the Treaty of the European Union, gender equality became a ‘fundamental value’ (art.2 TUE) and an ‘objective’ (art.3 TUE) of the EU. The Union is required to combat discrimination in defining and implementing its policies (Art. 10). Currently, the coordination of the EU’s work on this issue falls under DG JUST which develops and carries out the European Commission’s policies on justice, fundamental rights and gender equality (as well as consumers). DG JUST and Commissioner Jourova specifically highlighted the intention to improve prevention of DV as well as their determination to combat all forms of violence against women and to support actors who aim at ending GBV on a European level. More specifically, Commissioner Jourova made 2017 the ‘**European Year of Focused Actions on Ending Violence Against Women**’ which provided a framework for coordinated actions. Actions included the following:

- A special **Eurobarometer** survey on gender-based violence was published.<sup>6</sup> The **EIGE Gender Equality Index report 2017** was dedicated to violence against women as the most brutal manifestation of gender inequality.<sup>7</sup>
- The European Commission launched the **campaign NON.NO.NEIN. - Say No, Stop Violence Against Women (#SayNoStopVAW)** to raise awareness on VAW. EUR 15 million in funding were made available for Member States, local governments, relevant professionals and civil society organisations to help them intensify actions and campaigns to combat VAW and to disseminate good practice and connecting stakeholders across borders. The European Commission also supported the global campaign to end VAW (**#orangetheworld**) during the 16 Days of Activism aiming to raise public awareness and mobilise people to end violence against women and girls worldwide. **#MeToo** contributed greatly to combat VAW, supporting women to express sexual harassment and assault they have experienced.
- The **Annual Colloquium on Fundamental Rights** was entitled ‘*Women’s rights in turbulent times*’.<sup>8</sup> The prevention of GBV, particularly changing social norms and behaviour in order to end tolerance of all forms of GBV, was one of the 3 overall priorities of the Colloquium. The Colloquium conclusions explicitly mention homeless women being particularly vulnerable to GBV.<sup>9</sup>
- Under the Mutual Learning Programme in gender equality the Commission organised an exchange of good practices among Member States’ governmental representatives.
- Frans Timmermans, First Vice-President of the Commission, Věra Jourová, Commissioner for Justice, Consumers and Gender Equality, and 5 more Commissioners signed a **joint statement on the International Day for the Elimination of Violence against Women** (25 November 2016) expressing the commitment of the European Commission to end violence against women and girls once for

<sup>5</sup> The full name of the Istanbul Convention is the ‘Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence’.

<sup>6</sup> <http://ec.europa.eu/commfrontoffice/publicopinion/index.cfm/Survey/getSurveyDetail/instruments/SPECIAL/surveyKy/2154>

<sup>7</sup> <http://eige.europa.eu/rdc/eige-publications/gender-equality-index-2017-violence-against-women>

<sup>8</sup> [http://ec.europa.eu/newsroom/just/item-detail.cfm?item\\_id=115277](http://ec.europa.eu/newsroom/just/item-detail.cfm?item_id=115277)

<sup>9</sup> [http://ec.europa.eu/newsroom/just/item-detail.cfm?item\\_id=115277](http://ec.europa.eu/newsroom/just/item-detail.cfm?item_id=115277)





all.<sup>10</sup> The statement emphasized a series of actions to be launched throughout 2017 to combat violence against women and girls in all its forms, including the allocation of €10 million to support efforts by grassroots organizations, to prevent gender-based violence and support victims, to provide information and raise awareness about VAW and to target the general public as well as specific professionals (such as police officers, teachers, doctors, judges).

In the conclusion report of the above-mentioned Annual Colloquium on Fundamental Rights, the European Commission emphasizes its commitment for the next years to keep combatting VAW. The Commission states that it will continue to deliver on the actions of the Strategic Engagement on Gender Equality (2016-2019) whose 5 key areas include *dignity, integrity and ending gender-based violence*.<sup>11</sup> The EC will also continue to support the publication of reports on gender equality (together with EIGE). Specific attention will be given to the EIGE study on gender budgeting in the European Structural and Investment Funds which is currently being conducted (results are expected for 2019). Furthermore, the Commission commits to ensure women's rights and gender equality are properly reflected in all its political decision-making and will increasingly take into account multiple discrimination based on factors such as age, ethnicity, religion, and ability (in addition to gender).

Throughout the years, the European Union has adopted several **legislations**<sup>12</sup> on gender equality and violence against women and domestic violence. These include for instance directives on equal treatment, against human trafficking, against sexual exploitation, for the protection of victims of crimes, etc. These directives are based on a gender equality perspective, emphasize the importance of appropriate support for victims, including specialised support for women and children who have been victims of different forms of violence. Directives also call on Member States to ensure victims are provided with specialized support to access their rights and to ensure that victims' rights are reinforced at every stage of the criminal justice process. Prevention is recognized as a fundamental tool to combat violence against women (and children). Directives also establish minimum standards on the rights, support and protection of victims of crime<sup>13</sup> and emphasize the importance of monitoring implementation at local level. The directives are legally binding on Member States who have the obligation to transpose them into their national law, so as to give them legal force. Furthermore, the European Union has developed the following **soft-law instruments** to contribute to ending violence against women:

- **Mutual learning:** The European Commission is facilitating exchange of good practices through mutual learning. For instance, the Mutual Learning Programme in Gender Equality<sup>14</sup> organizes three exchanges a year. It provides an opportunity for debate and exchange of experience between governmental representatives, independent experts and other relevant stakeholders, to facilitate the dissemination of good practice on gender equality in Europe. Another example is the 2017 Malta Presidency European event on Violence against women that brought together cross-sector

<sup>10</sup> [http://europa.eu/rapid/press-release\\_STATEMENT-16-3945\\_en.htm](http://europa.eu/rapid/press-release_STATEMENT-16-3945_en.htm)

<sup>11</sup> The Commission's 2010-2015 strategy for equality between women and men prioritised five key areas for action: Equal economic independence for women and men; equal pay for work of equal value; equality in decision-making; dignity, integrity and ending gender-based violence; and promoting gender equality beyond the EU. Accessible here : [https://ec.europa.eu/anti-trafficking/eu-policy/strategic-engagement-gender-equality-2016-2019\\_en](https://ec.europa.eu/anti-trafficking/eu-policy/strategic-engagement-gender-equality-2016-2019_en).

<sup>12</sup> Directive 2006/54/EC on equal treatment; Directive 2011/36/EU on trafficking in human beings; Directive 2011/93/EU on combating the sexual abuse and sexual exploitation of children and child pornography; Directive 2011/99/EU on European Protection Orders; Directive 2012/29/EU establishing minimum standards on the rights, support and protection of victims of crime; Regulation (EU)606/2013 on mutual recognition of protection measures in civil matters, and; Communication COM(2013)833 final on the elimination of female genital mutilation.

<sup>13</sup> Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA: <https://eur-lex.europa.eu/legal-content/EN/TXT/?qid=1421925131614&uri=CELEX:32012L0029>

<sup>14</sup> [https://ec.europa.eu/info/policies/justice-and-fundamental-rights/combating-discrimination/gender-equality/who-we-work-gender-equality/mutual-learning-programme-gender-equality\\_en](https://ec.europa.eu/info/policies/justice-and-fundamental-rights/combating-discrimination/gender-equality/who-we-work-gender-equality/mutual-learning-programme-gender-equality_en)





stakeholders and Member States to exchange good practices to prevent and protect victims of gender-based violence and discuss how good practice can influence current policy.

- **Data collection:** The European Union is contributing to the work on domestic violence and violence against women through data collection in which several of its bodies are involved: the European Union Agency for Fundamental Rights (first ever EU-wide survey on women's experiences of violence in 2014), Eurostat which collected administrative data recorded by national authorities (e.g. police, judiciary) together with the United Nations Office on Drugs and Crime in 2015. Eurostat is also working towards an EU survey on gender-based violence. A Eurobarometer survey on gender-based violence was published in 2017 (see above *The development of a multi-piece legislative framework*). Finally, the European Institute for Gender Equality (EIGE) plays a leading role in providing information and research on violence against women across the European Union, to inform policy makers and assist the design and implementation of effective policies to combat gender-based violence.<sup>15</sup> EIGE published a first incidence study on VAW in the EU in 2017 (see also above).
- **Funding:** The European Commission has also made funding available for the fight against domestic violence and gender-based violence. In doing so, it is promoting a political framework to support Member States and Stakeholders to work together and address the issue at local and national level. As part of this effort, it financed the WOM-POWER project- Empowering women to fight against domestic violence through an integrated model of training, support and counselling.<sup>16</sup> It also launched a research call for proposals to prevent and combat gender-based violence and violence against children under the Rights, Equality and Citizenship Programme in 2017 and 2018 (and earlier under the Daphne/REC calls from 2015 and 2016<sup>17</sup>).

### **Towards a comprehensive European legal framework: The council of Europe ‘Istanbul Convention’**

The ‘Istanbul Convention’, also called the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, is a binding international instrument addressing violence against women and domestic violence. It is the most comprehensive legal framework addressing VAW and DV. The Convention covers a broad range of measures, including obligations ranging from awareness-raising and data collection to legal measures on criminalizing different forms of violence against women. It also provides for the implementation of comprehensive and coordinated policies between national and governmental bodies involved in prevention, prosecution, and protection.

The European Union signed the Istanbul Convention in June 2017. The EU Member States are parties to it but not all of them have ratified it. However, those Member States who have ratified it, have obligations relating amongst others to the prevention of violence and the protection of the victims. At present (13 July 2018), 14 EU Member States and 33 Council of Europe members have ratified the Convention.<sup>18</sup> As for the countries involved in the Safe at Home project, Belgium and the Netherlands have both signed and ratified the Convention whereas the UK has signed it but not yet ratified. The Istanbul Convention is not an instrument of the European Union but was developed by the Council of Europe which is an international organization and independent from the European Union.

<sup>15</sup> <http://eige.europa.eu/gender-based-violence/data-collection>

<sup>16</sup> <https://ec.europa.eu/justice/grants/results/daphne-toolkit/en/content/wom-power-empowering-women-fight-against-domestic-violence-through-integrated-model-0>

<sup>17</sup> [http://ec.europa.eu/justice/grants1/files/2015\\_action\\_grants/2015\\_sprob\\_ag\\_vict/victims\\_call\\_notice.pdf](http://ec.europa.eu/justice/grants1/files/2015_action_grants/2015_sprob_ag_vict/victims_call_notice.pdf)

<sup>18</sup> Chart of signatories and ratifications: <https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/210/signatures?desktop=true>



To monitor the implementation of the Istanbul Convention, GREVIO, an independent expert body, was established.<sup>19</sup> GREVIO has published several country-specific reports which evaluate legislative and other measures implemented by Member States. Reports evaluate the provisions of the Convention and may initiate a special inquiry procedure where action is required to prevent a serious, massive or persistent pattern of acts of violence covered by the Convention. GREVIO can also adopt general recommendations on themes and concepts covered by the Convention.

#### 4. How is DV related to women's homelessness? DV and social inequality of women

The FEANTSA Position Paper *Homelessness and Violence Against Women* (2016) clearly states that DV is a pathway into homelessness for women.<sup>20</sup> The experience of violence is one of, if not *the*, most commonly shared experience by homeless women. Forcing survivors to leave their home, domestic abuse leads to different forms of homelessness: rough sleeping, sheltered accommodation, residing in insecure or overcrowded housing, sofa surfing. The detrimental consequences of DV for the well-being of survivors are well evidenced: DV turns the home, 'a place of constancy, privacy, control and identity construction', into a place of permanent surveillance, unrest and a threat to women's and children's fundamental personal security.<sup>21</sup> Therefore, living with a violent partner is also referred to as being 'homeless at home' by research.<sup>22</sup> This extreme fragility is worsened for mothers: experiences of stigma, extreme stress and erosion of their perceived role as mothers, particularly when children are not in their care, are very strong common experiences among homeless women.<sup>23</sup>

Research on the causal link between DV and homelessness in Europe has often been described as localized and is therefore only comparable to a limited extent. However, most recent research by Mayock, Bretherton and Baptista from 2017, based on official European statistics, suggests that women are indeed more likely than men to lose their home because of DV.<sup>24</sup> This confirms previous research from different European countries which shows high rates of DV experience among homeless women: research by Baptista et al among women accessing homeless services in Lisbon and Porto shows that almost half of women left their home to escape intimate partner violence.<sup>25</sup> Mayock and Sheridan's research shows that two-thirds of homeless women in Ireland had experienced DV as adults and half of women experienced some form of abuse or violence during both adulthood and childhood. Pleace et al show that 41% of family homelessness in England is due to fleeing a violent partner.<sup>26</sup> Previous research by Mayock and Sheridan showed that abusive relationships emerge as a pattern among women with a history of long-term or recurrent homelessness.<sup>27</sup>

#### Survivors are more likely to face difficulties in accessing affordable permanent housing

The establishment of a new, independent life can be jeopardized by different constraints such as limited or inexistent economic resources, very limited social resources, as DV is strongly associated with the isolation

<sup>19</sup> <https://www.coe.int/en/web/istanbul-convention/grevio>

<sup>20</sup> FEANTSA Position Paper: Homelessness and Violence Against Women: Addressing the Link and Responding Effectively (2016). Accessible [here](#).

<sup>21</sup> Mayock, P., Bretherton, J., Baptista, I. (2017). Women's Homelessness and DV: (In)Visible Interactions, p 130. In P. Mayock & J. Bretherton (Ed.), *Women's Homelessness in Europe* (pp. 127-154). London, UK: Palgrave Macmillan.

<sup>22</sup> Wardhaugh, J. (1999): The unaccommodated woman: Home, homelessness and identity. *The Sociological Review*, 47(1), 91-109. In P. Mayock & J. Bretherton (Ed.), *Women's Homelessness in Europe* (pp. 127-154). London, UK: Palgrave Macmillan.

<sup>23</sup> Ibid.

<sup>24</sup> Ibid.

<sup>25</sup> Baptista, I., Silva, A., Silva, M. et al. (2005): Quartos, pensões e hospedarias: a realidade do alojamento apoiado em Lisboa e no Porto. Instituto de Segurança Social Estudo dos Sem-Abrigo. Lisbon: ISS.

<sup>26</sup> Pleace, N., Fitzpatrick, S., Johnsen, S. et al. (2008): Statutory homelessness in England: the experience of families and 16-17 year olds. Research Report. Department for Communities and Local Government. Accessible here: [http://eprints.whiterose.ac.uk/73926/1/Final\\_Communities\\_web\\_version.pdf](http://eprints.whiterose.ac.uk/73926/1/Final_Communities_web_version.pdf).

<sup>27</sup> Mayock et al; 2015b.



of the victim, a lack of available and/or affordable housing and the inadequacy of homeless hostels. Many hostels, emergency or short-term accommodations do not respond to the needs of survivors. As a consequence, a considerable number of survivors decide to leave hostels / shelters, feeling unsafe and distressed due to living conditions there. Women survivors of DV are also more affected by the shortage of affordable housing in many countries across Europe. The **economic discrimination of women**, most importantly lower pay, leaves women much more vulnerable to the effects of shortages of affordable housing, cuts of housing allowances or other social benefits. Gender-based discrimination on the labour market is another reason that keeps women and especially marginalized women (e.g. women with migrant backgrounds, women of colour) in a precarious economic situation, impeding transition into independent living. Various research highlights affordable housing as an ‘essential first step’ in solving homelessness (for instance Metraux/Culhane 1999<sup>28</sup>).

### The current lack of affordable housing in Europe exacerbating the vulnerability of survivors of DV

The increased **vulnerability of poor households** to increasing **housing costs** is well documented in the 3<sup>rd</sup> Housing Exclusion Report for Europe 2018, published by the Abbé Pierre Foundation and FEANTSA.<sup>29</sup> The report shows that housing costs for poor households have increased in three quarters of EU countries between 2010 and 2016. With regards to the ‘Safe at Home’ partner countries, poor households in the Netherlands spent 48% of their disposable income on housing in 2016 (compared to 25% of the total population). The situation in the UK is very similar where poor households spent 47% of their disposable income on housing (compared to 25% of the total population). In Belgium, poor households spent a bit less on housing, namely 39% of their disposable income (compared to 20% spent on housing by the total population).<sup>30</sup> On average, poor households in the EU spend 42% of their disposable income on housing, compared to 22% spent by the total population (2016). Furthermore, there is currently limited public interest and political will to provide more affordable housing. Budget cuts and the privatisation of housing markets contributed to the reduction of affordable housing in Europe in recent years. Despite of the lack of affordable housing, public spending on housing construction declined by 44% between 2009 and 2015 (from 48,2 to 27,5 million Euro).<sup>31</sup>

Gender-based economic inequality makes it harder for women, who are the majority of survivors, to leave abusive relationships.<sup>32</sup> The economic costs of DV for survivors is well evidenced: Sylvia Walby, UNESCO Chair in Gender Research and researcher at Lancaster University, shows that the more frequent and the more severe DV is, the least likely women are to own their home or to be in employment.<sup>33</sup> More precisely, 66% of the England’s and Wales’ population are home owners but only 35% of survivors own their homes.<sup>34</sup> The ‘*Hidden Hurt*’ report comes to the same conclusion for the UK: women who have experienced extensive

<sup>28</sup> Metraux, S., Culhane, D.P. (1999): Family dynamics, housing and recurring homelessness among women in New York City homeless shelters. *Journal of Family Issues* 20(3), 371-396. In P. Mayock & J. Bretherton (Ed.), *Women’s Homelessness in Europe* (pp. 127-154). London, UK: Palgrave Macmillan.

<sup>29</sup> Third Overview of Housing Exclusion in Europe 2018. Abbé Pierre Foundation / FEANTSA. Accessible here: <https://www.feantsa.org/download/full-report-en1029873431323901915.pdf>.

<sup>30</sup> Ibid.

<sup>31</sup> Koessler, G. (2017): Public expenditure on housing: the shift from capital spend to housing allowances. A European trend? Research briefing, National Housing Federation. Accessible here: [http://s3-eu-west-1.amazonaws.com/pub.housing.org.uk/public\\_spending\\_housing\\_europe\\_uk\\_briefing.pdf](http://s3-eu-west-1.amazonaws.com/pub.housing.org.uk/public_spending_housing_europe_uk_briefing.pdf).

<sup>32</sup> Indicators for women’s economic disadvantage: In the EU-28 countries, women still earn 16.2% less than men (average gross hourly earnings, source [Eurostat unadjusted gender pay gap](#)). Fewer women (65.3%) than men are in employment (71.1%) and more women than men work part-time (31.4% compared to 8.2%), EU-28, 2016, source [Eurostat employment rate by gender](#).

<sup>33</sup> Research is based on the Crime Survey for England and Wales.

<sup>34</sup> Walby, S., Towers, J. (2018): Untangling the concept of coercive control: Theorizing domestic violent crime, *Criminology & Criminal Justice*. Accessible here: <http://journals.sagepub.com/doi/pdf/10.1177/1748895817743541>. Data source is the CSEW Victim Form module.



physical violence are far more likely to live in rented accommodation and to have lower household incomes.<sup>35</sup> The *Hidden Hurt* report<sup>36</sup> also points out that survivors are not only more likely to experience homelessness but also more likely to live in **bad housing**: women with experience of violence are more likely to live in housing which is in a poor state of repair or has mould.<sup>37</sup> Recent research by Mayock and Bretherton eventually makes the point that the **availability of housing** stands at the core of women's homelessness: '*The relationship between DV and homelessness is complicated by the material nature of housing, the availability of multiple housing types and living arrangements.*'<sup>38</sup> To sum it up, existing research and evidence clearly indicates that DV needs to be contextualized and tackled as part of a complex process of **gender-based inequality and social disadvantage** which makes women far more vulnerable to all forms of homelessness and rooflessness. The evidence emphasizes that DV needs to be understood as symptom of women's general social disadvantage.

To support survivors in their recovery from DV, policy makers and local authorities need to give **greater emphasis** to the provision of **permanent housing**. Only long-term and safe housing, together with DV-specific support services, provide survivors with a space of ontological security and allows them to recover from the experienced violence.<sup>39</sup>

### The dramatic effects of DV on women's service trajectories

The UK-based DV-organization *Women's Aid* published the report '*Nowhere to Turn*' in 2017 which highlights the **consequences of DV** in survivors' **biographies and service trajectories**.<sup>40</sup> DV and abuse have to be emphasized as fundamental violation of women's physical and emotional integrity, exposing them to subordination in their most intimate relationships. The urgency and sudden changes that survivors of DV experience often result in women's homelessness trajectories being more chaotic. Women usually tend to be more self-efficient, using personal networks or sofa surf for accommodation. Women are hence more at risk of staying in a situation of hidden homelessness for a longer period before accessing homeless services. Longer (or recurrent) periods of hidden homelessness often lead to survivors accumulating experiences of violence and related trauma. As a consequence, survivors might develop complex support needs. Women who have developed challenging behaviour, because of experiences of violence and related trauma, are more likely to end up in emergency accommodation, after having been rejected by other services. Emergency accommodation services often have limited capacity to work with survivors and are probably unable to meet survivors' needs. Most emergency services are male-dominated what not only makes them an inappropriate place for recovery from DV but also keeps survivors from accessing them at all. The growing homelessness among women in Europe has given visibility to the gender dimension of homelessness which has been ignored in many local contexts until today. Homeless support services have acknowledged the need to transform their work with homeless women, who are DV survivors, by introducing gender-sensitive as well as psychologically- and trauma-informed approaches. The last edition of the '*Nowhere to Turn*' report, published in 2018, confirms the repeated failings from statutory services in providing for survivors fleeing domestic abuse.<sup>41</sup>

<sup>35</sup> Ibid, p 5.

<sup>36</sup> Scott, S., McManus, S. (2016): Hidden Hurt. Violence, abuse and disadvantage in the lives of women. DMSS Research for Agenda. Accessible here: <https://weareagenda.org/wp-content/uploads/2015/11/Hidden-Hurt-full-report1.pdf>.

<sup>37</sup> Hidden Hurt. Violence, abuse and disadvantage in the lives of women. Sara Scott and Sally McManus, DMSS Research for Agenda, January 2016. Accessible [here](#).

<sup>38</sup> Mayock, P., Bretherton, J. (2017), p 146.

<sup>39</sup> 'Ontological security' is defined by Anthony Giddens as a 'sense of order and continuity in regard to an individual's experiences'. In homelessness research, ontological security is often referred to as a type of security that is lost when becoming homeless and which can be re-established when a person is rehoused.

<sup>40</sup> Smith, K., Miles, C. (2017): Nowhere to Turn. Findings from the first year of the *No Woman Turned Away* project. Women's Aid. Accessible here: <https://www.womensaid.org.uk/research-and-publications/nowomanturnedaway/>.

<sup>41</sup> 'Nowhere to Turn' report 2018. Accessible here : <https://www.womensaid.org.uk/research-and-publications/nowhere-to-turn-2018/>.





## The need to improve collaboration between homeless services and specific DV services

In most local contexts, homeless and DV services work rather separately. Homeless services are usually less aware of specific DV experiences among female service users or feel insecure about how to address or respond adequately. Specialist DV services focus on the DV experience but might be less aware of women's housing needs or might face considerable barriers to access housing. Continuous and structured collaboration between homeless services and specific DV-services, and eventually housing providers to provide permanent housing, are key to accompany survivors during recovery. Collaboration should be based on inter-service protocols which specify individual responsibilities and procedures, acting as a single point of contact (and spare survivors reporting DV several times to different staff).

