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Multidimensional Trauma and Systems Change in Rotherham

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1 Introduction

This research report is the result of a one-year project funded by Sheffield Hallam's Early Career Research and Innovation Fellowship, aimed at supporting promising researchers to take the next step in advancing their research careers and independence.

The research is a development of the networks and knowledge gained through two significant influences: firstly, my PhD research exploring the experiences and needs of women with a history of survival sex working and problematic substance use. My PhD found that a primary driver behind women's problematic substance use and a barrier to their recovery is the experience of trauma at individual, systemic and community levels, which I term 'multidimensional trauma'. Secondly, since 2018 I have worked with Rotherham's Trauma and Resilience Service (TRS).

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The Trauma and Resilience Service (TRS)

The Trauma and Resilience Service (TRS) is a small multi-professional group made up of senior mental health clinicians with substantial experience; as clinicians and managers of services, and of working with people suffering from complex developmental trauma. The team is led by a consultant psychotherapist with a background of working with children and families who is also a trained organisational consultant. Senior clinical specialists with backgrounds in nursing, social work, clinical psychology, and child psychotherapy also have training in systems and psychodynamic approaches. The service sits within traditional NHS mental health services within RDaSH NHS Foundation Trust but is co-located within the voluntary sector. The service is supported by Rotherham CCG and is funded by NHS Health and Justice in relation to 'The Strategic Direction for Sexual Assault and Sexual Abuse Services 2018-2023' policy document. The service was commissioned in 2018 in response to the Jay report 2014.

The TRS is in its seventh year of developing services for adult survivors of child sexual exploitation (CSE) and their families. The TRS is a complementary service whose role is to facilitate the provision of trauma-informed support by providing training, supervision, consultation, liaison, and commissioning in collaboration with voluntary and statutory services across Rotherham. It partners and funds several voluntary sector agencies and is also interlinked with statutory services of an increasing range to develop a CSE survivor support pathway for adults across the borough. While the TRS model began in Rotherham, it is now expanding across South Yorkshire and beyond, working to support survivors of CSE and CSA (child sexual abuse) through supporting professionals who work with them. This is being done through a new Pathfinders Service commissioned by NHS England Health and Justice and includes rolling out the TRS model across South Yorkshire, offering Trauma Matters training, commissioning in mental health to reduce siloed working across organisations that support people who have been sexually abused, and enhance the mental health offer for people experiencing complex trauma.

The Trauma Network is an informal and inclusive community of practice made up of individual practitioners and organisations that have benefited from the training and workforce development opportunities that have been provided by the TRS. For example, over 1000 practitioners from a range of organisations have attended a variety of training since the inception of the service in 2018, mainly the 'Trauma Matters' day package. Also, numerous practitioners have attended CPD conferences and events linked to deepening the appreciation of complex trauma within a safeguarding context. Numerous others have been trained in the TRS trauma stabilisation programme. The vision of the TRS is to augment a systems wide approach across South Yorkshire to enable victims and their families suffering from CSE to be valued and understood and find services accessible and compassionate.