## Successful examples of collaboration

Several collaboration projects between DV-services, housing providers and homeless services have been set up in the last years. For instance, a project by the Brighton Women's Center in which a women's center and a homeless service work in partnership: the Brighton Women's Center provides gender-sensitive support while a local homeless service takes care of the housing part.<sup>42</sup> *Safe at Home* project partner 'Standing Together Against Domestic Violence' is running a pilot Housing First for survivors project which provides women with gender- and DV-sensitive floating support alongside housing. The Finnish Y-Foundation has initiated the NEA project<sup>43</sup> in 2017 which particularly targets homeless women of which many have experienced DV. The project provides survivors with permanent housing (based on the Housing First model), person-centred flexible support, including children-specific services, which follows a gender-sensitive approach with special attention given to safety concerns. The Housing First model takes on a rights-based and client-centred approach which allows to address survivors' trauma and mental and physical health needs and wellbeing. Interventions are based on the decision of the survivor.

## 5. Early prevention and signs of DV: What can housing providers do about DV?

DV takes place behind closed doors. The *'Safe at Home'* project recognizes that housing providers are in the unique situation of having access to tenants' homes and recognize DV long before any other service could. Housing providers have access to homes either through housing officers, who are in (regular) contact with tenants, or maintenance or repair staff. This allows early identification of support needs of tenants. Social and public housing providers are particularly well placed for early detection of DV, as they maintain regular contact with tenants and are therefore in an ideal position to recognise DV. The *Safe at Home* project aims at capacitating housing providers to identify signs of DV. Staff who can 'read' the signs of DV will be able to prevent further DV or even prevent DV, supporting families to access support before violence is used. During the SAH training, housing officers and repair staff will also learn how to address DV with tenants and how to make appropriate referrals to specific support services (such as specific DV services).

The objective of the SAH training is to provide housing professionals with an introductory understanding of domestic abuse, also as a social issue, and equip them with the skills to identify signs of domestic abuse. Trainees learn how to make appropriate onward referral to support services and how to better support tenants who are experiencing DV. The SAH training is a full-day training and addresses frontline and other staff of housing providers who are likely to come into contact with victims of DV during their day-to-day work, but who are not DV specialists.

The training is based on recent evidence on DV and uses interactive work methods that are related to the day-to-day work of housing provider staff. Trainings are facilitated by an experienced domestic abuse trainer, with knowledge on specific housing provider issues concerning this topic. SAH trainings took place in the UK and the Netherlands. Each of the 125 training days reached out to an average of 10 participants (50

<sup>42</sup> <http://www.womenscentre.org.uk>

<sup>43</sup> <https://ysaatio.fi/y-saatio/hankkeet/nea-naiserityisyys-asunnottomuustyossa>



trainings in the UK, 75 in the Netherlands). In total, 1320 housing provider staff was trained, 644 in the UK and 676 staff in the Netherlands.

In terms of content, the aim of the SAH training is to familiarise participants with the following:

- **Understand the dynamics** of DV/abuse
- **learn to identify** the **signs** of domestic abuse
- Adequately and confidently **responding** to (suspected) cases of domestic abuse
- Forming intrinsic **motivation and commitment** to the issue of domestic abuse
- Professional **monitoring, reporting and follow-up** of DV cases
- Understanding of existing **laws** and enforcement options and specific laws relating to housing (adapted to Dutch respectively UK context)
- Establish helpful **collaborations** with relevant local services (especially specialist DV services)
- Participants are encouraged and inspired to **incorporate the information in their day-to-day practise**, this maximises the effect of the training.

### The 'Safe at Home' Training

The SAH training advises housing officers / repair staff how to identify the signs of DV, how to address the issue with tenants and appropriate follow-up support and safety planning. To ensure survivors are safe, housing provider staff need to collaborate with other local services which is also emphasized in the training. The training allows participants to develop a proper understanding of the dynamics of abusive relationships and explains the impact of domestic violence on children. Participants also learn how to record domestic violence cases.

Furthermore, the training invites staff to reflect on how information is shared as disclosing information can be a threat to the survivors' safety. Sometimes, there might be a way to share information that protects the survivor's anonymity and keeps survivors safe. As said before, the training also specifies how housing provider staff can address DV with the tenant or alleged victim. The conversation should start by explaining the purpose of the interview, then facts and observations - the identified signs - will be presented and the tenant is invited to respond.

During the training, staff are encouraged to use messages of validation that emphasize that everyone has the right to live free from violence and abuse, that violence is never the survivor's fault and that there is support for survivors. The conversation should focus on safety and how to establish safety again for the survivor.

At the end of the training, all participants receive the SAH **booklet** which contains all key information from the training. The booklet describes the signs of DV and provides detailed guidance on how to document observations and concerns. For instance, staff should make sure to distinguish between facts and interpretations, a sign should be described as it really is by stating "I see ... I hear ... I notice ...". If staff want to document hypotheses, assumptions or own interpretations, this should be made clear. If information is provided by a third party, for instance by a neighbour, this should be recorded too. The booklet provides specific communication tips for talking with the tenant. Housing provider staff should take on a believing, non-judgmental and person-centred approach and *listen* carefully. Direct questions can support an active enquiry such as '*Do you get the support you need from your partner?*' or '*Do you ever feel frightened of your partner?*'.

Visible signs of DV are

- physical damages (punch marks in walls, smashed front and back doors, lock changes / broken bathroom door locks, damaged front or backdoor locks)
- arguing/ shouting and fighting in communal areas
- noise nuisance which is actually domestic abuse





- Drug and alcohol misuse (misuse is often involved and a high-risk factor for abuse, substances are also misused by victims as a coping mechanism)
- Loud sex which is potentially rape
- Physical injuries
- Scarf worn to cover strangulation marks, inappropriate clothing in hot weather
- Property unusually spotless/ very controlled, especially when there are children living on the premises

In terms of behaviour, the following can be signs of ongoing DV: Dominant behaviour by a partner (for instance not allowing the other person to speak), submissive / frightened behaviour, stalking at work, receiving incessant phone calls, lateness, sickness, alcohol / drug misuse, finding out about housing options or mentioning difficulties with partner. Rent arrears might also be a sign of DV.

### Feedback from the participants of the Safe at Home training

At the end of each training day, participants completed a feedback form (anonymously). The data collected from these forms have been collated and are presented in this chapter.

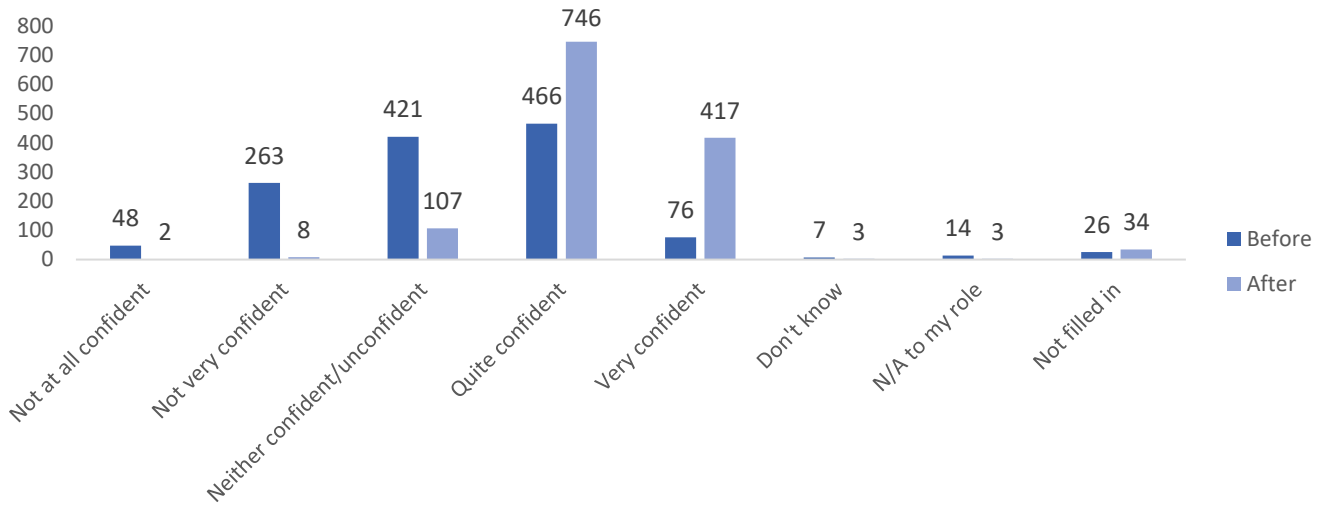
A total of 1320 staff members from 25 housing providers in the Netherlands and the UK were trained (15 housing providers in the Netherlands and 10 in the UK) during 1-day training sessions. 676 housing provider staff were trained in the Netherlands, 644 in the UK. Training sessions usually involved housing officers and repair staff.

Participants were asked to assess their confidence regarding different aspects related to the identification of and response to domestic violence, comparing for each aspect how confident they felt before and after the training. Aspects involved the capacity to identify signs of DV and respond safely to DV, the understanding of the dynamics of abusive relationships as well as the impacts of DV on children. The detailed results are provided in the following.

Figure 1 below shows that the training contributed substantially to building participants' confidence to **identify the signs of DV**: While before the training only 466 participants felt quite confident in identifying the signs of DV, after the training 746 participants felt quite confident. The number of participants who felt very confident increased even more, from 76 before to 417 after the training. While the number of participants who felt confident to identify DV increased through the training, the number of those who did not feel confident decreased: 311 participants felt not at all or not very confident to identify DV before the training but only 10 felt this way after the training.



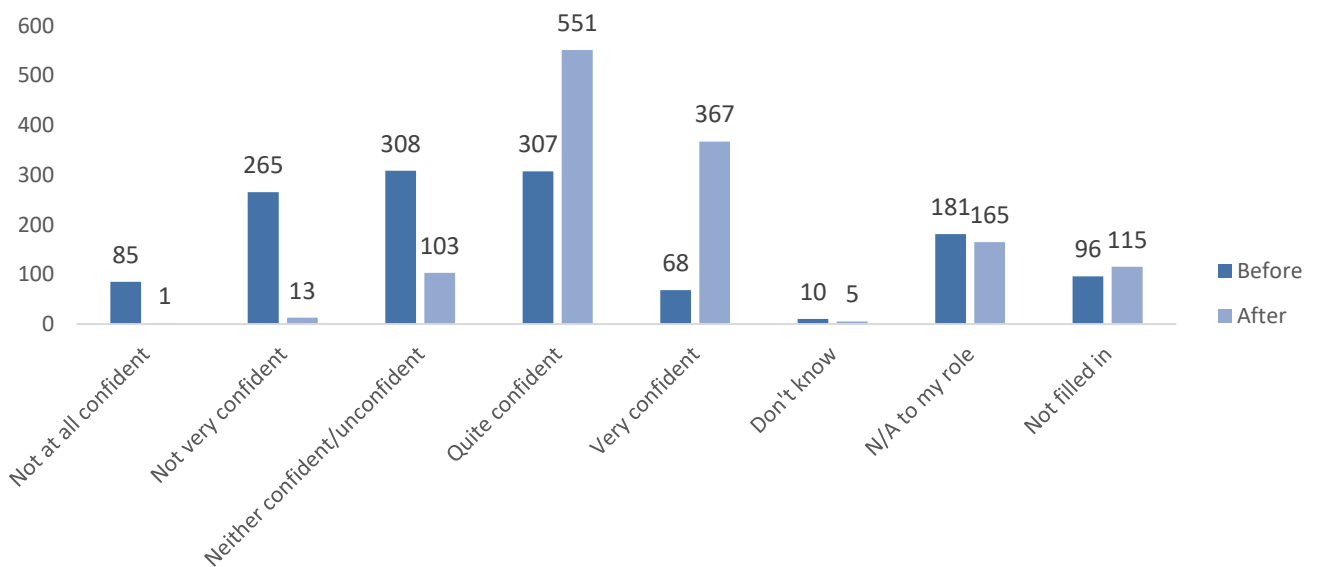
Figure 1: Confidence to identify signs of DV



N= 1320 (before), 1320 (after)

The next figure addresses the capacity of staff to actively **take part in responding to DV** in a safe way, which is another key capacity the training aimed to build. Evidence shows that the training succeeded in building the capacity of participants to take an active part in responding to DV: 918 participants felt very or quite confident in responding safely to DV after the training compared to 375 who felt quite / very confident before the training. The training also led to a substantial decrease of the number of participants who felt not at all / not very confident in responding safely to DV (decrease from 350 to 14 participants).

Figure 2: Confidence in taking an active part in responding safely to DV



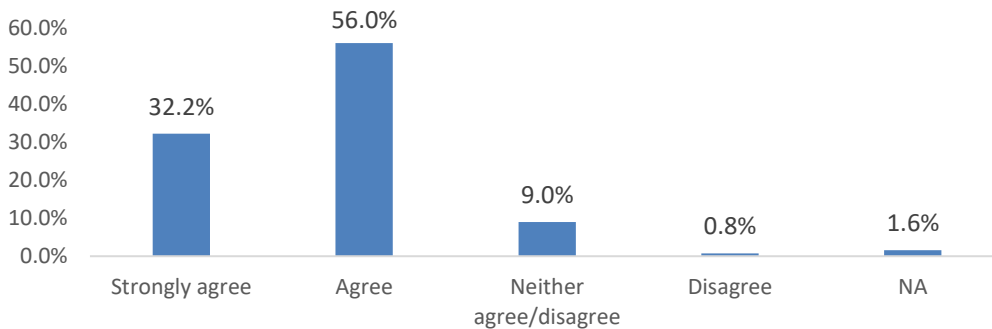
N= 1320 (before), 1320 (after)

Participants were also asked to assess to which degree the training supported them to better understand their role in **identifying tenants who experience or perpetrate DV**. 94% strongly agreed that the training supported them in identifying tenants experiencing DV (of which 37% strongly agree). The percentages of those who neither agreed nor disagreed and those who disagreed are very small (4% neither agreed nor disagreed, each 1% disagreed and strongly disagreed respectively).



These results are confirmed by two other questions which assessed the participants' capacity to take an active role in responding to DV: 57% of participants strongly agreed / agreed that they felt able to take a more active role in responding to domestic abuse as a result of the training. Only 10% neither agreed nor disagreed that the training did not impact their capacity to play a more active role in responding to DV, 3% disagreed / strongly disagreed (in total 1303 respondents). 88% of participants strongly agreed / agreed that the training equipped them to take safe actions to respond to domestic abuse of which 32% strongly agreed (1298 respondents).

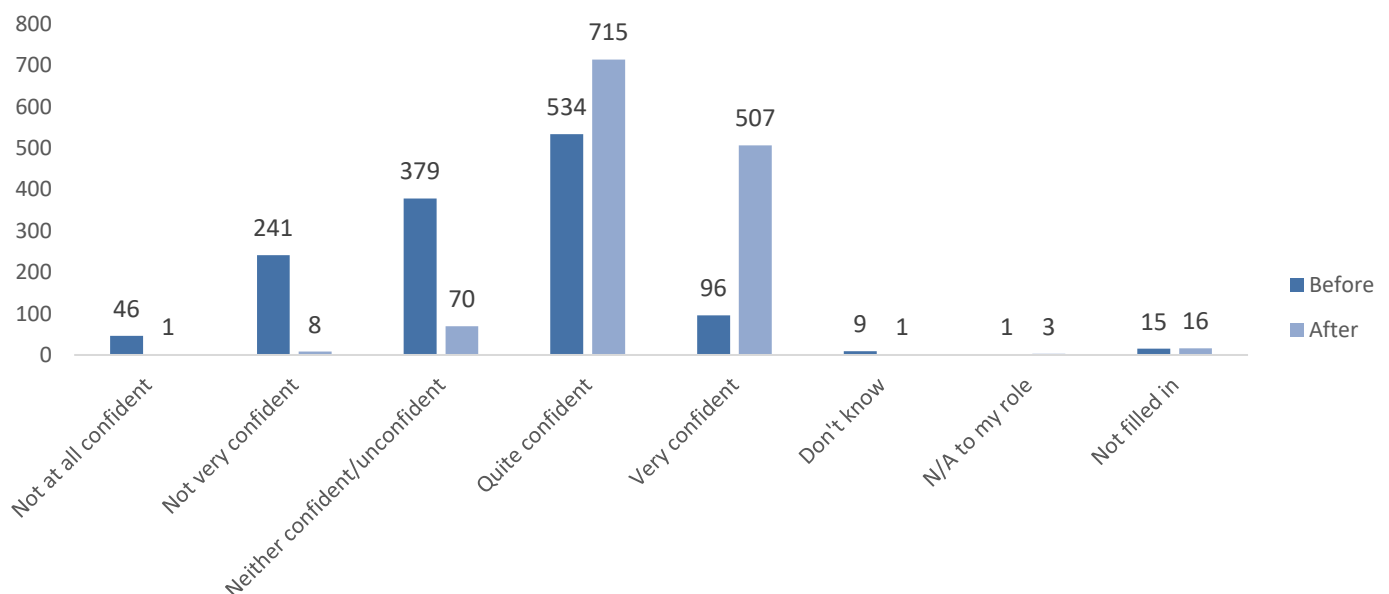
Figure 3: Agreement / disagreement with statement 'The training has equipped me to take safe actions to respond to domestic abuse.'



N= 1298

The feedback questionnaire also assessed whether the training contributed to the confidence of participants to define domestic violence and abuse. As the following figure shows, the training had a very positive impact on participants' capacity to define domestic violence and abuse: The number of participants who felt very confident about defining DV rose from 96 before to 507 after the training. The number of participants who felt confident increased from 534 to 715. At the same time, the number of participants who felt not very / not at all confident decreased substantially.

Figure 4: Confidence in defining domestic violence and abuse

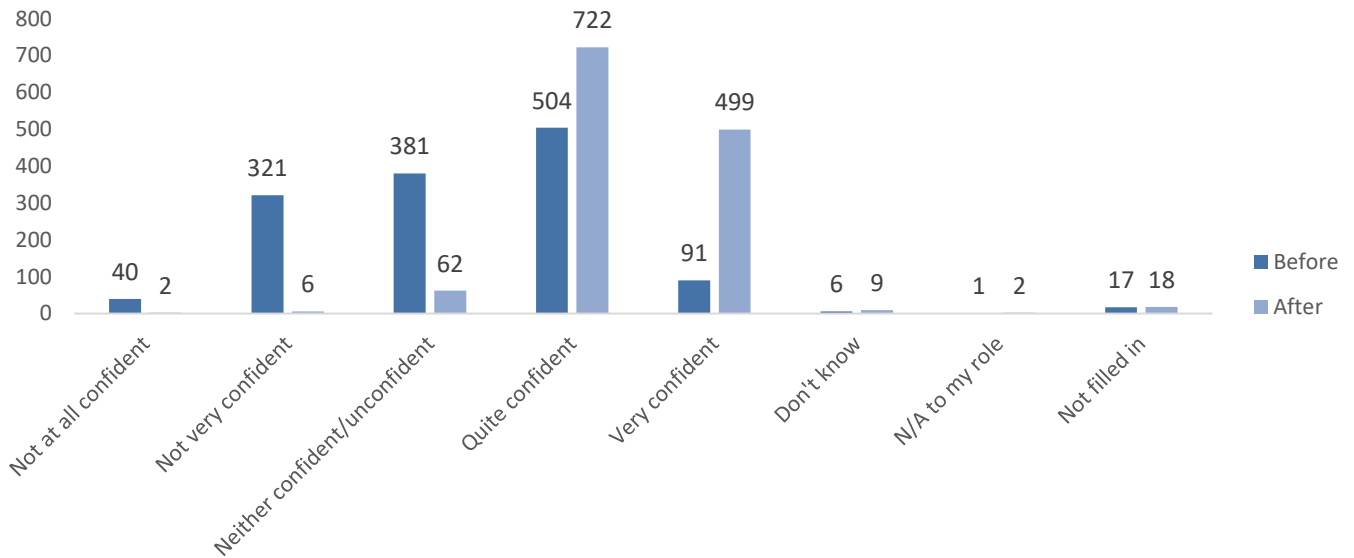


N= 1320 (before), 1320 (after)



Participants were also asked to assess how the training had contributed to a better **understanding of abusive relationships and their dynamics**. Data suggests that the training contributed substantially to the participants' understanding: While before the training only 91 participants felt very confident about their understanding of dynamics of abusive relationships, confidence levels were five times higher afterwards, precisely 499 participants. The number of participants who felt quite confident about their understanding also increased from 504 before to 722 participants after the training. At the same time, the number of participants who did not feel not at all / not very confident about their understanding of the dynamics of abusive relationships decreased dramatically from 321 to 6 participants.

Figure 5: Assessment of understanding of the dynamics of abusive relationships

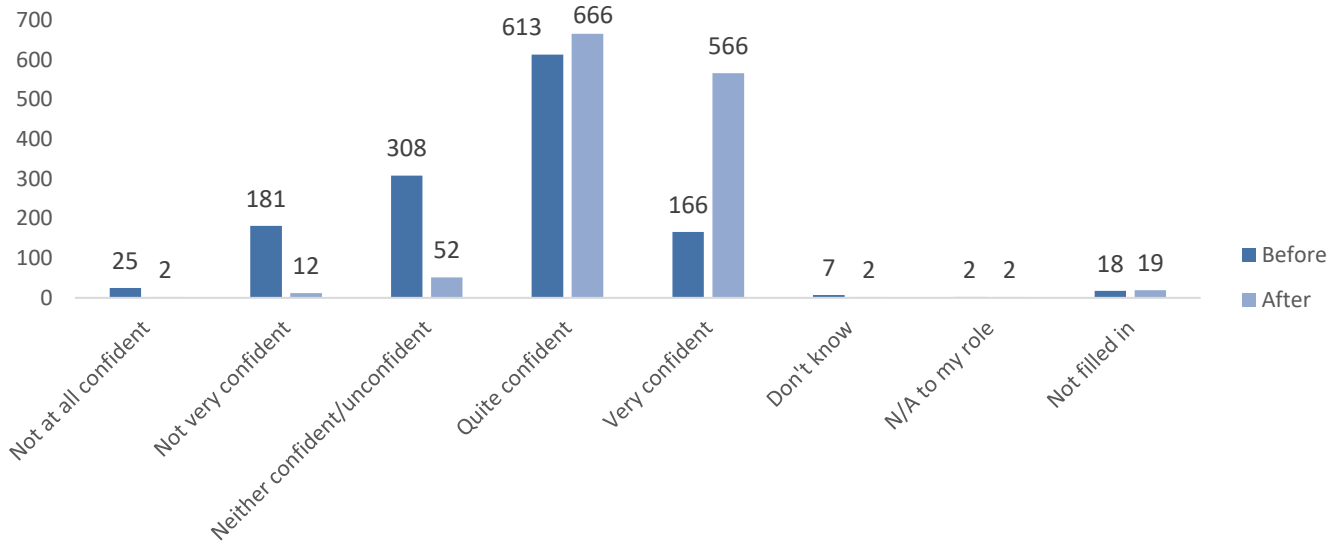


N= 1320 (before), 1320 (after)

With regards to the understanding of the **impacts of DV on children**, the participants' feedback is very encouraging. The number of participants who felt very confident about their understanding of the impact of DV on children increased from 166 before to 566 participants after the training. The number of participants who felt quite confident increased too, from 613 before to 666 after the training. The number of participants who felt not very/not at all confident dropped substantially (206 to 14).



Figure 6: Assessment of understanding of the impacts of domestic abuse on children

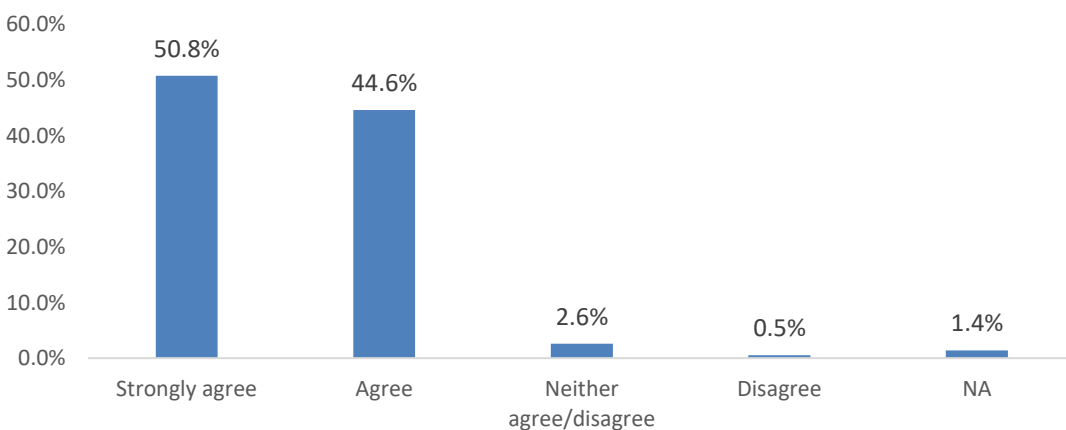


N= 1320 (before), 1320 (after)

This aspect of the training was also assessed in a slightly different way, asking participants to assess to which extent they agreed that the training supported them to better understand the ways in which domestic abuse harms children. A very big share, 94%, strongly agreed / agreed that the training did support them in growing their understanding of how children are harmed by DV, 13% disagreed with the statement and only 1% strongly disagreed (1302 respondents).

Feedback shows that the training also contributed to the broadening of participants' perspectives on DV and to increasing their awareness of DV. 45% of participants agreed and even 51% strongly agreed with the statement that 'the training has broadened my perspective of domestic abuse and increased my social awareness of this topic', as the following figure shows.

Figure 7: Assessment of statement 'The training has broadened my perspective of domestic abuse and increased my social awareness of this topic'

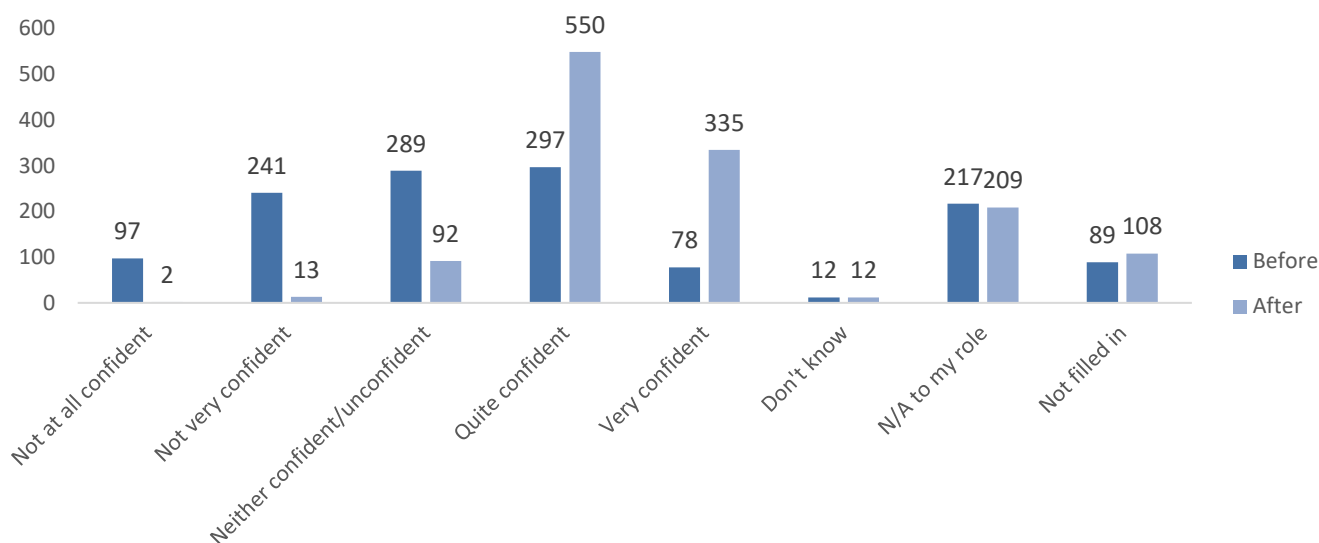


N= 1302

Participants were asked to assess whether the training helped in growing their confidence in **recording domestic abuse cases**. As illustrated in the graph below, confidence levels increased considerably among training participants: 335 participants felt very confident in recording domestic abuse cases (before the training it was only 78), 550 participants felt quite confident with identifying domestic abuse (287 before). At the same time, the number of participants who did not feel confident in recording DA cases decreased.



Figure 8: Confidence in recording domestic abuse cases



N= 1320 (before), 1320 (after)

Finally, participants were asked about their confidence in **collaborating with external services to provide safe outcomes** for tenants who experience(d) DV. Results are very positive as the number of participants who felt very confident tripled comparing levels before and after the training, 356 participants felt very confident about collaboration with local services (92 before the training). 496 felt quite confident after the training (compared to 312 before).

Finally, a short **summary** of the above data is provided. It should be emphasized that the training was very successful in terms of building the capacity of housing provider staff to identify and respond safely to domestic violence as well as other related aspects. Levels of confidence increased for all assessed aspects while the number of participants who felt not confident decreased. The training contributed substantially to building housing provider staff capacity

- to define domestic violence and abuse and to identify the signs of DV,
- to take an active part in responding safely to DV,
- to record cases of DV among tenants and collaborate with other local external services to provide safe outcomes for tenants who experience(d) DV,
- to understand the dynamics of abusive relationships and
- to understand the impact of DV on children.

### The importance of involving 'unusual allies' in tackling DV

The last part of this chapter is dedicated to emphasizing the important role which 'unusual allies', such as housing providers, homeless services or other non-DV specific services, can play in tackling DV at local level. These services can contribute greatly to identify DV, respond to victims and ensure right referrals to specialist DV services. Although most perpetrators who have to leave the shared tenancy move back in with family and friends, some access homeless services. Homeless services are in an ideal position to identify violent behaviour and refer to specialist support organizations who offer anti-violence training and behavioural change programmes.





## 6. Analysis of current service provision: State of play of identifying signs of DV among housing providers and homeless services

### 6.1 Background of the survey

The snapshot study was conducted online among housing providers and homeless services in Europe, taking advantage of FEANTSA's access to the European homeless service sector. The FEANTSA network encompasses more than 130 homeless services in all European Member States.

Main interest of the survey was to assess the levels of awareness of DV, to what extent housing providers and homeless services feel able to identify cases of DV and respond adequately. The survey hence sheds a light on the current level of awareness of DV among both housing providers and homeless services, levels to which staff at housing providers and homeless services receive training on DV and to what extent organizations set up specific DV policies.

Furthermore, the survey gathered data on existing best practices which, after revision by project partners, will be included in the "Safe at Home" good practice collection.

Chapter 6 provides an analysis of the results of the online survey which used a structured questionnaire (chapters 6.2 to 6.4) as well as those of the conducted expert interviews (6.5). Chapter 6.2 presents survey results for the whole sample, chapters 6.3 and 6.4 for two subsamples: One subsample contains respondents from all countries excluding the UK, another subsample contains UK-based respondents only. Subsamples were created to account for the difference in structures between respondents from 'continental Europe' (mostly homeless services) and the UK (mostly housing providers). Furthermore, UK respondents account for almost half of all respondents (101 of a total of 234 respondents). Subsamples were also created to account for the UK bias in the full sample, to get less biased and hence more precise results. Each data analysis chapter provides a summary of the respective data sample- for the full sample as well as for the 'Group excl. UK' and the 'UK only' subsamples. A comparative analysis of the subsamples 'Group excl. UK' and 'UK only' is provided at the beginning of chapter 6.4.

The analysis of the full sample is structured in the following way: Description of respondents (number of housing providers and homeless services participated, from which countries etc.); information on services which are available for survivors of DV, capacity of services to identify and respond to DV, activities and materials used by housing providers and homeless services to address DV. The report will then review organizational policies related to DV and present characteristics of good practice projects. Finally, a basic description, including demographic characteristics of respondents, is provided. The questionnaires which were used for the online survey can be found in appendix I.

The survey was disseminated by the project partners - Kadera in the Netherlands, Peabody and STADV in the UK and FEANTSA through its membership network as well as through social media. Target groups were social (public) housing providers and homeless services. Housing Europe, the network organization of social and public housing providers with members throughout the EU, participated in spreading the survey. It should be emphasized that it is not a randomized survey (what is visible further below under chapter 1 'Description of respondents'). Respondents were staff of housing providers and homeless services and the survey depicts their opinions and assessment of the current situation in their country.

As many questions were not answered by a considerable number of respondents, the exact number of respondents is indicated for each question (see N number below each figure). The abbreviations HLS and HP stand for 'Homeless Services' and 'Housing Providers'.



## 6.2 State-of-play: Current response of housing providers and homeless services to DV (data analysis of full sample)

### Summary of data analysis full sample (all countries)

Before presenting the results of the online survey, some methodological aspects should be clarified. The sample is not representative for housing providers and homeless services in Europe. In view of the main objective of the survey, a first assessment of the general awareness of DV and capacity of housing providers and homeless services to identify DV, results are still very useful. Outcomes point out important possibilities of improvement and contributed substantially to identify current good practice.

Homeless services are overrepresented in the full sample, representing 60% of the whole sample compared to housing providers (40%). Out of a total of 234 respondents, 100 are based in the UK (representing a share of 43%). Significant number of respondents are based in Spain (51 respondents), Belgium (36) and Italy (28).

Housing providers staff assess more positively the availability of specific DV services for survivors: 91% confirm the provision of specific DV support to survivors in comparison to 72% of homeless service staff (which, however, is still considerable). This is, at least partially, due to those respondents contacted through Peabody and STADV networks, which are organizations that can be assumed to have an advanced practice in responding to DV.

Housing providers and homeless service staff evaluate the availability of specific DV training equally positive: 63% and 65% respectively know of specific DV training which is available in their countries. This, however, does not indicate that staff gets trained, for numerous reasons: There is no training available in the region where a service is active, training is too expensive, staff cannot take time off to attend training etc. In terms of availability of DV-specific training for housing providers in the Netherlands, project partner Kadera points out that no training explicitly targeting housing providers was available in early 2017 when the 'Safe at Home' project kicked-off. This situation has remained unchanged (October 2018).

In contrast to the high share of respondents who know specific DV training, outcomes suggest that capacity to identify and respond to DV is somehow limited: A third of respondents think that more than half of housing providers in their country are able to respond adequately to DV cases, 29.6% believe that at least half are able to identify cases of DV. Homeless services assess service capacity to identify cases of DV more positively than housing providers: 48.4% believe more than half of services are able to identify DV in comparison to 29.6% of housing providers. 34.9% of homeless service think that at least half of services in their country are able to identify DV.

Looking at the type of support which is provided to survivors of DV by housing providers and homeless services, face-to-face contact to services users / tenants who are or were experiencing DV is most widely used to address DV. Both homeless services and housing providers make considerable use of awareness raising material to address the issue of DV among their service users or tenants as well as material that directly addresses service users resp. tenants who are or were experiencing DV. Very few respondents answered that none of the listed support options is provided to survivors, which suggests that most services do provide some type of support.

The survey suggests that most housing providers adopt Anti-Social Behaviour (ASB) policies at organizational level (76% of respondents think that more than half of housing providers in their country have adopted an ASB policy). However, this result is mainly due to legal regulations in the UK according to which housing providers are obliged to adopt ASB policies (as previously explained, the full sample has a strong UK bias). Regarding the homeless sector, stand-alone DV policies are the most common policy adopted by organizations.

Respondents from housing providers think their sector is more interested in addressing DV than respondents from the homeless sector do: 37% of respondents working with housing providers think that the sector is very



much interested, another 41% assess HPs to be ‘interested in addressing DV’. Among homeless services, the share of respondents who think that services are interested in addressing DV is comparable (46%) but only 15% think homeless services are very interested.

Quite striking is the big overlap between responses from housing providers and homeless services about the characteristics of good practice for support and service provision to DV survivors. Both housing providers and homeless services identify the following crucial elements of good practice: collaborative service provision, involving local service networks, user-oriented service provision, experienced and multidisciplinary staff who has been trained on DV, involvement of high profile service providers, provision of medium / long term support beyond crisis accompaniment, provision of housing (temporary and permanent), orientation of accompaniment towards fostering survivors’ self-esteem and sense of empowerment, provision of a safe space to ‘talk about DV’, provision of legal assistance, support for perpetrators and, last but not least, support provided free of charge.

Characterizing respondents from the full sample, data suggests that women are overrepresented in both sectors: 69,6% of housing providers staff are women as well as 59,7% of homeless service staff. This is a well-known characteristic of the social sector.

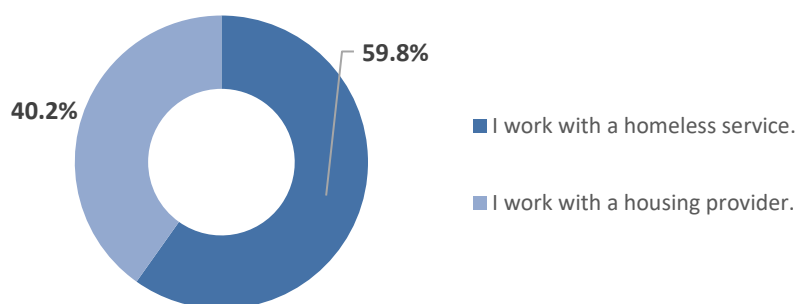
Both housing providers and homeless services have considerable numbers of staff who have been working many years in the sector: Almost a third of interviewed homeless service staff and even almost half of housing providers respondents has worked for 16 or more years in their respective sectors (29% and 46% respectively). Most respondents work in cities and urban areas: 54% of housing providers staff and 74% of homeless service respondents, which is quite obvious considering the greater number of homeless people in urban areas.

### Description of respondents and participating organizations

The survey was online for 2 months, between 31 May and 31 July 2017. In total, 234 persons responded, of which 140 worked with a homeless service (59.8%) and 94 with a housing provider (40.2%).

Housing providers and homeless services followed two different questionnaires which only differed on 1 question.

Figure 9: More homeless services participated in survey than housing providers



N=234<sup>44</sup>

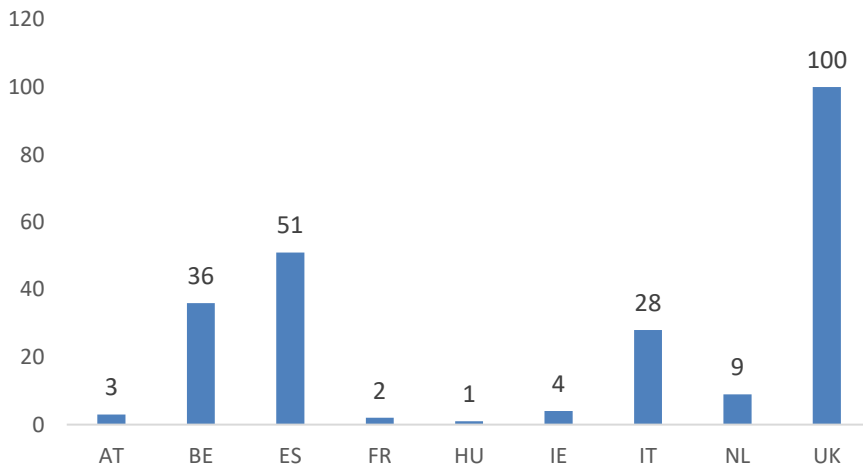
As the following figure shows, almost half of respondents are based in the UK (100 out of 234 or 43%). Significant number of respondents are based in Spain (51), Belgium (36) and Italy (28 respondents). Main

<sup>44</sup> Sample size: indicates number of valid (=given) responses for each question.



reason for this difference is that in the UK the questionnaire was mainly disseminated through project partners who are a housing provider and a second-tier DV specialist service which works closely with housing providers. For the other countries, the questionnaire was mainly disseminated to homeless service providers who are members of project partner FEANTSA.

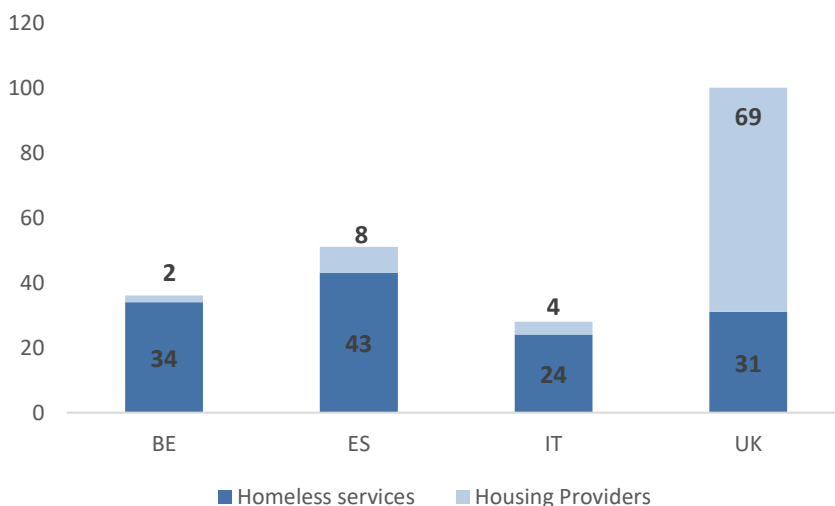
Figure 10: Country: Strong participation from UK, overall few countries participated



N= 234

For Belgium, Italy and Spain, 3 of the 4 countries with the most respondents, homeless services are overrepresented with a share of between 18% or 24 respondents (Italy) and 32% or 43 respondents (Spain). In the UK, the situation is reversed: of 100 respondents, 69 work with housing providers and only 31 with a homeless service. In the Netherlands, 6 of 9 respondents work with housing providers (the remaining 3 with homeless services).

Figure 11: Homeless services generally overrepresented with exception of UK where 2/3 of respondents are housing providers



N= 215, 132 HLS and 83 HP

#### Availability of support provided to survivors of DV

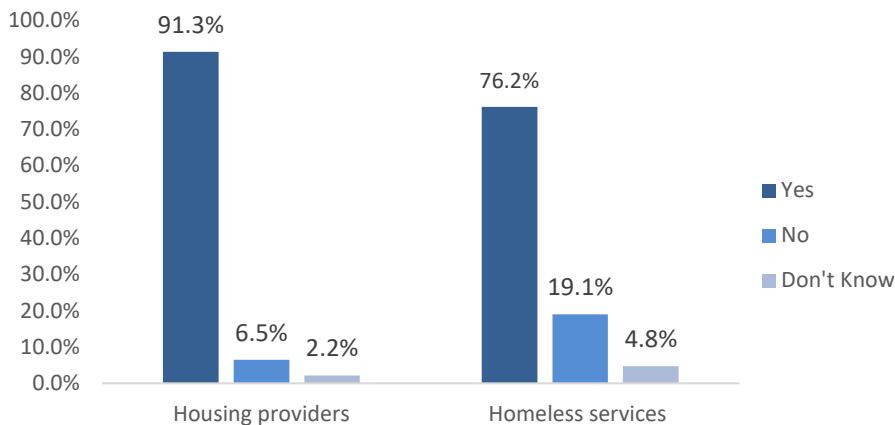
Respondents were asked to assess whether, in their country, housing providers or homeless services offer specific support to survivors of DV. This can be any kind of service that supports women, men or children



who are directly or indirectly affected by DV, such as shelters, temporary or permanent accommodation, counselling, vocational training or work integration programs, psychosocial counselling and accompaniment, legal assistance etc.

As Figure 12 shows, housing providers staff assesses more positively the availability of specific DV services for survivors: 91.3% confirm the provision of specific DV support to survivors in comparison to 72,2% of homeless service staff (which, however, is still considerable). This is, at least partially, due to those respondents contacted through Peabody and STADV networks, which are organizations that can be assumed to have an advanced practice in responding to DV.

Figure 12: Specific support provided to DV survivors: housing providers assess provision of specific support more positively than homeless services

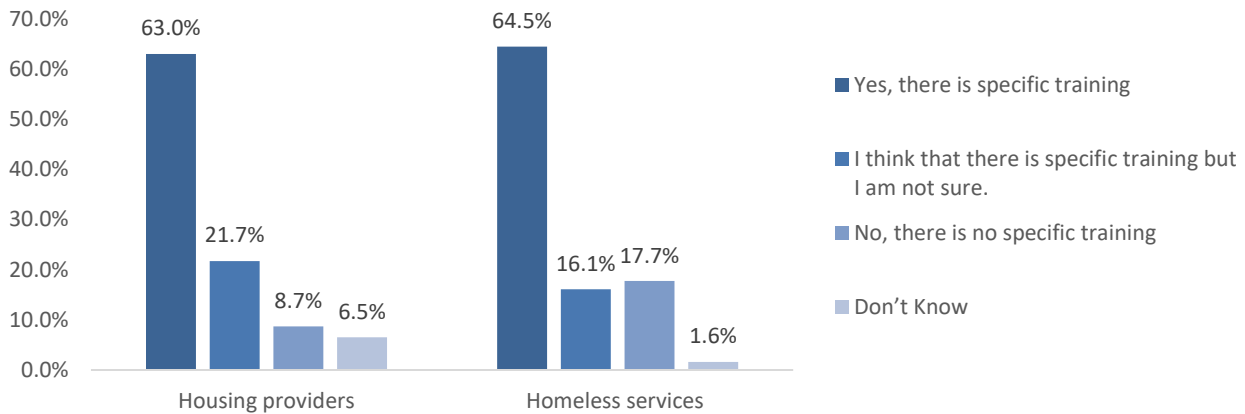


N=63 HLS, 46 HP

Both housing providers and homeless service staff evaluate the availability of specific DV training positively: 63.0% of respondents working with housing providers and 64.5% of those working with homeless services know of specific DV training which is available in their countries. This might be an indicator of a growing awareness of the necessity to build frontline staff's ability to respond adequately to DV. However, there are more respondents among homeless services saying that there is no specific DV training available in their country than among housing providers (17% compared to 8%).



Figure 13: Housing providers & homeless services assess both positively the availability of specific DV training for staff



N= 62 HLS, 46 HP

### Services capacity to identify and respond to DV

When it comes to assessing services' ability to identify cases of DV, almost half of respondents from homeless services (48.4%) think that more than 50% of homeless services in their country are able to identify persons with DV experience. It should be emphasized that respondents were asked to evaluate the capacity of their sector (housing providers or homeless services) to identify DV, not only the capacity of their organization.