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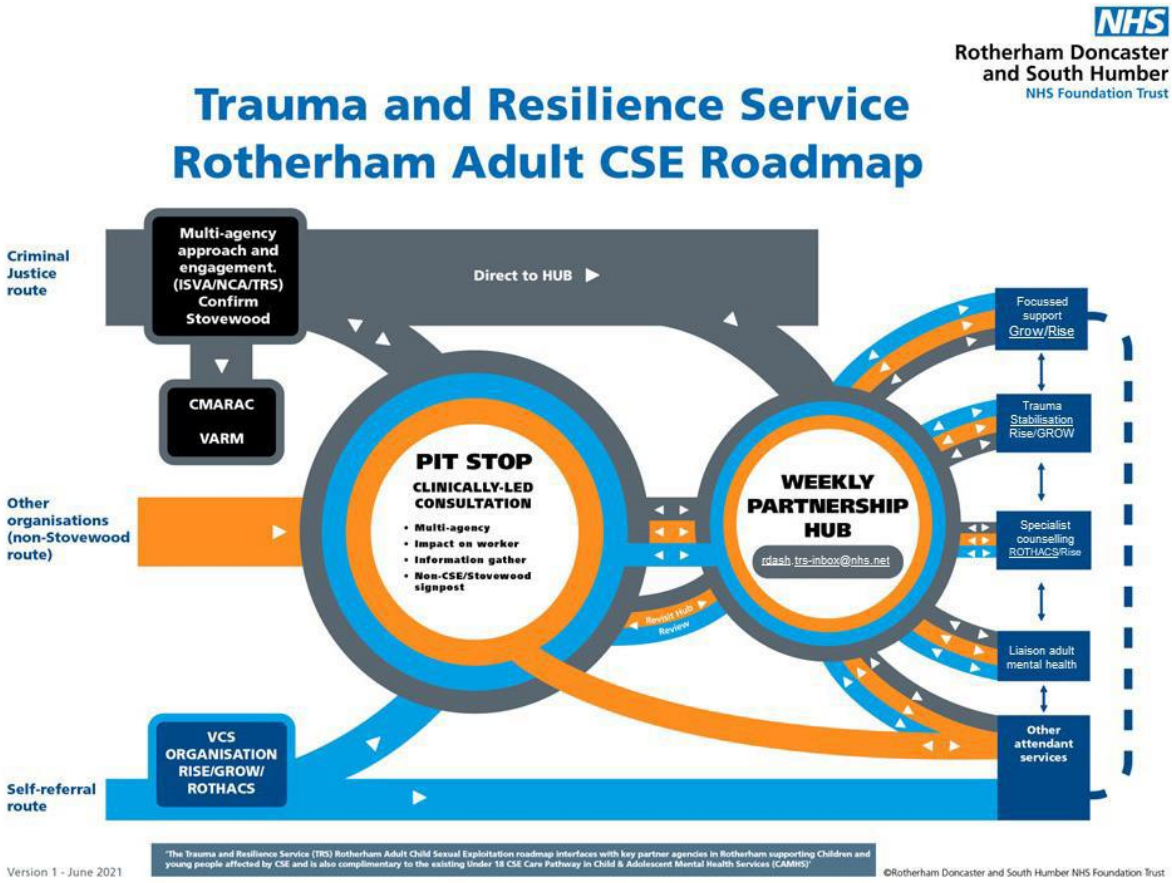
The research

This report describes the findings of a part time one year research project exploring the impact of trauma-informed systems change in Rotherham through partnership with the voluntary sector, part of a trauma-informed network developed across statutory and voluntary services, spearheaded and driven over six years by the Trauma and Resilience Service (TRS) through a unique model. The research highlights the voices and journeys of a small sample of survivors, and because of the research design and approach to engagement, unveils the impact of a trauma-informed voluntary sector via specialist training, consultation and multi-agency working.

This report uses the author's concept of Multidimensional Trauma to assess the impact of systems change, exploring levels of individual, community and systemic trauma and resilience. Namely, on the symptoms and wellbeing of individual survivors, upon community health including levels of social integration, education and employment and on the ability of systems and services to engage with and support those who have experienced trauma in empowering, compassionate and transformative ways.

My interviews with professionals were predominantly with voluntary sector workers from GROW and Rothacs[1] (Rotherham Abuse and Counselling Service) who had been survivors' regular point of contact and direct source of understanding of trauma and coping skills. This meant that survivors identified these professionals as trusted sources they were happy for me to speak with about their experiences and journey. Behind the scenes, the Trauma-Informed Network operates as a constellation of multidisciplinary relationships and interactions that support, guide and collaborate with the voluntary sector workers who, to survivors are the 'face of' rather than an aspect of the interface. This arrangement of commissioning and working is unique in its promotion of consistent, cohesive joint working where a range of services with different expertise come together to provide responsive, flexible whole-person care through formal and informal regular information sharing, reflection with the support of a trauma informed clinician and collective care planning. The interviews were unable to capture the nuance and the processes and interactions that have built the survivor-professional relationship that this report has focused on, but the diagram below demonstrates the structure of the Trauma Informed Network and the various ways professionals from a range of services are constantly working together to optimise the care provided to survivors. The complexity of the system and the vital creative and bold commissioning behind it,[2] which embeds multi-professional communication and collaboration, is explored in greater detail in the Case Study, which presents a single survivors' story and the experiences and interactions with and between services within the trauma-informed network.

[1] Rotherham Abuse Counselling Service - How Can We Help?
[2] The TRS is able to commission voluntary sector organisations, so they are able to act as sub-commissioners to design and develop the Trauma-Informed Network.



This research takes the concept of the Trauma Informed Network (TIN) further, exploring its impacts in terms of The Multidimensional Trauma-Informed Rotherham (MTIR). The MTIR findings advance a concept developed by the author following her PhD exploring the life course experiences and needs of women with histories of street sex working and problematic substance misuse (PSU) and her six years of research with the TRS. 'Multidimensional Trauma' recognises that trauma can occur on multiple levels that can interact and intersect to cause greater and more complex traumas. The Multidimensional Trauma Framework comprises:

1. Individual Trauma.
2. Community Trauma.
3. Systemic Trauma.

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Methodology

This research builds on relationships established with the TRS and voluntary sector, where services were already familiar with the researcher and her competence, intentions and trustworthiness.