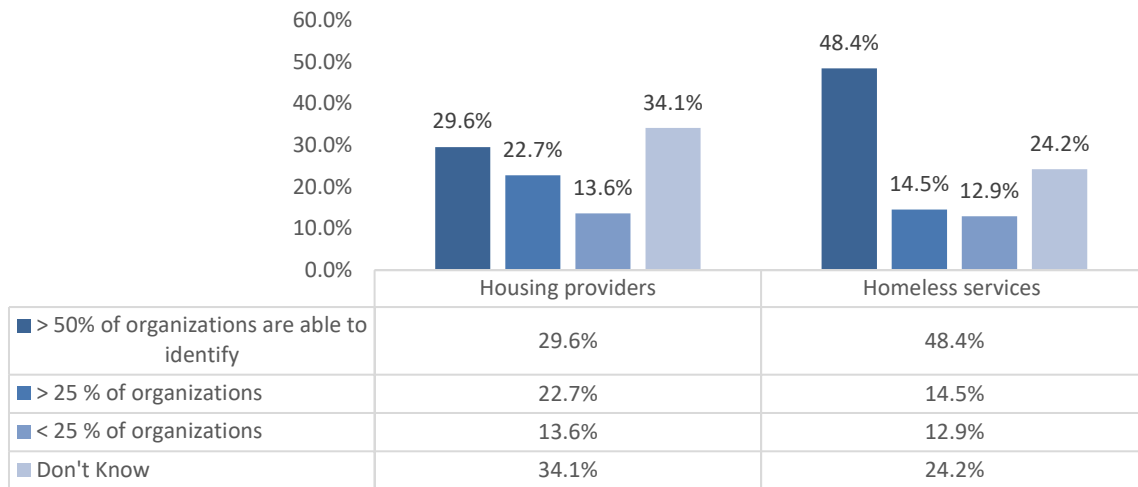
Results suggest that housing providers are less confident with identifying DV: 29.6% feel that more than 50% of housing providers in their country are able to identify cases of DV. However, there is also a considerable number of respondents who feel not able to assess the current situation: 34.1% of housing providers and 24.2% of homeless services don't know whether services in their countries are able to identify DV. Expert interviews suggest that most homeless services have rather limited capacity to identify DV but awareness has been growing in recent years. The main reasons are the rising number of women who access homeless services and/or who sleep rough. Consequently, more attention has been given to women's homelessness and many homeless services identified a need to better train staff on responding to the needs of homeless women and, particularly, women with experience of violence. Interviewed expert Lisa Raftery from Homeless Link UK emphasizes that there is a clear will of homeless services to improve their response to women survivors of DV. Demand for trainings is high and some improvement can be observed among UK-based homeless service providers.<sup>45</sup>

<sup>45</sup> See particularly expert int. 2, Joanne Bretherton, Centre for Housing Policy, York University and expert int. 5, Lisa Raftery, Development Manager London, Homeless Link, UK.





Figure 14: Homeless services are more confident in identifying DV than housing providers

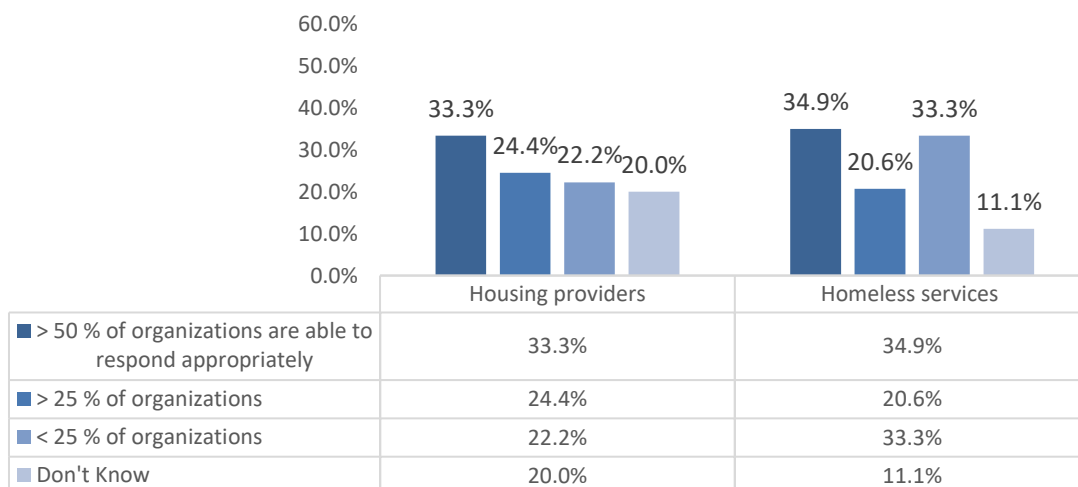


N= 62 HLS, 44 HP

When it comes to responding to clients who are experiencing or have experienced DV, about a third of respondents from both housing providers and homeless services feel that more than 50% of services in their country are able to respond appropriately to survivors, as shows *Figure 15* (33.3% and 34.9%). At the same time, one third of homeless services (33.3%) thinks that less than 25% of homeless services in their country are able to respond appropriately to clients with experience of DV which is a considerable share.

Comparing services' ability to identify and respond to DV cases, data suggests that housing providers feel more confident in responding adequately to DV than to identify cases of DV: 33.3% feel that more than 50% of housing providers in their country are able to respond adequately to DV cases whereas 29.6% believe that the same share is able to identify cases of DV. Homeless services assess service capacity to identify cases of DV more positively than housing providers (48.4% believe more than half of services are able to identify DV in comparison to 29.6% of housing providers). However, when it comes to adequately responding to DV, homeless services and housing providers feel equally confident about services' ability to do so (34.9% and 33.3%).

Figure 15: Both homeless services & housing providers rather confident in responding appropriately to DV cases



N= 63 HLS, 45 HP

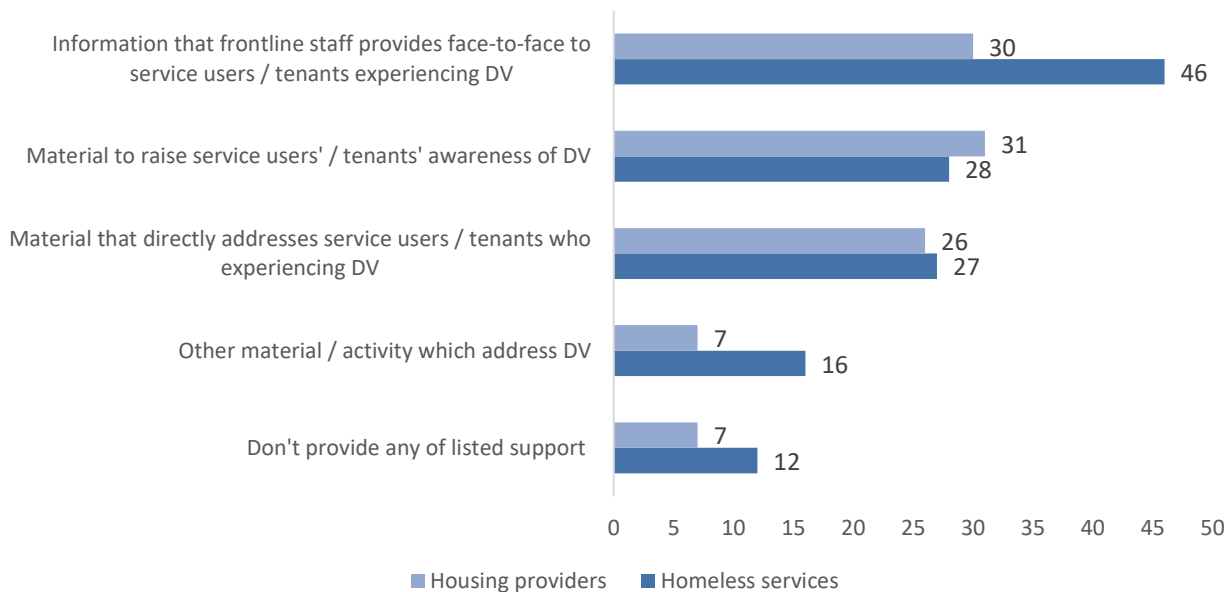


### How is DV addressed by housing providers and homeless services?

The following question aimed at assessing *how* housing providers and homeless services address the issues of DV vis à vis tenants and homeless service users respectively. This is a multiple-choice question and results are presented in absolute numbers.

Most widely used is face-to-face contact which both homeless services and housing providers employ to address DV with service users and tenants respectively. Homeless services reported to provide information through face-to-face contact 46 times as a way of addressing DV, housing providers 30 times. Both homeless services and housing providers make considerable use of awareness raising material to address DV: Homeless services reported to use DV-related awareness raising material 28 times, housing providers 31 times. Almost equally important is material that directly addresses service users and tenants: Housing providers mentioned 26 times to use such material, homeless services 27 times. Few housing providers / homeless service said to not provide any of the listed support materials (12 namings by homeless services and 7 by housing providers). This suggests that most services do provide some kind of support to survivors.

*Figure 16: Homeless services provide more often face-to-face support to survivors than HPs, awareness raising materials & materials directly addressing survivors quite widely used*



N= 129 HLS, 101 HP (multiple-choice question<sup>46</sup>)

Under the “other material / activity” category, respondents from housing providers indicated provision of housing (both for female and male survivors of DV), different types of accompaniment (visiting survivors at home, legal assistance) as well as referrals to local specialist DV support services. In the UK, for instance, it has become good practice for housing providers to refer to specialist DV services.

Some of those are equally mentioned by homeless services, most importantly housing, together with full wrap-around support services (e.g. Housing First-led services), legal assistance, referrals to specialist DV services (e.g. anti-violence centers) and accompaniment in administrative / other procedures.

<sup>46</sup> Namings, not respondents. Multiple-choice means that each respondent can give more than 1 answer. The numbers presented indicate the number of times a specific answer was chosen.



Furthermore, homeless services

- provide discussion groups for survivors & organize self-defence trainings,
- provide psychological programmes with aim at creating an understanding of healthy relationships,
- run parenting workshops for mothers,
- run programmes / organize events that address DV and challenge perceptions of gender & violence against women as an acceptable concept (discussion events, movie screenings, exhibitions, awareness raising workshops),
- provide continuing education to survivors of DV (de-victimization, empowerment, elaboration of claims, professional insertion),
- support child witnesses and victims,
- establish / run intersectoral collaborations to establish and maintain survivors' safety, including perpetrators work and collaboration with legal services/courts.

### To which extent is DV addressed in organizational policies?

The following paragraphs address the topic of organization-level policies on DV: Respondents were asked to assess the prevalence of stand-alone DV policies, stand-alone ASB policies as well as DV policies as integrated parts of ASB policies (respondents were asked to assess each policy in a separate question). The term ASB stands for Anti-Social Behaviour and refers to actions that harm or lack consideration for the well-being of others. ASB is also used to label behaviour which is deemed contrary to prevailing norms for social conduct.<sup>47</sup>

Answers suggest that stand-alone ASB policies are still the most widespread policy among housing providers at organizational level. 76.1% of housing providers respondents believe that more than 50% of HPs in their country have a stand-alone ASB policy.<sup>48</sup> Among homeless services, it is only 20% of respondents who believe that more than 50% of homeless services have a stand-alone ASB policy which also makes sense given the context of work of homeless services. Rather few respondents believe that more than half of all national homeless services have a stand-alone DV policy (22.6%), among housing providers it is 30.4% who think that more than half of HPs have a stand-alone DV policy. Furthermore, 35.6% of housing providers think that more than half of national HPs have a DV policy as part of their more general ASB policy.

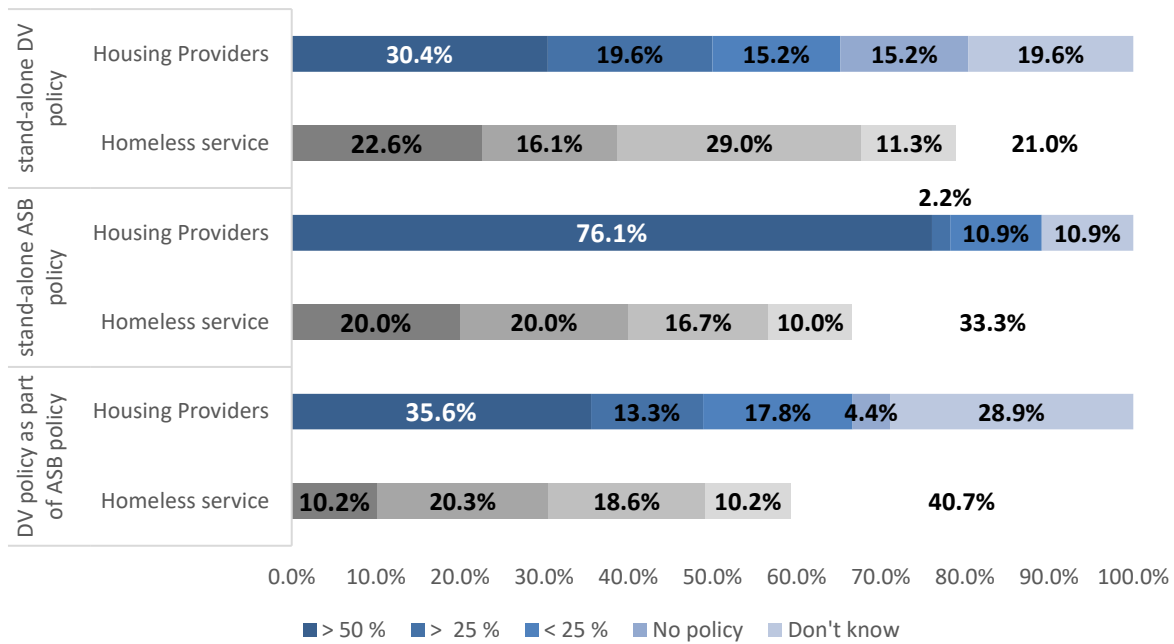
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<sup>47</sup> It should be mentioned that the concept of ASB is much more common in the UK and Ireland than in continental Europe.

<sup>48</sup> In the UK, the adoption of an organizational ASB policy is mandatory for housing providers by law.



Figure 17: ASB policies continue to be more common than DV policies

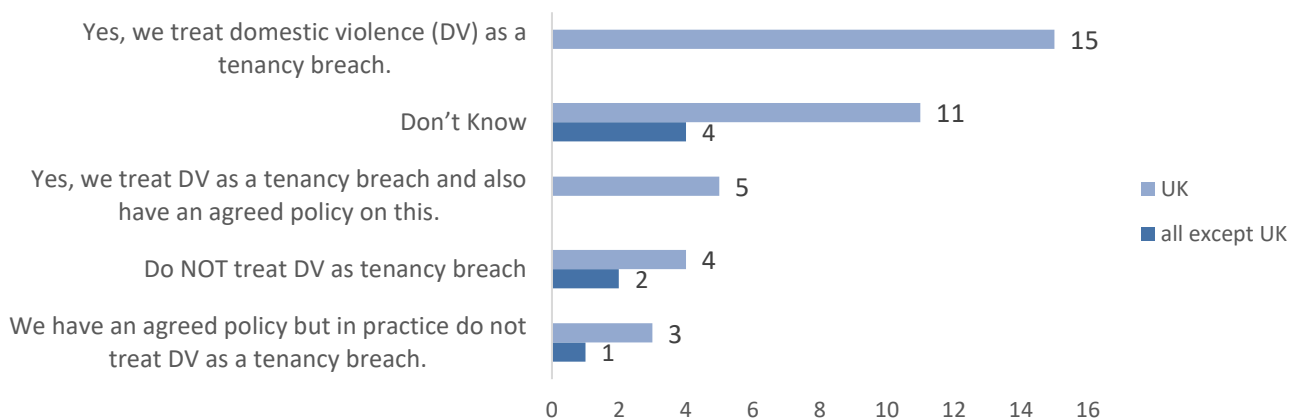


N= 63 HLS, 46 HP

The only question exclusively asked to housing providers was whether DV is treated as a tenancy breach and if agreed policies exist in their organizations.

Figure 18 provides information on whether housing providers actually treat DV as a tenancy breach. Almost half of UK-based housing providers actually treats DV as a tenancy breach (15), 5 treat DV as a breach and also have an agreed corresponding policy. However, due to the few responses, answers should be interpreted very carefully- of a total of 67 UK-based housing providers only 38 responded and only 7 of 27 housing providers based in other European countries. This result also reflects the very different legal regulations in the UK compared to other European countries. Unlike in the UK, housing providers in other Member States cannot break a tenancy contract because of DV, according to national law regulations (e.g. in the Netherlands).

Figure 18: Treating DV as tenancy breach is very UK-specific and actually not possible in other countries



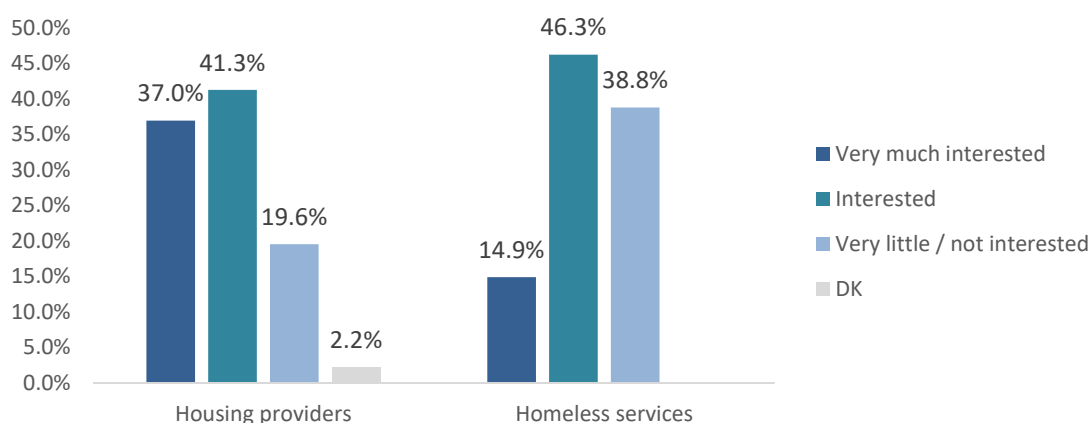
N= 38 HP (UK), 7 HP (all countries except UK)



The survey asked respondents to estimate the general interest their sector has in addressing DV. Data suggests that respondents from the housing provider sector assess their sector's interest in DV far more positively than respondents from the homeless sector. 41.3% of housing providers think that providers are interested in addressing DV and 37.0% even think that they are very much interested. Among homeless services, the share of those who think that services are interested in DV is still 46.3%, hence comparable to the housing providers sector, but 38.8% think that homeless services are only very little or even not at all interested in addressing DV.

These results suggest that further awareness raising and knowledge sharing on the strong relationship between homelessness and DV, particularly in the case of women who become homeless, is needed.

Figure 19: Housing providers more interested in addressing DV than homeless services



N= 67 HLS, 46 HP

### Identifying good practice

Both questionnaires, the one designed for housing provider staff as well as the one designed for homeless service staff, contained a question asking for existing good practices in the different countries of the survey. Furthermore, respondents were asked about specific features which actually make a programme, project or initiative a good practice.

Quite striking is the big overlap between responses from the housing provider and the homeless service sectors. The following characteristics were named by **both housing providers and homeless services** as being most relevant for creating good practice in terms of support and service provision for DV survivors.

- **Collaborative service provision** within local network, including police department and other social support services
- **High profile** within community / locally well-known organization
- **User-oriented** service provision
- **Experienced and multidisciplinary team with specific DV education / training**
- Provide **support beyond short-term/crisis** accompaniment (medium / long-term), support survivor to build an autonomous pathway and “a new life project”
- Provide **housing** (temporary and long-term housing)
- Accompaniment primarily **fostering survivors’ self-esteem** and sense of **empowerment**, also including employment-related training & assistance to get (back to) work



- Provide a **safe space** to “talk about DV” / “listening”, create safety for survivor, provide **psychological support** and (referrals to) psychotherapy
- Provide **legal assistance**
- **Perpetrators work**, work with both survivor and perpetrator (including “relationship education” on how to build healthy relationships), collaboration with perpetrator support programmes
- Provide service **free of charge**

There is one single item which was only mentioned by a respondent from the homeless sector which was the importance of providing an immediate response to the DV survivor.

There are some more characteristics which were only mentioned by respondents working with housing providers, some of them being very much tied to their mode of operating. Housing providers staff emphasized the importance of providing support 24/7 and being also reachable. Respondents mentioned the importance of offering floating support, which helps to keep the survivor, in most cases women (and children) safe on the premise, aimed at moving away the perpetrator, not the survivor.

In terms of service set-up, a multi-agency approach is crucial to provide survivors with the necessary support, involving psychological support and medical assistance, legal assistance, financial counselling, employment-related counselling etc. Also, there should be an accreditation process that standardises HP’s practice (the national DAHA<sup>49</sup> accreditation process was mentioned several times as best practice). Finally, housing providers should strive for financial backing from the public sector to be able to provide tenants with support needs in a sustainably way. Housing providers should ensure sufficient funding to get staff regularly trained on DV and other relevant issues. However, ensuring financial sustainability can be a big challenge for many public and social housing providers. Involving mainstream society and particularly men in the fight against DV, challenging the status quo of gender-based power relationships, is pivotal to go beyond ‘fixing the problem’ of DV and to strive for a more just society.

### Description & demographic characteristics of respondents

The last chapter provides a brief description of respondents, relying on basic characteristics which are relevant for the present issue such as years on the job and area of activity (urban / rural area) as well as gender.

Data shows that women are clearly overrepresented in both groups, among the interviewed housing providers staff as well as among respondents from homeless services, which is a well-known characteristic of social sector staff. 69,6% of housing providers staff are women and 30,4% men. Among respondents from homeless services, the gender ratio is slightly more balanced with 59,7% of staff members being women and 40,3% men.

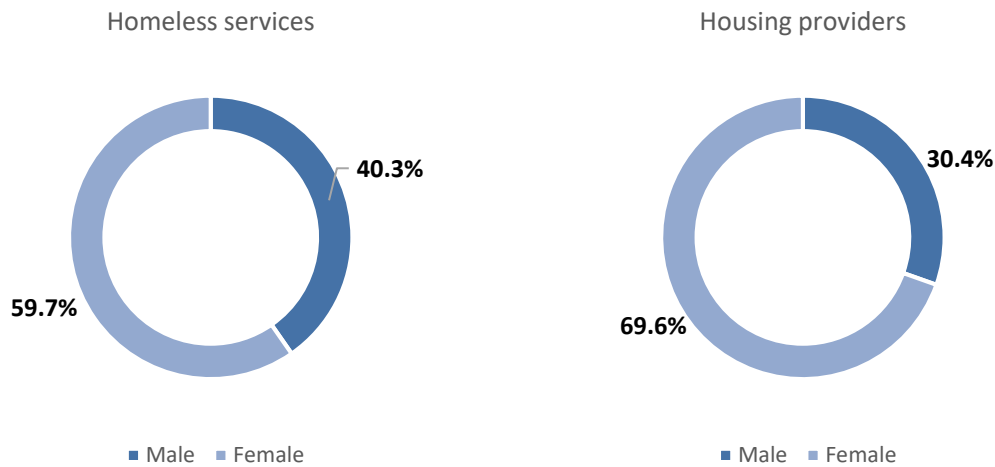
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<sup>49</sup> DAHA is the first accreditation for housing providers that looks at an organisations whole response to DV. It looks at 8 priority areas which are key in ensuring that the organisation is responding well: <https://www.dahalliance.org.uk/>. DAHA is an alliance of two housing providers, Peabody & Gentoo, and Standing Together Against DV, a 2<sup>nd</sup> tier DV-support organization (all UK based).





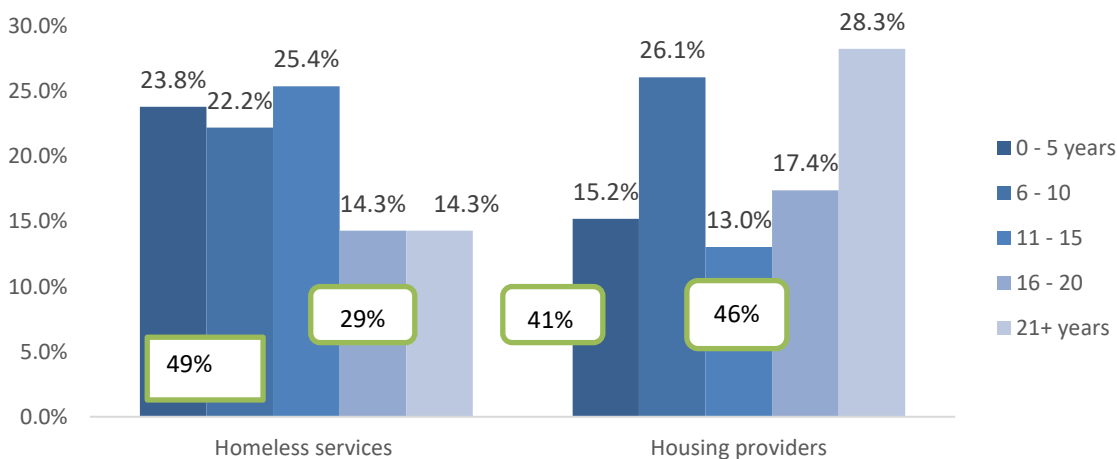
Figure 20: Gender of respondents: Women overrepresented among housing providers & homeless services



N= 62 HLS, 46 HP

Both housing providers and homeless services feature big staff segments with a considerable number of years on the job. Almost a third of interviewed homeless service staff have worked for 16 or more years in the homeless sector (29%). This applies to almost half of housing providers respondents (46%). Looking at respondents from housing providers, 28.3% have spent even more than 20 years working in the sector.

Figure 21: Years on job: Both homeless services and housing providers have staff with many years job experience, HPs even more so

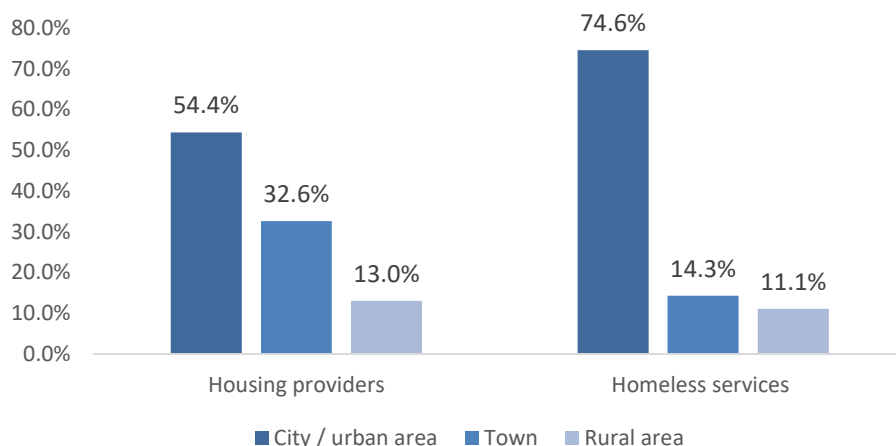


N= 63 HLS, 46 HP

Respondents from both housing providers and homeless services mostly work in cities and urban areas. Homeless service staff even more so (74.6%), which is obvious considering the greater number of homeless people in such areas. Twice as many respondents from housing providers report to work in towns (32.6%) than among homeless service respondents (14.3%). Remarkable is the low percentage of housing providers respondents who work in rural areas - only 13%.



Figure 22: Housing providers & homeless services most active in cities and urban areas, homeless services even more so



N= 62 HLS, 46 HP

### 6.3 Data analysis for subsample without UK

#### Decision to form subsamples 'UK' and 'all countries except UK'

After a first data analysis which included all respondents from 10 different European countries, the decision was taken to carry out a second round of data analysis in which the overall sample would be split into 2 subsamples: one subsample which only contains UK-based respondents and another one for the other 9 countries from which data had been collected (AT, BE, ES, FR, HU, IE, IT, NL and RO). This decision was taken due to the UK 'bias' of the sample: 100 of a total of 234 respondents are UK-based, which means that the overall results would be strongly determined and biased by the situation in the UK. Also, the UK sample has a strong housing provider bias: 67 of all 101 UK-based respondents are housing providers whereas the sample for all other countries shows exactly the opposite situation: here, 106 of a total of 133 respondents are homeless services. Also, UK housing regulations are often very different from those in other countries (for example regulations which allow housing providers to treat DV as a tenancy breach). Another very distinctive characteristic of the UK situation is the use of ASB legislation by housing providers and the incorporation of DV into ASB policies, which is not at all the case for other European countries. Some housing providers in the UK confuse their process and policies in terms of ASB and DV, treating DV as ASB which can have very dangerous consequences for families (for instance, taking enforcement actions, actions of eviction).

For many questions, the non-response was (rather) high. For each question, the number of valid responses is indicated under the graph (N=...) which needs to be taken into account for data analysis and interpretation. In extreme cases with very low case numbers, percentages were not calculated (cf. indications for individual questions).

#### Summary for subsample 'Group excl. UK'

Subsample 'Group excl. UK' contains 133 respondents from 9 European countries of which 80% works with a homeless service and only 20% with a housing provider. In absolute numbers, the subsample consists of 106 respondents from the homeless service sector and 27 respondents working with housing providers. For better readability, this chapter refers to the subsample 'Group excl. UK' as 'subsample'.



Specific support to service users is provided by most homeless services (72%) while a fifth does not provide DV-specific support services (21%). Among housing providers, 6 respondents indicate that specific support is provided to DV survivors, 1 indicates that this is not the case.

With regards to the capacity of services to identify cases of DV, results suggest space for improvement: 41% of respondents working with homeless services think that more than half of all homeless services in their country are able to identify DV with a considerable share of 'Don't Knows' (28%) and 17% who think that less than a quarter of services is actually able to identify DV. Services are less confident when it comes to their capacity to respond to DV in an appropriate way, which requires further knowledge and know-how: only a third of homeless services think that more than half of services in their country are able to respond appropriately to a survivor of DV (32%). DV-specific training is however widely available for staff working with homeless services (62% confirms such training is available and 20% think it is).

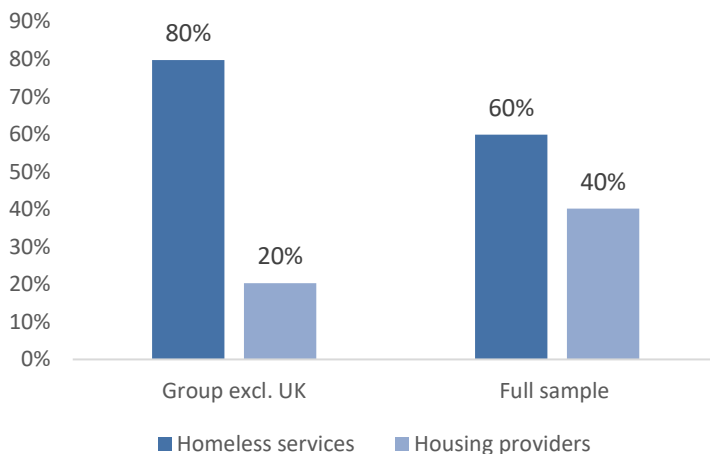
Homeless services address DV mostly during face-to-face contact with service users who have experienced, are experiencing or might be experiencing DV. Homeless services also use materials that directly address service users as well as DV-specific awareness raising materials to address DV with service users.

Survey results suggest that only few homeless services have organizational policies on DV or ASB in place (insufficient information for housing providers).

### Description of respondents for the subsample 'Group excluding UK'

The subsample contains 133 respondents from 9 European countries (Austria, Belgium, France, Hungary, Italy, Ireland, Netherlands, Romania and Spain), of which 106 respondents work with a homeless service and 27 with a housing provider, as Figure 23 below shows. The questionnaire was mainly disseminated to homeless service providers (except for the UK) which explains the significantly higher number of homeless services in the subsample.

Figure 23: Homeless services overrepresented in subsample 'Group excl. UK'



N=133 (group excl. UK), 234 (full sample)

### Availability of support provided to survivors of DV

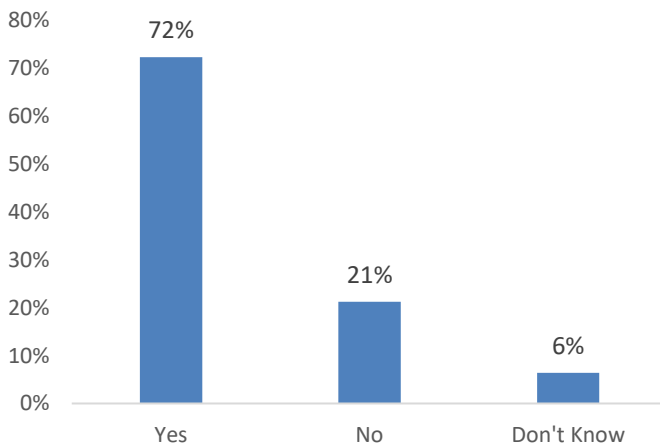
As the Figure 24 suggests, most homeless services confirm that they provide some specific support to survivors of DV (72%), 21% do not provide specific support to survivors and 7% do not know whether such support is provided.



Only 7 respondents from the housing provider sector answered this question, of which 6 confirm that specific support is provided to DV survivors. Due to very low case numbers, percentages were not calculated for housing providers on this question.

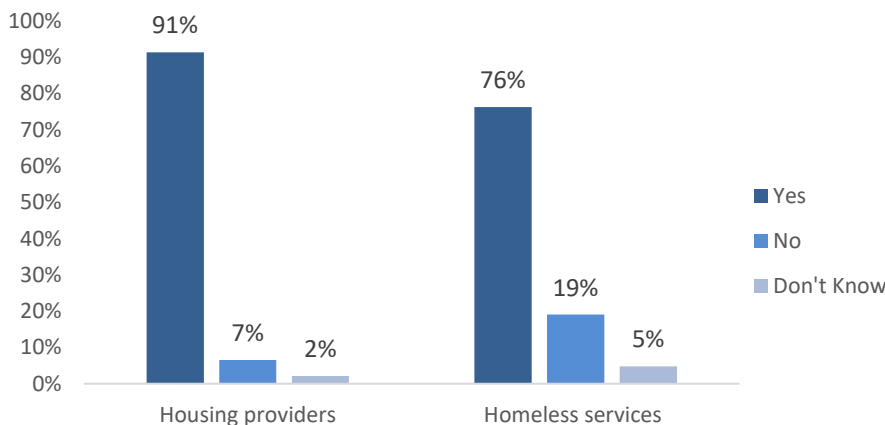
The following two figures allow to compare to what extent homeless services and housing providers provide specific support to DV survivors in the full sample and the subsample. 72% of homeless services in the subsample provide specific support to DV survivors compared to 76% of homeless services in the full sample. 19% of homeless services in the subsample do not provide DV specific support, compared to 21% in the subsample (the percentage of respondents who do not know whether specific DV support is provided are very - 6% and 5% respectively).

Figure 24: Most homeless services provide specific support to DV survivors - subsample



N= 47 HLS

Figure 25: Specific support provided to DV survivors - full sample

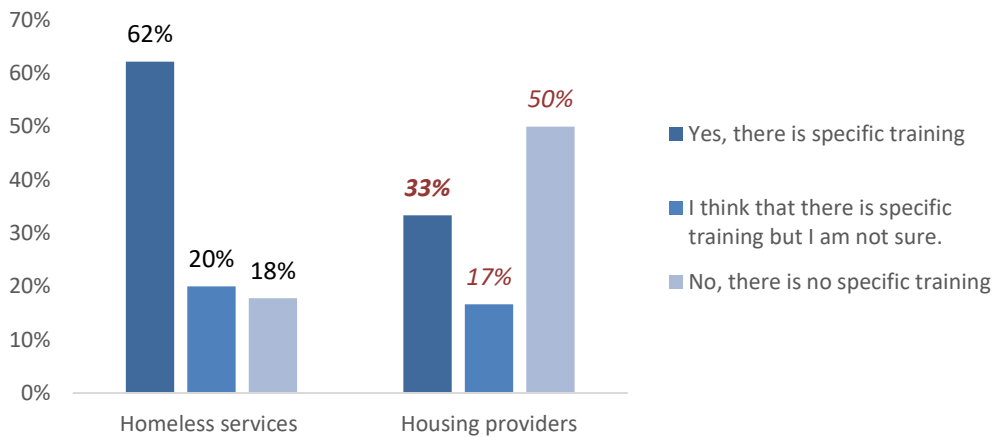


N=63 HLS, 46 HP

When it comes to specific DV training, 62% of homeless services confirm such training is available for staff. 20% think that DV-specific training is available but are not sure and another 18% state that there is no such training available. Results for housing providers are highly unreliable as only 6 providers answered this question (signalized in *Italic*).



Figure 26: Almost 2/3 of homeless services confirm availability of DV-specific training for staff



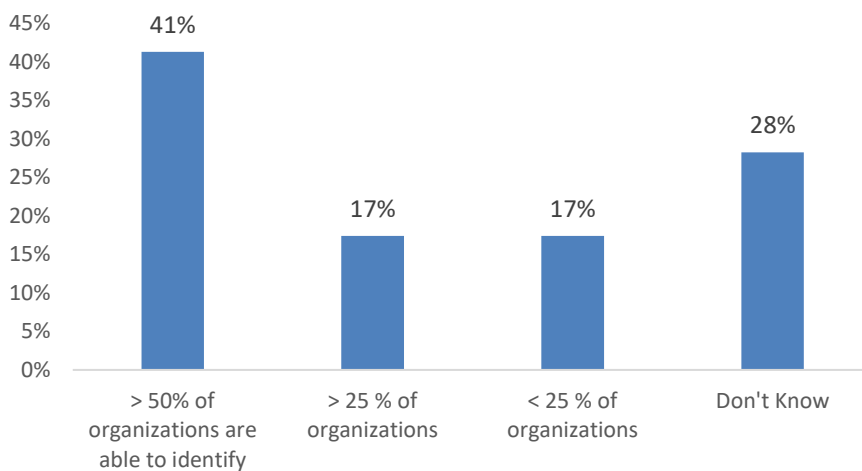
N=46 HLS, 6 HP (0 respondents answered 'Don't Know')

### Service capacity to identify and respond to DV

The biggest share of homeless services, 41%, thinks that more than half of all homeless services in their country can identify cases of DV, another 17% think that more than a quarter of services are able to identify DV. However, the share of 'Don't Knows' is quite high too (28%) and another 17% think that less than a quarter of homeless organizations in their country are able to identify cases of DV. Results definitely suggest space for improvement.

Only 2 housing providers answered this question which means it too small for data analysis.

Figure 27: Homeless services rather confident with identifying DV but considerable scope for improvement



N= 46 HLS

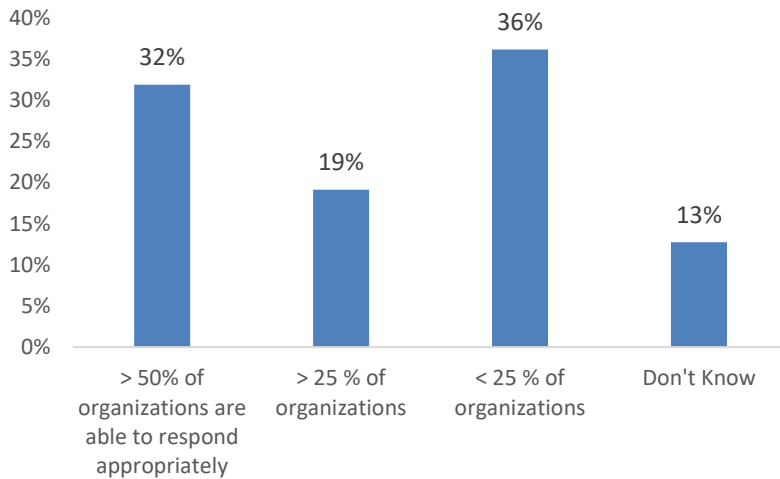
Almost a third of homeless services (32%) think that more than half of services in their country are able to respond appropriately to a survivor of DV. However, 36% also feel that less than a quarter is actually able to do so. Results suggest considerable scope for improvement in terms of homeless services response to DV. Findings indicate quite a strong need to improve homeless service staff's capacity to respond to DV cases in an appropriate (professional) way.

The sample of housing providers is too small to be included in the data analysis (7 cases). From the 7 housing providers who did answer this question, 4 think that more than 25% of housing providers in their country are



able to respond appropriately to cases of DV, 2 think less than 25% of HPs are and one respondent thinks more than half of HP are able to respond appropriately.

Figure 28: Considerable need to improve homeless services' capacity to respond appropriately to DV

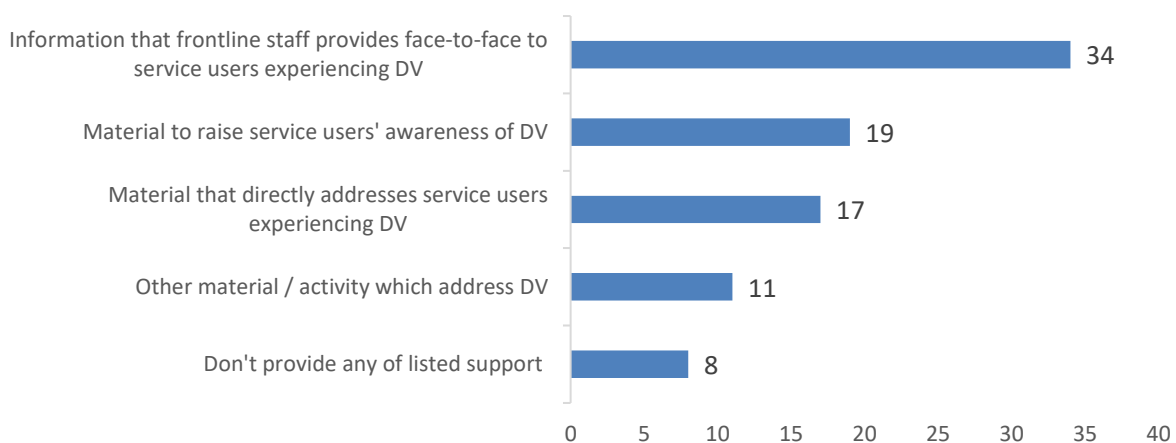


N= 47 HLS

### How is DV addressed by homeless services and housing providers?

There are many ways in which frontline services can address DV with their service users. Figure 29 suggests that homeless services most frequently address DV in face-to-face contact with service users who have experienced or are experiencing DV (34 times mentioned). Materials that directly address service users with experience of DV are also quite important in addressing DV as an issue with homeless service users (17 times mentioned) as well as awareness raising materials related to DV (19 times mentioned). Very few respondents report to not provide any of the suggested materials / interventions (8 times mentioned).

Figure 29: Face-to-face contact with service users most frequent way how homeless services address DV



N= 89 HLS (namings, not respondents, multiple-choice question)<sup>50</sup>

<sup>50</sup> Namings, not respondents. Multiple-choice means that each respondent can give more than 1 answer. The numbers presented indicate the number of times a specific answer was chosen.





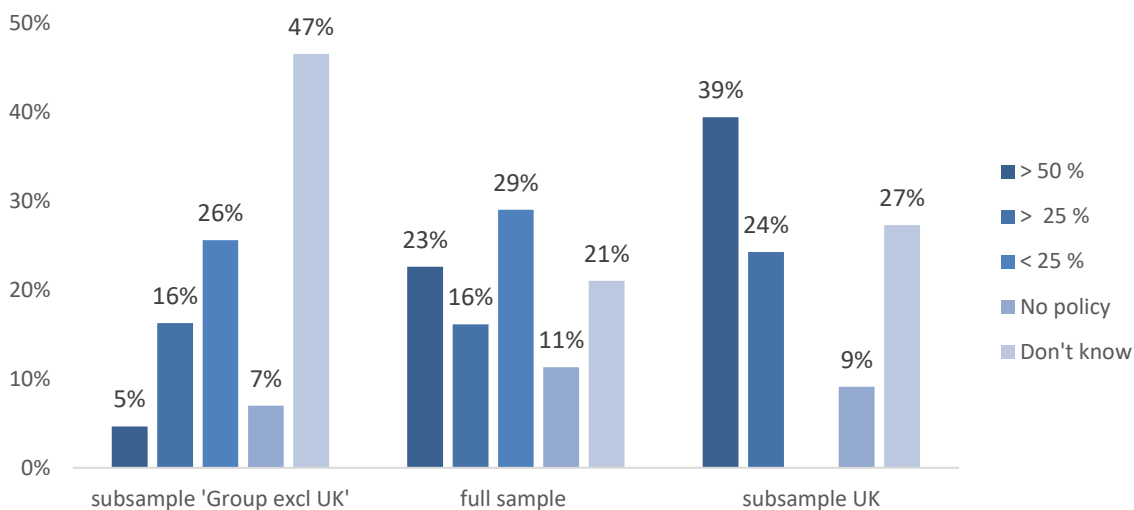
The survey could only collect a few responses on this question from the housing providers sector. From the 9 mentions in total, it was reported 5 times that none of the listed material / interventions are used to address DV with tenants. The usage of material which directly address DV survivors was reported twice. Provision of DV-related information through face-to-face contact with tenants and providing DV-related awareness raising material was reported once each.

### To which extent is DV addressed in organizational policies?

Setting up a policy at organizational level can be very useful way to shape an organization’s response to specific issues. Organizational policies ensure that different staff groups are aware of an issue and provide support in a coordinated way and ideally allow best possible service set-up and delivery with regard to a specific demand.

Respondents were asked to assess the current prevalence of DV policies at organization level in their countries. Figure 30 suggests that very few homeless service providers established organizational DV policies (in the subsample). Only 5% of respondents think that more than 50% of homeless services in their country have set up a DV policy compared to 23% in the full sample (and 39% in the UK subsample). This suggests that services are less effective in identifying signs of and responding to DV, especially in the countries which are best represented in this subsample (Belgium, Italy, Spain).

Figure 30: Comparison of samples regarding the prevalence of DV policies at organizational level



N= 43 subsample ‘Group excl UK’ (only HLS), 63 full sample, 34 subsample UK

Respondents were also asked to assess the prevalence of ASB policies. Answers do only have very limited explanatory power as the concept of ASB and ASB policies is not at all common outside of the UK (and Ireland). Therefore, answers might not reflect the reality of practice as respondents might not have a clear understanding of ASB.

Due to the very low number of housing providers that provided an answer to this question, a proper data analysis is not possible (only 5 housing providers responded).

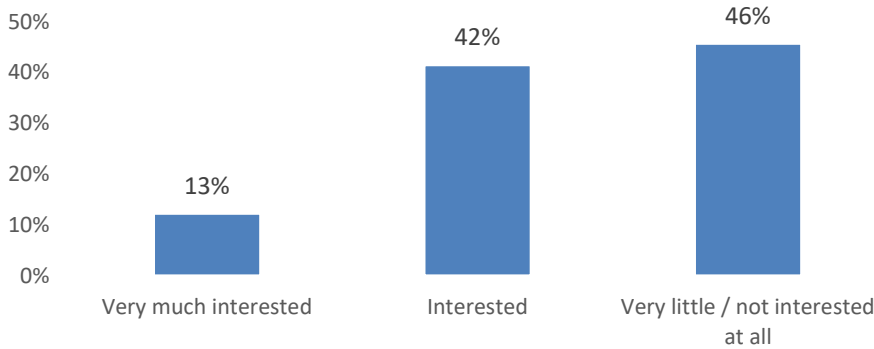
The online survey also asked respondents about the practice of treating DV as a tenancy breach and about related organizational policies. However, the number of housing providers who responded to this question (7) is too small to provide any valid evidence.

Last but not least, homeless services and housing providers were asked to assess the interest of their sector in addressing DV. Too few housing providers answered this question (only 6) to make a valid statement. Responses from the homeless sector were more numerous - 48 services answered. However, respondents



disagree about the sector’s interest in addressing DV: 42% think that homeless services are interested, while 46% think that interest in addressing DV is very little or that there is no interest at all. The high number of non-respondents suggests the contentious perception of this question (58 homeless services did not answer).