The aim of the research was to build a holistic understanding of a handful of survivors' experiences and journeys, to develop a baseline understanding of the potential impact of trauma-informed systems change in the multidimensional impact upon trauma at individual, community and systemic levels. The findings indicate that the systems change pioneered by the TRS and occurring across voluntary and statutory sectors in the borough to varying degrees, is transforming the impact of trauma and thus building resilience, reducing shame and improving quality of life and futures at every level. The result of which is conceptualised as a Multidimensional Trauma-Informed Rotherham, a borough that is overcoming its historical and ongoing experiences and reputation through systemic change that supports individuals and organisations, with consequences for survivors, their families, services and the wider community.

To encapsulate both the experiences of survivors and the impact of and processes behind systems change, survivors *and* **trusted professionals** identified by survivors were interviewed. Trusted professionals were voluntary sector workers who played and continue to play key roles in the Trauma-Informed Network and who have benefitted from the support, training and guidance provided by the TRS model. These professionals are described as 'trusted' because, a.) survivors have built therapeutic relationships with them over time, and b.) survivors taking part in the research gave their consent to the professionals being interviewed in their capacity as a trusted other with in-depth, reliable knowledge of the survivor's experiences.

The design of the research was first and foremost trauma-informed and this involved careful consideration of the principles of trauma-informed care at every stage of the research design and an element of co-production via ongoing workshops with professionals from the TRS to inform an iterative, responsive and flexible design. The core principles of Trauma-Informed Care that have served as a framework for the TRS Evaluations and that merge the definitions as per Harris and Fallot's (2008) Trauma-Informed Systems of Car and SAMSHA's[3] (2014) Guide to Trauma-Informed Care. Safety, Trust, Choice and Control and Empowerment underpinned every decision and aspect. This included ensuring survivors were carefully selected with the support of familiar trauma-fluent workers who could advise on those who would be most able to engage without risking retraumatisation (this meant having successfully undergone trauma stabilisation work and so having a toolkit of proven strategies they could use to self-regulate), and who felt participation could be empowering and beneficial (for more, see Fisher et al, 2018).

[3] Substance Abuse and Mental Health Service's Administration.

Survivors' choice and consent was of critical value, and so approaching and engaging with participants followed a carefully designed process to ensure that survivors were informed about, consented to and informed the responsive design of research every step of the way:

1. First, survivors who had been identified were approached by their trusted worker who provided them with a flyer and information about the research, asking if they were interested.
2. If survivors gave consent, I would begin by interviewing the professional in the voluntary sector who was supporting them. These professionals had all benefited from and been involved in the TRS' training, clinical consultation and multidisciplinary networking and so are key elements in the Trauma Informed Network. Interviews with professionals allowed me to explore experiences that survivors might find triggering to discuss and so provided a valuable opportunity to conduct thorough research while protecting survivors from revisiting trauma. These interviews also allowed me to ask professionals about any less overt triggers for survivors and to use this extra layer of more intimate knowledge to tailor research questions to each individual survivor, again prioritising safety.
3. Survivor interviews were designed according to this insider knowledge and focusing on empowering survivors through exploring their strengths and successes, including their knowledge of self, confidence, achievements and plans for the future.
4. Survivors were asked about other professionals who had been important on their journey; two survivors mentioned ISVAs, (Independent Sexual Violence Adviser, both of whom worked through the voluntary sector service partnered with the TRS), one a police officer (who had initially been willing to be interviewed but after the riots of 2024 went 'off the radar', understandably). Other survivors did not have professionals (beyond their voluntary sector trusted professional) they could mention in a positive light; this could be due to the absence of them or the nature of the Trauma Informed Network and the 'behind the scenes' nature of a lot of the training and consultation that has benefitted survivors without their knowledge. However, this is something that I hope to explore in future research.

In total, I interviewed seven survivors and 13 professionals. All 20 interviews were thematically analysed according to the Multidimensional Trauma Framework and the principles of Trauma Informed Care. I constructed a case study around one survivor where I interviewed multiple professionals involved in provision of support and I received a clinical case consultation with the TRS on my findings and reflections around this survivor, to add an extra layer of trauma-informed understanding to the research experience and design as well as to the processing of the data.

4.1. Context and limitations

This research makes an important and original contribution to knowledge on the impact of trauma-informed systems change upon levels of multidimensional trauma and resilience in and around Rotherham.