Figure 31: Homeless services disagree on sector’s interest in DV

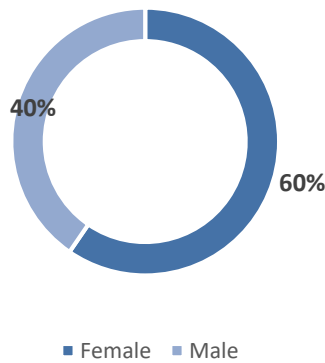


N= 48 HLS

**Demographic characteristics of respondents of subsample ‘Group excl. UK’**

Not surprising for the social sector, more women than men are represented among respondents. More precisely, 60% of respondents from the homeless service sector are women and 40% men. Only 7 respondents from the housing provider sector indicated their gender, of which 4 women and 3 men.

Figure 32: Gender of respondents from homeless service sector: 60% women



N= 47 HLS

The biggest share of respondents works in cities or urban areas (33% of homeless services staff and 22% of housing providers staff). A very small share of homeless service staff works in rural areas (5% or 5 persons). A big share of both sectors did not indicate their area of activity: 74% of housing providers respondents and 56% of homeless service staff. Results are hence of limited reliability.

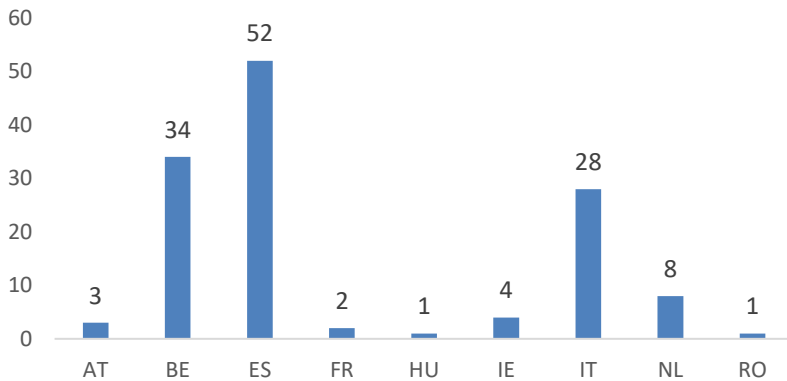
Asked about their years on the job, most homeless service staff did not provide an answer (66 respondents). From the remaining 40 who did respond, quite a heterogeneous picture is suggested: About a tenth has been working up to 5 years with a homeless service, another tenth between 11 and 15 years. 10 respondents have been working more than 15 years with a homeless service of which 6 even more than 21 years. Among housing providers, only 7 respondents provided an answer to this question, of which 3 have been working up to 5 years in the sector, two persons 16-20 years, 1 person 6-10 years and 1 more than 21 years.



## Country of residence

A considerable number of respondents comes from Spain (52), Belgium (34) and Italy (28), few ones from the Netherlands (8) and Ireland (4), Austria (3), France (2), Hungary and Romania (each 1).

Figure 33: Apart from UK, biggest shares of respondents live in Spain, Belgium, Italy



N= 133 (subsample 'Group excl. UK')

### 6.4 Data analysis of subsample UK

As described earlier, a separate data analysis was conducted for the UK subsample which, differently from the subsample 'Group excl. UK', contains far more housing providers. The presentation of results follows the same structure as the previous chapter on 'Group excl. UK' and the full sample. The chapter begins with a summary comparing the results for the UK with those of the subsample 'Group excl. UK'.

#### Summary for the subsample UK & comparison to subsample 'Group excl. UK'

Both subsamples 'Group excl. UK', which comprises all respondents from countries excluding the UK, and 'UK' contain almost the same number of cases: The subsample UK comprises 134 respondents, the 'Group excl. UK' 133 respondents. Women are clearly overrepresented in both subsamples: 60% of respondents in the 'Group excl. UK' are women, working<sup>51</sup>), in the subsample UK, women represent even 71% of respondents. However, the two subsamples differ greatly with regards to the share of respondents from the homeless service sector and the housing providers sector. Whereas in the 'Group excl. UK' 80% work with a homeless service (and respectively 20% with a housing provider), two thirds of respondents from the UK subsample work with a housing provider (66%) and only 34% for a homeless service.

**In the UK subsample, more organizations report to provide specific support services** to persons with experience of DV: 92% of housing providers and 88% of homeless services provide specific support to tenants/service users with DV experience. In all other countries, the share of homeless services that provide specific DV support services is 72% (numbers for housing providers are very low for this question with only respondents of which 6 say that specific support is provided to survivors).

With regards to the **capacity of services to identify cases of DV**, results are similar for UK-based organizations and organizations in all other countries: 41% of respondents working with homeless services in the UK think that more than half of homeless services are able to identify DV. In the 'Group excl. UK' the share is 52%. Ratios for housing providers cannot be compared as only 2 housing providers from 'Group excl.

<sup>51</sup> For the 'Group excl. UK', women represent 60% of respondents from homeless services. In this subsample, only 7 respondents from the housing provider sector filled in their gender- 4 women and 3 men.



UK' answered this question. In the UK, a third of respondents from the housing provider sector thinks that more than half of all HPs are able to identify DV (35%).

With regards to the **ability of services to respond appropriately to DV**, respondents from the UK are more confident than those from the other countries: 44% of homeless services and 37% of housing providers think that more than half of organizations in the UK are able to respond to DV in an appropriate way. In 'Group excl. UK', it is only a third of homeless services who think that more than half of services in their country are able to respond appropriately to a survivor of DV (only 7 housing providers answered this item).

Comparing the UK subsample to the 'Group excl. UK' we see that DV-specific training is reported to be far more available for staff in the 'Group excl. UK' than in the UK: Almost two thirds of homeless service respondents from outside the UK are sure that DV-specific training exists in their countries (62%) compared to only one third of UK-based homeless services (38%). Unfortunately, numbers for respondents from housing providers cannot be compared due to the small case number for the 'Group excl. UK'. In the UK, a third of housing providers staff agrees that DV-specific training is available (36%).

Results show a remarkable difference between the share of respondents who reported not to know whether DV-specific training is available for staff in their country: Half of respondents in the UK (in both sectors) answered 'don't know' while only 18% of respondents from homeless services in all other countries did.<sup>52</sup> This suggests that homeless services are better informed about existing DV-specific training and/or that more such training is available for homeless services or targeting homeless services more actively.

Results suggest that **housing providers and homeless services tend to address DV with service users and tenants respectively in similar ways**: Most organizations address DV in one of the following ways: by providing DV-specific awareness raising materials in services, offices and on premises; providing information during face-to-face contact with service users/tenants; providing material which directly addresses service users/tenants with DV experience. Non-response is high for this question in both subsamples 'UK' and 'Group excl. UK' while the number of respondents who said to address DV in a different way is low too (which means that the high non-response is due to something else than a bad selection of answer categories).

The comparison of UK-based housing providers and homeless services with those in other European countries in terms of DV and ASB policies is challenging as case numbers are low, particularly for homeless services in the UK subsample and for housing providers in the 'Group excl. UK' subsample. However, data for housing providers in the UK and other European countries suggests that **organizational policies are far more common among UK-based housing providers than for housing providers in the other countries** (and more common in UK-based housing providers than in homeless services in other countries). In the UK-only sample, most respondents think that more than half of housing providers have a stand-alone ASB policy in place (89%), while stand-alone DV policies and 'integrated' DV policies, as part of ASB policies, are far less common. As already explained above, legal regulations in the UK oblige housing providers to adopt an ASB policy at organizational level and hence it is actually surprising that not more than 89% of respondents think that housing providers have a stand-alone ASB policy in place (cf. also explanations for Figure 40).

Results suggest that **housing providers in the 'Group excl. UK' have the strongest interest in addressing DV** (37% of respondents say HPs are 'very much interested'). In the UK the number is also quite high: 28% of respondents think that HPs are 'very much interested' in addressing DV. When the question is formulated in a slightly moderate way - 'services are interested' - content is equally high in the different subsamples: In the 'Group excl. UK', almost half of respondents (49%) think that homeless services and 41% of housing providers are interested in addressing DV. In the UK subsample, 35% of respondents think that housing providers are interested in addressing DV. Interest to address DV is comparatively weak among homeless

<sup>52</sup> There are too few case numbers for housing providers in 'Group excl. UK' to compare.



services in the ‘Group excl. UK’: 39% of respondents think that homeless services in their country have very little or no interest at all in addressing DV.

Many questions related to personal characteristics (country of residence, area of work such as city, rural area etc., years on the job and even gender) have very low response rates. This might indicate that many respondents wanted to avoid that a link between their assessments / opinion and the sector or country (or both) could be established. The following two paragraphs present the provided data on respondents’ characteristics.

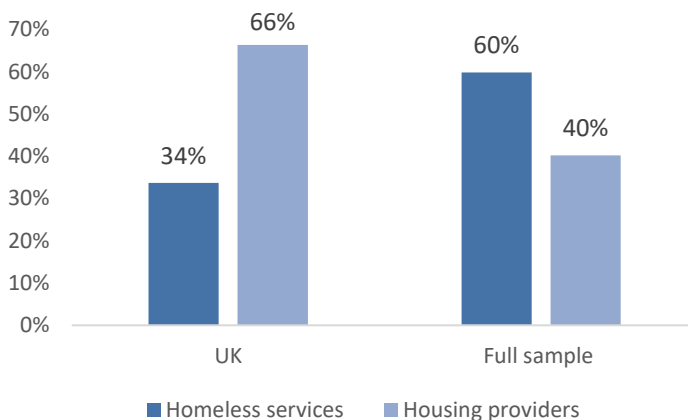
In both the UK and the ‘Group excl. UK’ subsamples, most respondents work in cities or urban areas: Almost half of UK-based housing providers (49%) as well as a third of homeless services in other countries. In both subsamples, non-response to this question is very high.<sup>53</sup> Results are hence of limited reliability.

With regards to respondents’ years on the job, comparison is only possible between homeless services in the UK and homeless services in other countries (‘Group excl. UK’). Reason is the missing data for housing providers in the ‘Group excl. UK’ (high non-response rate). Looking at respondents who work with homeless services, there are far more respondents in the ‘Group excl. UK’ who have been working less than 6 years with a homeless service (11%) than in the UK (only 3%). The share of respondents who have been working with a homeless service for a very long time, i.e. for more than 20 years, is the same in both subsamples (6% in each). The subgroup who shows to stay longest on the same job are respondents who work with a housing provider in the UK (18%).

### Description of respondents for the subsample UK

Housing providers are highly overrepresented in the subsample for the UK, with two thirds of respondents working with a housing provider. This can be explained by the project partners in charge of disseminating the survey in the UK who partially are housing providers themselves (Peabody) or have very strong connections to the sector (second UK partner is Standing Together Against DV). In the full sample (all 9 countries) housing providers represent ‘only’ 40% of respondents, in the subsample without the UK respondents from housing providers represent 20%.

Figure 34: Housing providers highly overrepresented in UK subsample



N= 101 UK, 134 full sample

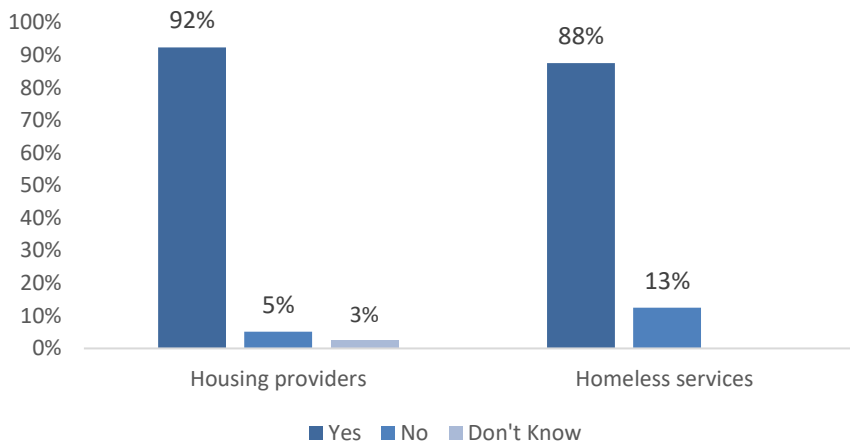
<sup>53</sup> Non-response-rates for this question in the UK subsample are of 42% (housing providers) and 53% (homeless services). For the ‘Group excl. UK’, non-response-rates are of 74% (housing providers) and 45% (homeless services).



### Specific support provided to survivors of DV

The majority of housing providers and homeless services provide tenants and service users respectively who experience(d) DV with specific support services (92% resp. 88%). Only 5% of respondents working with a housing provider say that specific support is not provided (13% of respondents from the homeless service sector). However, as case numbers for the homeless service sector are very low for this item (16 respondents), results have limited validity and should be interpreted very carefully.

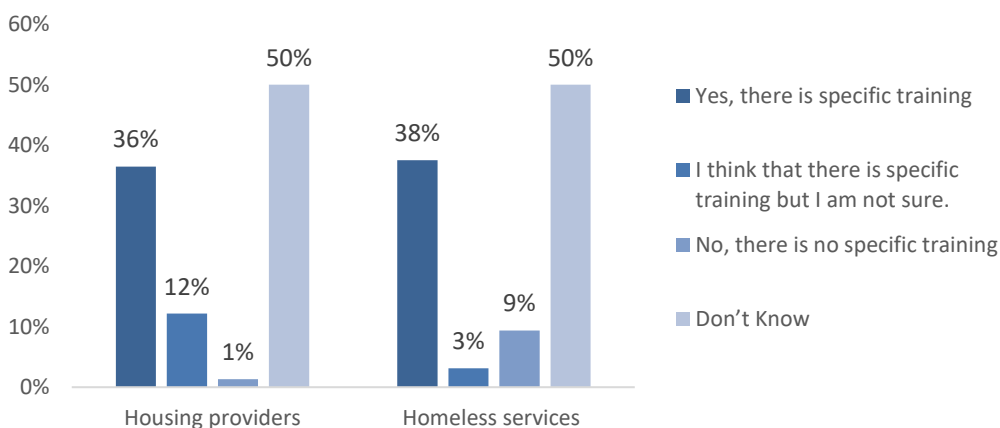
Figure 35: Majority of housing providers do provide specific support to DV survivors



N= 39 HP, 16 HLS

Housing providers and homeless service staff agree on the availability of specific training on DV: In both groups, around a third of respondents confirms that such training is available in the UK (36% of housing providers staff and 38% of homeless service staff). However, 9% of respondents from homeless services think that there is no DV-specific training available compared to only 1% of housing providers. In both groups, half of respondents do not know whether such training is available which suggests considerable scope for improvement in making such training available, in particular at affordable cost, and making them widely known.

Figure 36: DV-specific training is available but half of respondents do not know



N= 74 HP, 32 HLS

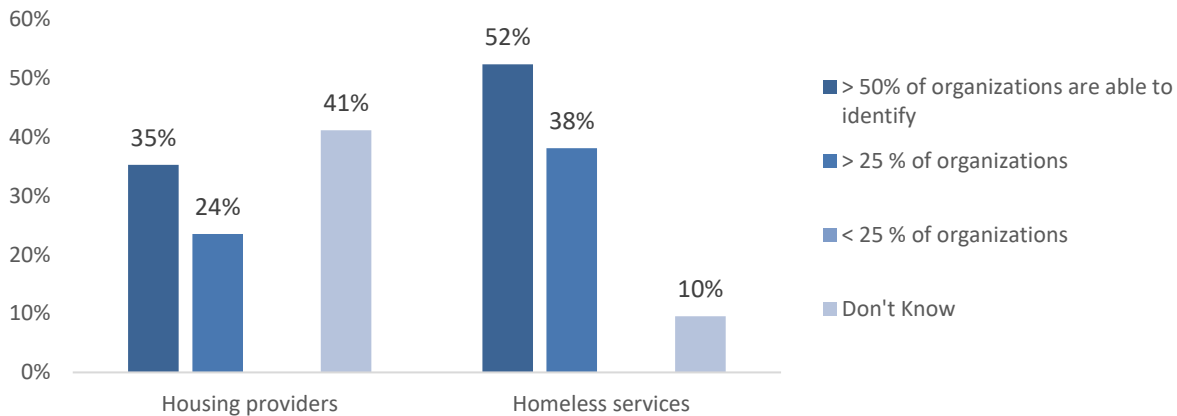




### Service capacity to identify and respond to DV

Results suggest that homeless services feel more confident in their ability to identify DV: 52% of respondents working with homeless services think that more than half of all services in the UK are able to identify cases of DV whereas only a third of housing providers think that more than half of housing providers are able to identify DV (35%). The share of respondents who responded with 'don't know' are particularly numerous among housing providers respondents (41%).

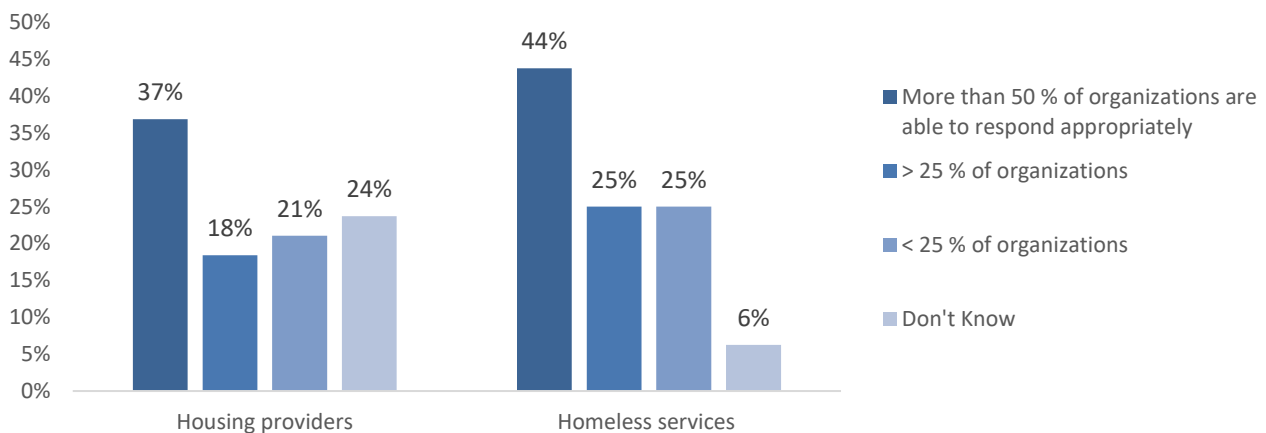
Figure 37: Homeless services more confident in identifying DV than housing providers but considerable scope for improvement



N= 34 HP, 21 HLS

More than a third of respondents feel that more than half of housing providers in the UK are able to respond appropriately to cases of DV (37%) which is just slightly higher than the number of respondents who think that half of housing providers are able to identify DV (35%). For the housing providers sector, a significantly smaller share does not feel able to assess the situation (24% compared to 41% on the previous question say 'don't know'). Respondents from the homeless service sector are slightly more confident in assessing their sector's ability to respond appropriately to cases of DV: 44% think that more than half of homeless services in the UK are able to appropriately respond to survivors of DV and only 6% think that less than a quarter of all homeless services in the UK can respond appropriately to DV. However, it must be emphasized that results for the homeless sector should be interpreted very carefully as only a small number of homeless services answered this question (16).

Figure 38: Homeless service more confident in responding appropriately to DV



N= 38 HP, 16 HLS

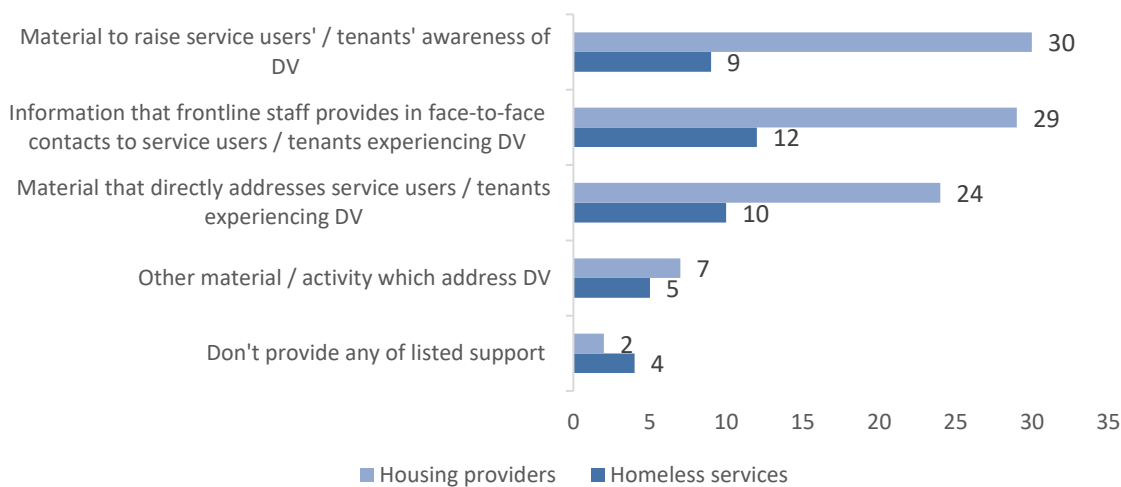


### How is DV addressed by homeless services and housing providers?

The following question asked respondents in what ways housing providers and homeless services address DV.

Figure 39 suggests that DV-specific awareness raising materials as well as information that support staff provides in face-to-face contact with tenants are the most relevant ways for housing providers to address DV (30 respectively 29 times reported). Materials that directly address tenants who have experienced or are experiencing DV are also quite important (24 times reported). Such materials are provided on premises or at housing providers offices. Homeless services provided far fewer responses to this question. However, results suggest that homeless services address DV in the same ways as housing providers do.

**Figure 39: Awareness raising materials and face-to-face contact most relevant for housing providers to address DV**



N= 92 HP, 40 HLS (namings, not respondents, multiple-choice question)<sup>54</sup>

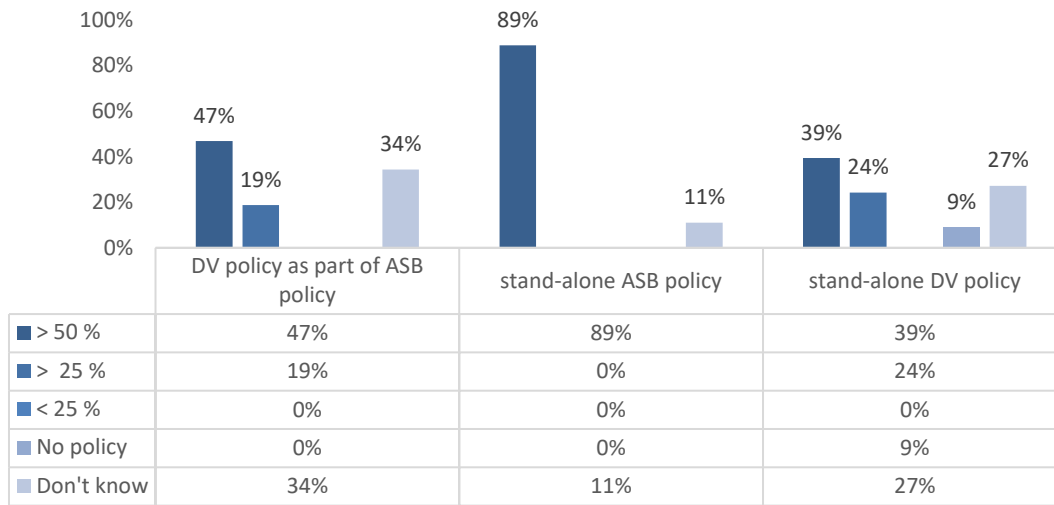
### To which extent is DV addressed in organizational policies?

Figure 40 suggests that the clear majority of housing providers think that more than half of UK-based housing providers have a stand-alone ASB policy in place (89%), compared to only 39% who think that more than half of UK-based housing providers have a stand-alone DV policy in place. Housing providers in the UK are obliged to have an ASB policy in place by law. Therefore, it is surprising that the number of respondents who report that housing providers have an ASB policy in place is not higher than the reported 89%. Legal regulations on ASB policies urge housing providers to establish clear guidelines on ASB and how to respond to ASB on their premises. Housing providers hence give a great deal of attention to ASB but do not apply the same vigour to DV. This also explains why DV-related policies and procedures are often part of more general ASB policies.

<sup>54</sup> Namings, not respondents. Multiple-choice means that each respondent can give more than 1 answer. The numbers presented indicate the number of times a specific answer was chosen.



Figure 40: ASB-policies most frequent organizational policies in UK housing providers

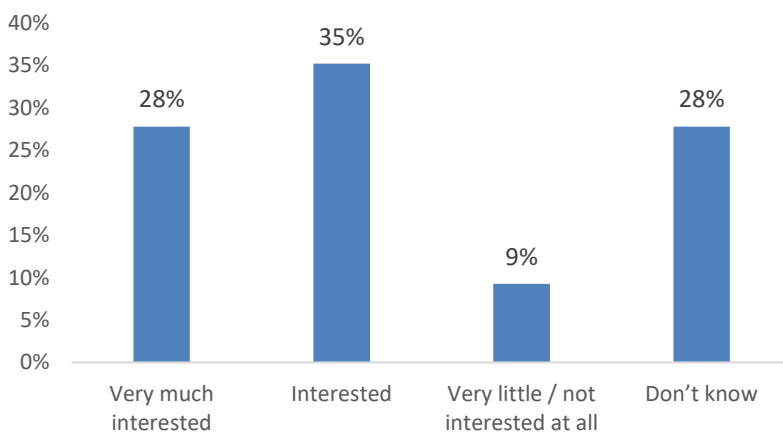


N (only HP) = 61 (DV policy part of ASB policy), 64 (stand-alone ASB policy), 34 (stand-alone DV policy)

Results for UK-based homeless services are only of very limited viability due to low case numbers (16 respondents for each sub-question). However, data suggest a tendency towards either stand-alone ASB or stand-alone DV policies. DV policies as part of a more general ASB policies are less frequent in homeless services in the UK.

Finally, respondents were asked to assess the interest of their sector in addressing DV. Figure 41 suggests that interest in addressing DV is very high among housing providers in the UK: Almost two thirds of respondents say that housing providers are interested or even very much interested in addressing DV (63% of which 28% very much interested), only 9% think housing providers are very little or not at all interested in addressing DV. However, more than quarter of respondents did not know what to answer.

Figure 41: UK-based housing providers show strong interest in addressing DV



N= 54 HP

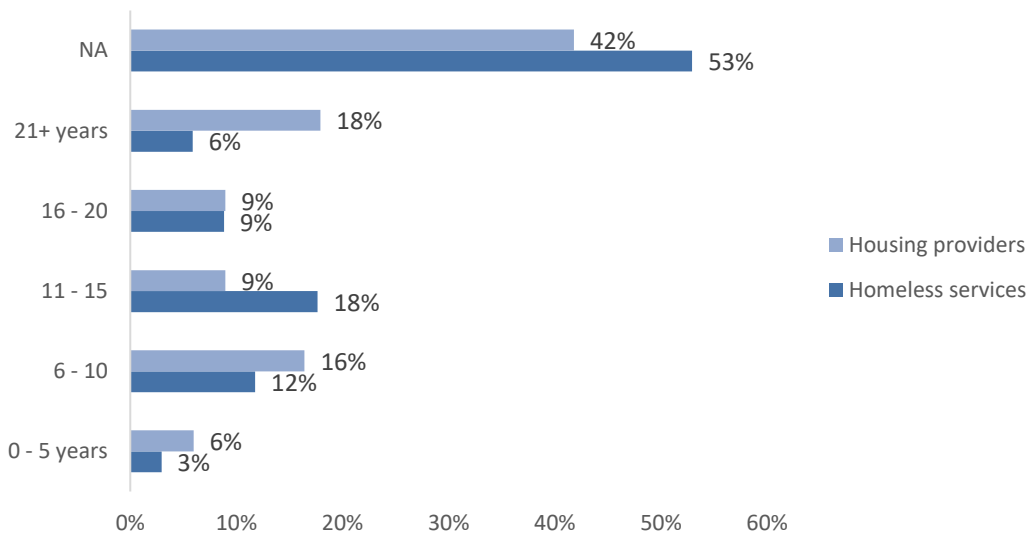
Case numbers for the homeless sector were too small to calculate percentages. From the 23 respondents working with a homeless service in the UK, 10 assess services as 'interested' in addressing DV, 4 as even very much interested and 5 as very little or not at all interested (4 did not know).



### Demographic characteristics of respondents of the subsample UK

Very similar to the subsample of all countries without the UK (cf. also Figure 21), many respondents did not indicate their work years in the sector (42% of respondents from housing providers and even 53% for the homeless sector). However, almost a fifth of respondents working with a housing provider have been working there for many years- 18% even more than 21 years. Almost a fifth of respondents from the homeless service sector has been working for the sector between 11 and 15 years (18%), 9% between 16 and 20 years.

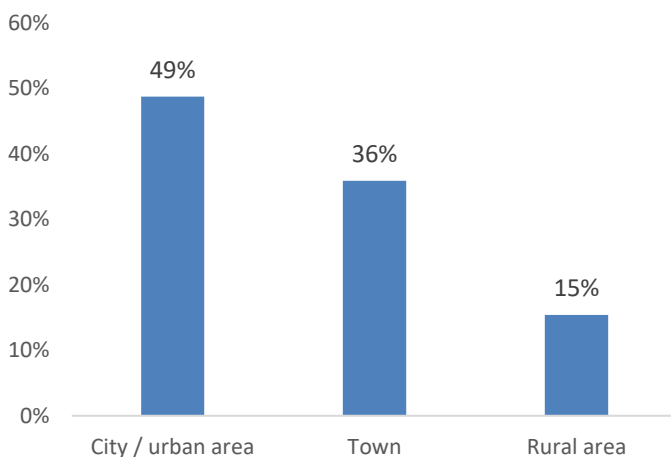
Figure 42: High non-response on work years in sector, considerable number of respondents works in sector since many years



N= 67 HP, 34 HLS

Almost half of respondents from UK-based housing providers work in cities or urban areas (49%), more than a third in towns (36%) and 15% in rural areas.

Figure 43: Most respondents working with housing providers work in cities or urban areas

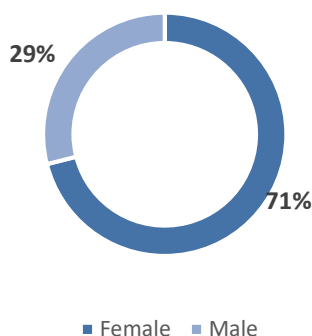


N= 39 HP

The sample for homeless services is too small to do a proper data analysis. From the 16 respondents working with homeless service, 10 work in cities or urban areas, another 4 in towns and 2 persons works in a rural area.



Figure 44: Women represent 71% of interviewed housing providers staff



N= 38 HP

The subsample for homeless services only contains 15 respondents of whom 9 respondents are women and 6 are men.

### 6.5 Results from expert interviews

To complement the online survey conducted among housing providers and homeless services, a series of experts was interviewed. The main interest was to complement information from the survey which mainly represents the perspective of staff with the perspective of the whole organization and to gain deeper insights into the functioning of support services in different local context. Altogether, 7 expert interviews were conducted, involving

- 2 representatives from housing providers;
- 2 representatives from homeless services;
- researcher Joanne Bretherton (Centre for Housing Policy, York University, UK) who works on housing and women's homelessness and its relationship to DV;
- 2 specialist gender-based violence services (Safe Ireland and WAVE- Women Against Violence Europe).

The interview guideline is available in ANNEX I at the end of this report.

The following analysis of the expert interviews reflects the most interesting insights into the type of support which is provided to survivors, how support is organized, what works well and what are the biggest challenges in supporting survivors.

#### Psychosocial support and different types of counselling

Staff at DV support services provide a wide range of support services ranging from immediate support in the crisis, which might also include helping with packing and moving out from the shared household, to accompaniment during transition while moving to a shelter, refuge or transition apartment, as well as post-crisis support. Case workers provide psychosocial support, including the provision of psychotherapy (or referrals to psychotherapists), referring and accompaniment to health care and mental health services, provision of legal counselling in case the survivor wants to file a complaint, accompaniment to court or police, provision of or referrals to child-specific services. DV services also provide debt and financial counselling as well as employment counselling, some organizations provide professional reorientation and labour market integration support or offer even training programs for survivors. Support to claim social benefits is provided too. Some DV services refer to organizations working with perpetrators or work with both survivors and perpetrators, taking on a systemic approach (e.g. Kadera in the Netherlands). Supporting survivors to access housing is another key task of support staff. Case workers work as much as possible as



'single point of contact' for other services, sparing survivors the need to 'tell their story' over and over again. Support workers are employed by specialist DV or GBV services, women's refuges or DV/GBV crisis centers or work directly with the public service (e.g. city councils). Establishing good individual relationships to e.g. specific medical services / health care professionals or the local police department is crucial for support workers. However, establishing collaboration rather at organizational and less at individual level helps ensuring the sustainability of support provision.

### **Short excursus on WAVE report 2015 on specialist women's support provision**

The [WAVE report 'On the Role of Specialist Women's Support Services in Europe'](#)<sup>55</sup> (2015) provides very useful information on special service provision to women survivors of gender-based and DV. The report is based on data collected from practitioners working with women's and DV services in 33 European countries. Data suggests that the number of specialist women's support services existing in a given country and the widespread availability of information and referral mechanisms are most crucial in ensuring support for survivors of GBV / DV.

According to the report, in most cases, it is survivors themselves who seek support, mostly via health care services, a victim support helpline or by accessing the nearest women's shelter. Women's shelters are the most important services for women and their children providing accommodation and support. In countries with no direct referral schemes and in areas with few or no shelters general social services are often the first point of contact. The report suggests that, where support services are absent or information on how to access them, women would often turn to the police. The police is also very probably the first contact for the survivor (and children) where emergency barring orders and/or protection orders have been implemented. Health care professionals are another main port of contact for survivors (see also FRA report 2014).<sup>56</sup> Personal social networks, friends and family, are particularly important for survivors who distrust public authorities or survivors who live in rural areas respectively areas without (sufficient) shelter space. The WAVE report emphasizes the importance of national women's helplines and public awareness about them as key elements to accessing specialist support.

### **The contribution of housing providers to better tackle DV**

Housing providers staff, housing officers and particularly repair staff, have unique access to very specific information which enables them to identify cases of DV. Housing providers are hence well placed to identify ongoing DV and help survivors by making the right referrals to local DV specialist support services. The situation in the UK is quite unique as housing providers can provide advice and support themselves. Housing officers would signpost DV or suspected DV to specialist DV staff if available. However, housing officers and repair staff still need DV-specific training to identify the signs of DV. Training for HP staff usually focuses on creating an understanding of DV, why it is difficult to leave violent relationships, and explains the dynamics of an abusive relationship and coercive control. Bigger housing providers might even be able to rehouse survivors within their premises, others might collaborate with other social/public housing providers in their region.

### **Access to housing for DV survivors**

Interviewed experts agree that quick access to housing stands at the core of support to survivors of DV. Public housing is crucial as survivors often cannot afford private rental, even less so in certain capital / bigger cities. Access is usually facilitated by the local specialist DV services, women's shelters/refuges who collaborate with municipalities and/or local social/public housing providers. Many municipalities give DV

<sup>55</sup> [http://fileservers.wave-network.org/researchreports/WAVE\\_Report\\_2015.pdf](http://fileservers.wave-network.org/researchreports/WAVE_Report_2015.pdf)

<sup>56</sup> Violence Against Women, FRA- Agency for Fundamental Rights, 2014, p 60.

<http://fra.europa.eu/en/publication/2014/violence-against-women-eu-wide-survey-main-results-report>





survivors high priority on access to social housing. Survivors receive ‘extra points’ to move up on the waiting list, or, where more housing is available, might get first placed. The latter case is, however, rather seldom due to the housing shortage in almost all European countries. Temporary housing is particularly crucial for survivors who filed a complaint against the perpetrator to have a safe place to live while waiting for the court decision. This is even more the case when survivors live with dependent children. In many municipalities, support services collaborate with specific contact persons at the housing provider or municipality in a continuous way.

Experts explain that rehousing survivors within the same area helps them to maintain personal support networks, to keep the same job, for the children to continue attending the same school.<sup>57</sup> Professional risk assessment and work with the perpetrator contribute greatly to have survivors stay in the same area. However, if risk assessment identifies high risk and immediate danger for the survivor and children, rehousing to a different region / area is necessary.

### The importance of organizational DV policies

The central role of organizational DV policies was emphasized throughout the expert interviews. The capacity of an organization to identify and respond appropriately to DV is strongly determined by whether a DV specific policy had been adopted and implemented. DV-specific staff training has to be embedded in an overall organizational DV response to be effective. DV expert Rosa Logar from the WAVE network (Women Against Violence in Europe) explains that an organization’s response to DV will only be effective if management has taken on an attitude of responsibility for addressing DV and established clear procedures for DV cases. Although organizations vary greatly in their capacity to identify and respond to DV, the lack of a DV policy (and DV guidelines) are indicators that staff is most likely not even screening for DV. It should be emphasized that it is not about expecting general social services to respond to DV in the sense of providing support and accompaniment to the survivor but about making the right referrals to local DV specialist services. Making referrals, however, implies that staff are able to identify cases of DV and knows how to address the issue when talking to a (suspected) victim.

Expert interviews confirm results from the SAH online survey which suggests that most homeless services in Europe do not have a DV policy at organizational level. However, awareness of DV has increased among homeless services in the last few years, both in ‘continental Europe’ as in the UK, particularly because of the increase of women’s homelessness.

### Current good practice

The following presents good practice which can inspire services for their own work with survivors of DV.

Experts agree that support to DV victims is most efficient where **homeless services, housing providers and DV services cooperate**. Only a continuous collaboration with housing providers can ensure access to permanent housing for DV survivors. Some housing providers have established referral networks at local / regional level which work in a rather informal way and at individual level, still, can make a big difference to support survivors into housing.

‘**Bilateral protocols**’, i.e. formalized procedures for collaboration, between housing providers, homeless services and DV specialist services proved effective in enhancing support for survivors. The condition is that such ‘protocols’ specify the tasks of each involved organization. Survivors can be spared having to report the same incident several times. Furthermore, the improved collaboration also supports sharing of knowledge and good practice.

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<sup>57</sup> Expert interview 2, Joanne Bretherton (Centre for Housing Policy, York University), expert interview1 Isabel Baptista (Centro de Estudos para a Intervenção Social).



Introducing gender-sensitive work within homeless services has led to a few **women-only homeless services** which are absolutely crucial to meet the needs of homeless women survivors of DV, overall survivors' need for safety. Where a lack of funding (or other reasons) does not allow for women-only service provision, a pragmatic solution are women-only floors or women-only drop in sessions at specific days and time. Women know at least that during this time, no men will be around which can already make a considerable contribution to their feeling of safety.

An alternative to women's shelters or refuges which has proved to work well are **safe homes**. A safe home is a shared apartment with specific safety features such as video camera for entrance area, direct alarm to police station who knows about the Safe Home. A Safe Home is usually shared by several women (and their children), each occupying an individual bedroom. Transitory housing meets survivors' needs when wrap-around support on the spot is provided. Apart from psychological support, specific support for rehousing is crucial.

Homeless services who support survivors efficiently have good referral systems to DV-specific support services and housing providers in place to ensure wrap-around support and access to permanent housing.

Another alternative to women's shelters or refuges are so-called '**Sanctuary Schemes**', which have been established in the UK in recent years. They allow women to stay in their own home, keeping them in touch with support networks and giving survivors the feeling of taking back control over their life by providing additional security measures to the homes. However, such schemes also have several risks: Most importantly, they do not work for cases of high risk as the perpetrator knows where to find the survivor. There is also a financial interest from public authorities to establish sanctuary schemes as they help saving lots of money, compared to emergency housing in shelters / refuges / Bnbs etc. whenever appropriate.

Housing providers are most effective in identifying DV where repair staff reports suspected signs of DV (also referred to as 'repair data'). The importance of repair data cannot be emphasized enough. Data on repairs allows to detect DV and sign post to DV specialists who get in touch with the woman / family / couple. Some women also decide to speak up about ongoing DV during a routine contact with their housing provider or when searching for a new flat.

**Legal regulations** can improve the response and support provided to DV survivors through entitlement to specific support services, e.g. The Housing Act (1996) in the UK places a statutory duty on local authorities to support women fleeing DV. The Housing Act has been built on in the UK with the introduction of the Homeless Reduction Act in April 2018 which recognises that suffering domestic violence / abuse would make individuals and their family vulnerable. The Homeless Reduction Act amends homelessness law in different ways: The Act improved the advice and information available about homelessness and the prevention of homelessness. It led to an extension of the period defined as 'threatened with homelessness' (from 28 days to days). It introduced new duties to prevent and relieve homelessness for all eligible people, regardless of priority need, intentionality, and local connection. The Act led to the introduction of housing assessments and personalised housing plans, setting out the actions housing authorities and individuals will take to secure accommodation. The Act encourages public bodies to work together to prevent and relieve homelessness through a duty to refer.

In the UK, **DAHA** - Domestic Abuse Housing Alliance - jointly developed an DV accreditation for housing providers and other social services. DAHA involves two social housing providers and a second-tier DV specialist service. DAHA accreditation has been mentioned several times as good practice in terms of raising awareness and providing a framework to improve the capacity of housing providers to identify and respond to DV. DAHA accreditation has been designed to work with both housing providers, local authorities/ municipalities and homeless services and focuses on 8 priority areas including policies and procedures, case management, risk management, perpetrator management, equality and diversity, staff training, partnership



working, publicity and awareness in order to transform the whole organisational response to DV. Detailed information on DAHA and the accreditation process is available here <https://www.dahalliance.org.uk>.

### Changes needed to improve support for survivors

- *Provide sufficient permanent and temporary housing for survivors*

Taking up on an aspect which had been mentioned many times during all expert interviews, the **lack of housing** is crucial and detrimental to support for DV survivors (even more so when living with dependent children). Most survivors do not want to move to a safe house/refuge or shelter but to a new permanent tenancy. Still, many get stuck in shelters or refuges, unsure when they will be able to move on to permanent accommodation which exacerbates mental strain and jeopardizes recovery from DV and trauma. Access to permanent housing is particularly difficult in big cities and capitals where people might stay on waiting lists for years. Austerity policies have worsened the housing situation in many European countries. In the UK, the Welfare Reform worsened access to housing as housing allowances were capped below market level. Due to the lack of permanent housing, many women get rehoused in temporary accommodation which is often of very bad quality (for instance cheap BnBs, hostels). A homeless sector expert from the UK calls on policy makers to invest in permanent good quality housing instead of commissioning bad-quality temporary accommodation.

Lack of housing jeopardizes rights-based policies such as the statutory duty regulations for local authorities in the UK according to which women fleeing DV are entitled to priority support. However, the capacity of local authorities to house survivors even temporarily is strongly limited due to the lack of refuges and shelters.

Countries with an ongoing housing crisis, such as Ireland, see women staying in violent relationships knowing that shelters are full and that no permanent housing is available. Furthermore, due to the **lack of women's refuges /shelters** in most European countries, survivors risk to stay too long in temporary / transitional housing which does not meet their safety needs, and might even be gender-mixed, nor provides sufficient support services. Gender-mixed environments are unsuitable for women who have just left a violent relationship. Women's refuges, unlike hostels, offer DV-specific support and employ specialist and women-only staff. A general lack of shelter places also leads to situations in which women with so-called 'complex needs' are more often turned away from women-only shelters and end up in homeless (or other) services which are less able to meet their support needs. The mental strain for women who are in a situation of homelessness and have had their child taken into custody is tremendous.

Temporary housing is particularly important for survivors with ongoing judicial proceedings. Experts also state that not enough legal support is available to survivors to get perpetrators moved out, temporarily or for longer periods (emergency barring orders exist in 22 European countries<sup>58</sup>).

- *Ensure immediate protection for persons fleeing DV*

The situation of persons fleeing DV remains an unsolved challenge in many Member States. DV and other support services observe that violence and abuse continue even after the survivor has left the relationship, sometimes leading to the murder of the individual experiencing abuse. Research suggests that survivors are most at risk when leaving the violent relationship, respectively in the days following.

<sup>58</sup> WAVE report 2015 'On the Role of Specialist Women's Support Services in Europe', p 86. [http://files.wave-network.org/researchreports/WAVE\\_Report\\_2015.pdf](http://files.wave-network.org/researchreports/WAVE_Report_2015.pdf).



- *Build capacity of homeless services to address DV*

Experts from the homeless sector confirm that, by the time women have reached homeless services, they often have more and complex needs, often with a whole story of homelessness and hidden homelessness, related mental health issues and trauma (many with adverse childhood experiences). Homeless services usually are not equipped to deal with these needs and the services themselves are mostly used by men (who still represent the majority of people who are homeless). To improve support to survivors, homeless services need to train their staff more adequately on DV and, more generally, on women's safety, and need to adopt standard DV procedures and policies.

The expert from the WAVE network emphasizes that specific knowledge and attitude are needed to adequately support and accompany survivors as they often are further discriminated against (in social services or other sectors such as the juridical system). Inappropriate support can also lead to re-traumatization or re-victimization. Non-specialist DV services, such as homeless services or housing providers, should take it seriously to properly train staff on how to identify and respond to DV with service users.

A particularly difficult user group for homeless services are homeless couples. Many homeless women are in a relationship, some/a few with abusive partners. Many services don't know how to deal with couples or, not knowing how to recognize DV, might be simply working with both persons individually without getting the "full picture" of the relationship.

Although experts regard the capacity of homeless services to identify DV to be rather limited, they also note that awareness of DV is high, in particular awareness of the relationship between DV and women's homelessness. The already existing high awareness of DV should encourage efforts to build capacity of homeless service staff to address DV with service users and learn how to refer to DV-specific support services. Costs are often a barrier to training and local authorities should be encouraged to provide more training for free.

- *Establish networks & enhance collaboration between services*

From a structural perspective, more service networks should be established, facilitating collaboration between DV support services, homeless services and housing providers. Homeless services are still part of DV-related referral networks in many local contexts. Homeless services are an important partner to reach out to women with DV experience, many with particularly strong support needs (as discussed above). Other support services, such as, notably, health care services but also general social support / social security, employment service, child protection services or the police should also form part of such a network.

- *Establish more women-only homeless services*

Being designed for men, who still are the biggest share of the homeless population, most homeless services are unfit to meet the needs of homeless women, of which many experienced violence either before or during their situation of homelessness. Homeless services need to take the needs of homeless women more seriously, not at least because of the growing number of homeless women throughout Europe.<sup>59</sup> As mentioned above (cf. 'Current good practice'), a few women-only homeless services have been established in different European countries in recent years but there is need for more. Efforts should also aim at making services (more) gender-sensitive, paying greater attention to needs of safety.

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<sup>59</sup> The UK-based homeless service Homeless Link who does an annual review of services showed for 2017 that 30% of all people accessing services are women but only 11% of services are women-only.



- *Build capacity of medical professionals to identify DV*

Survivors of DV often disclose to medical professionals. Raising awareness and training on identifying signs of GBV for medical staff is hence crucial. WAVE expert Rosa Logar refers to the constant situation of overwork in the care sector which strains professionals' capacity to 'do this one more question' on DV.

- *Establish expert or steering groups to improve service set-up*

Setting up an expert or steering group can contribute substantially to the improvement of local service set-up, including homeless services, DV-specific support services as well as public / social housing providers. In Portugal, for instance, such an expert / steering group was set up to improve the set-up and delivery of homeless services, involving representatives from homeless services, the DV sector, secretary of state and researchers. Issues addressed were for example the improvement of minimum staff training requirements for the homeless sector, the evaluation of DV policies of women's refuges and the establishment of monitoring mechanism for DV cases.<sup>60</sup>

- *Establish a clear distinction between DV and ASB*

Particularly for UK and Irish contexts, evidence suggests an ongoing confusion between Anti-Social Behaviour and domestic violence which is shared by many housing providers. This situation makes it more difficult for survivors to speak up about DV and seek help, or, they might even lose their tenancy due to their partners' violence without getting any support as a victim, particularly when the perpetrator has damaged the property or when there are rent arrears. At the same time, DV might remain hidden for years when no ASB is involved and when there are no rent arrears.

Accreditation of HP's and training provided by DAHA, an alliance between two social housing providers and a second-tier DV specialist service in the UK, has been mentioned several times as good practice in terms of raising awareness and providing a framework to improve the whole HP response to DV. DAHA accreditation has been designed to work with both housing providers, local authorities/ municipalities and homeless services. DAHA can contribute greatly to build the capacity of social organizations to identify and respond to DV. Countries are encouraged to explore the DAHA framework and accreditation process (more information on DAHA is available in the chapter 'Current good practice' above).

- *Implications of austerity politics for specialist DV and other support services*

The consequences of austerity policies have been referred to several times during expert interviews, several times with regards to the UK but also for other European countries. Budget cuts and, particularly relevant for the UK, the Welfare Reform, are limiting the work of DV services as well as of homeless services and housing providers. Cuts in housing allowance and benefits caps have affected women more than men. Single mothers are a strongly affected group. According to expert Lisa Raftery from Homeless Link, 'in London, there is no decent rent for housing allowance'.<sup>61</sup> The cut of housing allowance below market level strongly limits recipients' access to decent rental options in the UK. Services often find themselves in a situation where a considerable number of policy makers show awareness and political will to improve the situation for DV survivors but where budget cuts are affecting the work of DV and other social support services, sometimes resulting in their closure.

## 6.6 The perspective of the survivor: What works, what needs to change?

The last part of this chapter is dedicated to gaps in service provision and necessary changes to improve support for DV survivors from the survivor's perspective. The first part describes 'good practice' -

<sup>60</sup> Unfortunately, the expert group stopped working after a change of government in Portugal (March 2018).

<sup>61</sup> Expert interview 5, p 5.





characteristics of service set-up and delivery that are supportive and beneficial to the recovery from DV. The second part identifies necessary changes to improve support provided to DV survivors.

### What works well? Providing the right support to survivors<sup>62</sup>

**Trustworthy relationships** with support workers stand at the heart of the recovery process for survivors of DV. Survivors emphasize that support workers need to be available and they need to have time ‘to be around’. Building a trustful relationship is particularly crucial at the beginning of the recovery process. Researcher Joanne Bretherton emphasizes that most women survivors of DV are extremely reluctant to talk about DV. However, evidence suggests that **disclosure** is more likely in face- to-face contact with support workers with whom survivors could build a relationship of continuous support and trust.

Survivors need to have **full control** over the support process and **choice** over any decision concerning their lives. Regaining control and choice is fundamental for survivors as DV always involves coercive control and tries to limit individual choice.<sup>63</sup> In cases where survivors chose to get rehoused, it is fundamental that they are given **more than one option to be rehoused** (if they decided to go for rehousing). Having choice and control also implies that support workers keep survivors informed about any developments (for instance once a rehousing request was deposited). Spaces must be safe at all times and women must feel safe. Service providers should regularly check with survivors that all spaces, individual or shared, meet safety needs (it is not only about ‘objective’ safety but also about service users’ perception of spaces).

**Women-only environments** strongly support survivors’ recovery (cf. ‘Rebuilding Shattered Lives’ report by St Mungo’s<sup>64</sup>). More than half of women service users interviewed for the Shattered Lives report said that they would choose women-only accommodation if available. Women would also prefer accompaniment by female staff. Women-only services/environments support mental health recovery and recovery for women with complex needs. The cleanliness of spaces is fundamental to women’s well-being.

Evidence suggests the very positive impact of **client involvement** (peer work) in terms of the quality of service design and delivery. Survivors very much appreciate the involvement of peer workers.

Staff is perceived as most supportive when taking on an attitude of **empathy and compassion**.

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<sup>62</sup> This subchapter on the survivors’ perspective is mainly based on the research ‘The role of housing in a co-ordinated community response to domestic abuse’ by Kelly Henderson, Business Manager- Domestic Abuse at Gentoo and PhD candidate at Durham University. She conducted research among housing providers in the UK, including interviews with staff members from 10 housing providers from England and Wales, interviews with survivors from 2 housing providers (Peabody and Gentoo) as well as interviews with perpetrators from the Gentoo perpetrator’s programme. The research was presented at various events but has not yet been formally published.

<sup>63</sup> Expert interview 3 Kelly Henderson, Business Manager Domestic Abuse at Gentoo Housing. She also did an PhD on the coordinated community response to domestic abuse in the UK. The coercive control aspect of domestic violence is well evidenced in the following publication by researcher Even Stark: Even Stark (2012): Coercive Control. In N. Lombard & L. McMillan (Ed.), Violence against Women. Current Theory and Practice in Domestic Abuse, Sexual Violence and Exploitation (pp. 17-34). London & Philadelphia: Jessica Kingsley Publishers.

<sup>64</sup> Rebuilding Shattered Lives report, St Mungo’s, based on an online call for evidence over 18 months among local agencies in the UK, with a different theme related to women’s homelessness posted every two months, desktop research and peer research. The report also included testimonials of service users, women who with experience of homelessness and many with experience of DV. Available here <https://www.mungos.org/publication/rebuilding-shattered-lives-final-report/>.





## What needs to change?

**More information on emergency accommodation** needs to be provided. There still is a considerable number of women fleeing DV who struggles to access information about emergency accommodation and finishes up sleeping rough though emergency accommodation is available.

**More women-only services** or at least women-only environments (spaces) should be established. As mentioned above, women-only services can contribute greatly to the recovery of women with DV experience.

**More training on gender-sensitive, psychologically- and trauma- informed service provision** needs to be available for housing providers and homeless services so that staff can identify DV, respond appropriately to survivors and make the right referrals. Housing providers and homeless service providers need to offer more training on gender-sensitive service delivery, ensuring staff takes on a non-judgemental and empowering attitude towards survivors. Staff needs to be aware of feelings of guilt and shame, many times related to the separation from children, and stigmatisation when addressing DV with service users who have experienced DV. Gender-sensitive approach also implies to recognize the importance of relationships to their children (e.g. supporting women into custody arrangements). Training is also fundamental to avoid any kind of **victim blaming**.<sup>65</sup> For instance, survivors would be criticized for not leaving the abusive relationship or for moving back in with the perpetrator.

**More and better collaboration with other relevant local services** such as mental health organizations, child protection services, sexual abuse organizations etc. Evidence from the Stella Project, implemented by the organization AVA, shows that homeless services and housing providers need to collaborate with different support services to meet the needs of DV survivors: ‘No single service is likely to be able to address all of a woman’s needs fully’.<sup>66</sup> Collaboration should be based on cooperation agreements which specify responsibilities for involved services and spare survivors from having to tell their story several times. Referrals, signposting and co-location of services are ‘lighter’ ways of cooperation.

## Need for change at organizational level

For the UK context, recent research shows that a considerable number of housing providers feel **uncomfortable with taking concrete actions against perpetrators** among their tenants although most HPs are supposed to treat DV as a tenancy breach, according to their DV policies. For instance, recent research among housing providers in England and Wales shows that 65% of housing providers stated that domestic abuse was situated within their anti-social behaviour policy but just over half (53%) had actually taken any action against perpetrators.<sup>67</sup> A different survey among staff of Scottish Women’s Aid, a GBV organization with a strong focus on domestic abuse prevention, suggests that a considerable percentage of staff does not feel confident in taking action against perpetrators (52%). Taking action does not only mean to evict the perpetrator. Referrals to behaviour change programmes and organizations who work with perpetrators are crucial, especially in terms of protecting other women and avoid having perpetrators ‘going from victim to victim’.

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<sup>65</sup> ‘The role of housing in a co-ordinated community response to domestic abuse’ by Kelly Henderson (see also above), according to interviews with service users of 2 English housing providers and an anonymous survey among housing professionals (232 respondents).

<sup>66</sup> Ibid, pg 24.

<sup>67</sup> Ibid.



Experts emphasize the importance to **involve management** in building an organization's response to DV. Getting support from management is decisive for an organization's capacity to build a comprehensive organizational response to DV.

To conclude, the following changes have been identified to be fundamental to improve support to survivors of DV:

- Provide more emergency accommodation and make shelters known,
- provide more and quickly accessible permanent housing,
- set up more women-only services (or at least women-only spaces),
- provide staff working with housing providers and homeless services with training on gender-sensitive, psychologically- and trauma- informed service provision;
- strengthen collaboration with relevant local services.
- At organizational level, it is crucial to get management to effectively respond to DV.
- Housing providers should also enhance the actual application of their DV policies according to which DV is to be treated as a tenancy breach or, at least, take actual actions to keep the perpetrator away from the survivor and the formerly shared home (such as professional safety planning, also involving the police).

## 7. Conclusions and outlook 'How to better support survivors of DV?'

The last chapter of this report recaps the report's overall conclusions as well as suggestions on how to improve support for women survivors of DV.

### 1- *More capacity building on identification and response to DV needed to improve prevention of DV*

**More training on identifying and responding to DV is needed** among housing providers and homeless service providers- this is the clear outcome of the state of art survey conducted by the 'Safe at Home' project: Only 30% of housing providers think that at least half of service providers in their country are able to identify DV, among homeless services, the share is 49%. This clearly indicates a **need for more DV-specific training** to improve the **early identification and prevention** of DV. When it comes to the capacity to respond to DV, both housing providers and homeless services assess that around a third of services in the respective sector are able to respond adequately to DV. This confirms the great contribution training on identification of the signs of DV can have, as delivered by the 'Safe at Home' project (676 housing provider staff in the Netherlands and 644 in the UK were trained). The high share of housing providers who provide support to DV survivors **confirms the approach chosen by the 'Safe at Home' project to stronger involve housing providers in tackling DV** (91% support survivors in some way or other). The fact that each respondent named at least one way<sup>68</sup> of how the organization addresses DV shows that DV is an issue and that services recognize the need to address DV. Face-to-face contact is the most frequent way to address DV with tenants and users of homeless services respectively. Training staff on how to respond to DV can hence make a huge difference, enabling staff to address DV and offer further support in a sensitive and informed way.

### 2- *Protection: a safe housing or accommodation as a must for recovery from DV*

As DV turns the home, 'a place of constancy, privacy and identity construction', into a place of permanent surveillance and a threat to the personal security of women and children, safe accommodation is

<sup>68</sup> 230 namings from 234 respondents.



fundamental for the recovery from DV. **Housing** is hence a **key aspect** in supporting survivors which, however, is jeopardized by the scarcity of affordable housing in most European capitals and bigger cities. The **provision of affordable housing** remains a challenge for many European cities and calls for more action by policy makers and local authorities (i.e. rent regulation, construction of affordable housing etc.). Austerity policies in recent years have significantly contributed to worsen the housing situation in many European countries. In the UK, the Welfare Reform has capped housing allowances which affects women more than men, due to the gender-pay gap, and particularly affects single mothers. When housing options are scarce, **prevention** and the **identification of DV as early as possible** are even more important to prevent survivors from becoming homeless. Very recent research by Mayock and Bretherton emphasizes the **lack of housing** as a key cause for survivors to become homeless.<sup>69</sup> Domestic violence makes women homeless but, to be more specific, it is the lack of accessible housing, in the short and long term, that makes survivors homeless. In the case of DV-related homelessness, the gender-based economic discrimination of women gets very visible and shows that DV needs to be understood as a societal issue, as a crystallization of gender-based power relationships: Women are more often victims of DV which makes them more vulnerable to become homeless. This relationship between DV and homelessness is exacerbated by women's structural economic disadvantage. Furthermore, women in a situation of homelessness are more vulnerable to experience (further) GBV.

### 3- Enhanced collaboration between local services

Results from both the online survey and the expert interviews show that there clearly is a **shared understanding of good practice** in terms of service provision to DV survivors. Good practice involves collaboration between local services, user-oriented service provision, training staff on DV, involvement of high-profile service providers, provision of support beyond the crisis moment which fosters survivors' self-esteem and sense of empowerment, provision of permanent housing, provision of legal assistance and, last but not least, support provided free of charge. In terms of innovative practice, work with both survivor and perpetrator to develop safe solutions should be cited (e.g. project coordinator Kadera) as well as 'Sanctuary Schemes' which allow the survivor to stay at home in a safe way.

Organizations are much more effective in supporting survivors of DV when the whole organization is DV-informed. Housing providers and other social services should aim to provide all staff who directly works with women with basic DV training, based on **gender-sensitive, psychologically- and trauma- informed** approaches. Housing providers and homeless services should strengthen **collaboration** with local **DV-specialist services**. As for the UK context, DV training can also contribute to establish a better understanding of DV and particularly for how it is different from ASB and needs a different organizational response.

### 4- Support services: follow women's needs, empower women, build trustful relationships

In terms of **improvement of current service provision**, research among survivors provides excellent guidance: Services need to provide time and space so that trustworthy relationships between survivors and support workers can be established, based on empathy and compassion. Women must have full control over the support process, in case of rehousing, more than one option should be provided. Particularly with regard to homeless services, more **women-only services** or at least women-only spaces should be established as gender-mixed services do not meet survivors' safety needs. **Active involvement of service users** contributes greatly to improve service set-up and delivery, ensuring that women's needs are met. Many women benefit greatly from exchange with other survivors.

As a conclusion, we would like to underline the progress that have been made in DV increased awareness and the consequent improvement in preventing and addressing the issue. The issue of DV and GBV remains a

<sup>69</sup> Mayock, P., Bretherton, J., Baptista, I. (2017). Women's Homelessness and DV: (In)Visible Interactions, p 130. In P. Mayock & J. Bretherton (Ed.), Women's Homelessness in Europe (pp. 127-154). London, UK: Palgrave Macmillan.



dramatic reality that must continue to be addressed. We believe the above-mentioned recommendations and the overall conclusion of the SAH project will enable public authorities and service providers to work better together for an increased protection of the victims of DV and GBV.



## 8. Appendix I - Questionnaires

### Questionnaire housing providers & homeless services

1. Please indicate:
  - a. I work with a homeless service.
  - b. I work with a housing provider.
  
2. In your country, do homeless services // housing providers provide specific support services to individuals affected by DV? We refer to any kind of service that supports women, men and children who are directly or indirectly affected by DV, such as shelters, temporary or permanent accommodation, counselling, vocational training or work integration programs etc.
  - a. Yes
  - b. No
  - c. Don't Know
  
3. In your country, is specific training on responding appropriately to DV available for staff in your sector?
  - a. Yes, there is specific training
  - b. I think that there is specific training but I am not sure.
  - c. No, there is no specific training
  - d. Don't Know
  
4. Please think of the services that work with homeless persons in your country // Thinking of housing providers in your country: To what extent are services able to IDENTIFY cases of DV?
  - a. More than 50% of organizations are able to identify
  - b. More than 25 % of organizations
  - c. Less than 25 % of organizations
  - d. Don't Know
  
5. Again, regarding homeless services // housing providers in your country: Do you think that services are able to RESPOND appropriately to cases of DV?
  - a. More than 50 % of organizations are able to respond appropriately
  - a. More than 25 % of organizations
  - b. Less than 25 % of organizations
  - b. Don't Know
  
6. Does your organization address DV in any of the following ways? Please indicate: (multiple choice)  
**HOMELESS SERVICES**
  - a. Providing material which aims at raising service users' awareness of DV (DV)
  - a. Support material that directly addresses service users experiencing DV
  - b. Information that your frontline staff provides in face-to-face contacts with service users experiencing DV
  - c. No, we do not provide any of the above listed
  - d. Other material / activity which addresses DV among homeless service users- please specify:  
**HOUSING PROVIDERS**
  - a. Providing material which aims at raising tenants' awareness of DV (DV)



- b. Support material that directly addresses tenants experiencing DV
- c. Information that your frontline staff provides in face-to-face contacts with tenants experiencing DV
- d. No, we do not provide any of the above listed
- e. Other material / activity which addresses DV among tenants- please specify:

7. (HOUSING PROVIDERS & HOMELESS SERVICES) Please think of the housing providers // homeless services you know in your country: Organizations have a (multiple answers)

	More than 50 % of organizations	More than 25 % of organizations	Less than 25 % of organizations	Have no policy	Don't Know
Stand-alone DV policy					
Stand-alone anti-social behaviour policy					
DV policy as part of an anti-social behaviour policy					

8. (HOUSING PROVIDERS ONLY) In your country, do housing providers treat perpetration of DV as a tenancy breach?

- a. Yes, we treat DV (DV) as a tenancy breach.
- b. No, we do not treat DV as a tenancy breach.
- c. Yes, we treat DV as a tenancy breach and also have an agreed policy on this.
- d. We have an agreed policy but in practice do not treat DV as a tenancy breach.
- e. Don't Know

9. In the last 2 questions, we would like to ask you about services that you consider to be good practice in terms of responding adequately to the needs of individuals affected by DV. Do you know a service or project that could be considered as good practice? If yes, please indicate the name of the organization, the name of the service / project and a website:

- a. Yes, please indicate below: & text box
- a. No, there is no good practice I am aware of in my country / city / region
- b. I don't know any good practice

10. What makes this service a good practice? Please give at least 2 reasons:(Text box)

**DESCRIPTIVE CHARACTERISTICS**

11. How many years of experience do you have working in the homeless // housing sector?

- a. 0-5 years
- b. 6-10
- c. 11-15
- d. 16-20
- e. 21+ years

12. Please specify in which environment you mainly work:

- a. City / urban area
- b. Town
- c. Rural area





13. Do you identify as:
- a. Female
  - b. Male
  - c. Other
14. In your opinion, are housing providers // homeless services in your country interested in addressing DV?
- a. Very much interested
  - b. Interested
  - c. Very little / not interested at all
  - d. Don't know
15. Please select your current country of residence:
- a. Austria
  - b. Belgium
  - c. Bulgaria
  - d. Croatia
  - e. Cyprus
  - f. Czech Republic
  - g. Denmark
  - h. Estonia
  - i. Finland
  - j. France
  - k. Germany
  - l. Greece
  - m. Hungary
  - n. Ireland
  - o. Italy
  - p. Latvia
  - q. Lithuania
  - r. Luxembourg
  - s. Macedonia
  - t. Malta
  - u. Netherlands
  - v. Norway
  - w. Poland
  - x. Portugal
  - y. Romania
  - z. Serbia
  - aa. Slovakia
  - bb. Slovenia
  - cc. Spain
  - dd. Sweden
  - ee. United Kingdom



## Questionnaire expert interviews

1. In your country: How do you estimate the homeless sector's / housing sector's general ability to provide individuals affected by DV with appropriate support?  
E.g. keeping affected persons safe (adults and children), work with perpetrators and hold them accountable, hold agencies into account etc.
2. How would you describe the level of awareness of DV and how DV affects people among homeless services / housing providers in your country?
3. (Housing providers only) How do public or social housing providers usually deal with cases of DV?
4. In your opinion, in your country, do frontline staff receive the necessary training to respond appropriately to individuals affected by DV (women, men and child survivors and also perpetrators)?
  - a. Do homeless services / housing providers have a policy of mandatory DV training for staff who directly works with affected persons (adult and child survivors)?
  - b. Is there mandatory training for staff working with perpetrators?
  - c. Do homeless services / housing providers have a DV policy?
5. (Homeless services only) How do you estimate the service staff's ability to identify cases of DV?
  - a. Do you know if services measure their staff's ability to identify cases of DV?
  - b. How? What criteria would services use to determine whether their staff is able to identify cases of DV?
6. (Housing providers only) How do you estimate the ability of housing providers to identify cases of DV among tenants?
  - a. Do you know if housing providers measure their staff's ability to identify cases of DV among tenants?
  - b. How? What criteria would housing providers use to determine whether their staff is able to identify cases of DV?
  - c. Do you know of housing providers that work in close and continuous contact with their tenants and can thus better detect cases of DV?
7. (Housing providers only) Are there organizations that provide specific support to tenants who have experienced DV?
  - a. If yes, what type of support?
8. (Homeless services only) In your view, to what extent do women become homeless because of DV?
  - a. In your view, to what extent do perpetrators become homeless (due to tenancy breach rules, after a complaint at the police etc.)?
9. In your country, are there any referral systems in place to support women affected by DV? For example, do homeless services cooperate with public / social housing providers on a regular basis or are there other forms of cooperation? Do housing providers cooperate with anti-DV services or other housing providers to house survivors as quickly as possible and refer them to specific support services?
  - a. If yes- please describe who is involved and how
  - b. No
  - c. Don't Know
10. To what extent are policy makers at local or national level aware of DV as an issue?
  - a. In your view, how much priority is given to DV? How would you rate that on a scale of 1 to 5, with 1 representing low priority and 5 high priority?



11. In the homeless / housing sector: Is DV perceived as a stand-alone issue or rather as a form of anti-social behaviour? Can you see a difference between how services respond to DV compared to ASB (also in terms of identifying ASB and related organizational policies)?
12. Do you know about any best practice projects? I am thinking here of outstanding and/or innovative initiatives / programs that tackle DV (e.g. very good in identifying / tackling DV, organizations that have developed specific ways of working with tenants or homeless women with experience of DV or with perpetrators, have built up very good reference networks etc.)?



## 9. Appendix II

Housing providers: all answers to “what makes this service a good practice” (previous question was on naming good practices)

- Regular feedback and auditing
- MATAC - perpetrator focus / working with perpetrators
- Work in networks & collaboration: with other HPs, with local housing providers and the local authority
- mediation and de-escalation services
- 24-hour reachability and consulting, particularly psychological consultancy
- Provides housing 2 (mentions) / helping keep tenancies
- support to grow into new community
- People know it / community knows it / provides DV training to other services
- support open to all
- Multi agency approach
- Trained staff/ expertise / taking on expertise and best practice of others
- Focus on work with DV survivors 2 / specific service/support
- offering floating support and help to stay (move perpetrator away not survivor)
- strong financial backing
- outreach work
- DAHA - whole organisation accreditation
- Get men involved to stand up against DA
- victim led
- provide safety and wellbeing
- psychological support

Homeless services: all answers to “what makes this service a good practice” (previous question was on naming good practices)

- Red working between specialize police department and social support / local contacts / locally well known (2 mentions)
- support survivor to build an autonomous pathway
- listening
- provide temporary housing & support to help to start a “new life project” (2)/ focus on empowering survivor
- provides training on labour market relevant skills (Financial Literacy Training & soft skills training) & assistance to get back to work
- offer safe place where survivors can “talk about violence” / Protection - therapy
- well trained & experienced staff
- User oriented 2
- victims and potential perpetrators are educated in healthy relationships.
- Free and public service
- collaboration with perpetrators support programme / Direct work with victims and perpetrators
- immediacy
- continuous (beyond short-term) accompaniment
- Multidisciplinary team, legal assistance & psychological