However, it is important to acknowledge and contextualise the project's limitations. It is a small-scale project and thus restricted in scope and length. Due to this, there are several caveats to bear in mind when reading this report:

1. My relationships with services in Rotherham and the Trauma Network have been established over seven years; systems, professionals and organisations in the borough have experienced organisational trauma due to both the scale of the abuses suffered and the public focus on professional culpability, and so similarly

to survivors, professionals also had and have barriers and issues with trust, so there were many protective barriers to overcome to be able to conduct this research. This raises an important point about expectations of researchers to be able to swiftly engage with services and populations who have experienced trauma and stigmatisation. It takes time for survivors to feel safe through being able to take a leap of faith in placing trust in the unknown, and to have that leap validated, through receiving compassion, and seeing that positive words are followed by positive actions. The same is true when building the relationships that are critical to precede a research relationship when working with professionals who may have experienced organisational and vicarious trauma and whose work is especially complex, who are held responsible for complicated and difficult problems, and whose role can be misunderstood and critiqued.

2. The survivors I was able to speak with are those who are in a stable, supported place and who, through higher levels of human, social and physical capital, may have experienced fewer traumatic experiences and thus higher levels of resilience and capacity to resist the impact of trauma. Because of this, these survivors may be considered 'high functioning' compared to those survivors who are perhaps most in need of trauma-informed support due to their marginalisation and the extent and complexity of their unmet need and trauma. However, these survivors are harder to ethically and safely engage in research because they are often earlier on in their 'journey', more vulnerable and less engaged with available support because of their often entrenched distrust of others, socially and in terms of professionals.

The survivor whose experiences are presented as a case study is one of the more vulnerable survivors, who did not have the levels of capital that enabled other survivors to engage with and benefit from support more effectively, and to progress further in their trauma recovery.[4] This survivor's challenges and the complexity of her trauma due to the repeated, ongoing nature of the traumatic experiences she has suffered might meet normative expectations about survivors in Rotherham. However, it is important to note that there is no 'typical' survivor, and that survivors may have higher or lower levels of complexity, unmet need, and resilience but all are equally valid and deserving of the compassion and appropriate, accessible support that can accompany trauma-informed systems change.

Because of the limitations of time and capacity, the most effective and efficient approach to engaging survivors and speaking with the professionals supporting them was through the trauma-fluent voluntary sector who have been jointly commissioned by the TRS, and so the findings of this report are somewhat centred around the impact of the voluntary sector on individual, systemic and community trauma. However, this is not to say that other sectors are not playing important roles and also undergoing system change to better engage, understand and empower survivors. The Trauma Network is incorporating statutory services including the police, social services, healthcare and mental health services. While survivors in this report describe challenging and upsetting experiences with these services, this is not an indictment of the sectors as a whole, but an illustration of what survivors experienced and felt in their interactions with them at moments in time. These snapshots of survivor experience can inform future approaches from these services, justifying their increased use of trauma-informed approaches and the value of collaboration with the Trauma Network.

[4] Judith Herman (2015) describes trauma recovery as a three-stage process, albeit one that is non-linear. This entails 1.) the establishment of stabilisation and safety to empower survivors to be resilient against the effects of the past in the present, 2.) processing of the trauma by looking to the past and 3.) integration where survivors are able to look to the future. However, as discussed in this research, whether survivors progress through all three stages is dependent upon what the individual finds helpful but also the level and complexity of their trauma and the extent to which safety can be achieved.

This research reveals an important piece of a critical puzzle; that is, the role that trauma-informed systems change may play in supporting a community to recover from and build resilience against complex and chronic trauma at multiple levels. Rotherham is by no means alone in having experienced complex, chronic and recurring trauma that has taken effect on individuals, services and the whole community. The next steps are the submission of an ambitious proposal for a longitudinal project over several years to a.) capture the journeys and experiences of harder to reach, more vulnerable survivors. b.) assess the economic impact of providing long-term, open door trauma specific support to survivors in comparison to the likely consequences of untreated trauma, including its intergenerational transmission c.) delve further into the nature and impact of vicarious trauma for professionals supporting survivors- how it manifests and the impact of management strategies including clinical consultations and grounding techniques d.) further highlight the entirety of the Trauma Network as it expands across South Yorkshire, incorporating services from the statutory sector including mental health care, primary health care and the criminal justice system. e.) capture any regional differences in trauma and resilience within South Yorkshire using the multidimensional trauma concept, including; survivor histories, needs and presentation, services' remit, capacity and experiences of becoming trauma-informed and how this plays out in the community.

Many illustrations of the importance of longitudinal research arose during this project, although one stands out. I discovered after my interview with their voluntary sector professional that I had previously interviewed one survivor in 2021; in the three years since that interview, the woman described by their professional bore little resemblance to the person I had spoken to, having blossomed in wellness and confidence and now pursuing her passions professionally and in the community. Unfortunately, for reasons I cannot know, I was unable to arrange an interview with this survivor this time. Because of my time constraints, I did not want to 'chase up' contact repeatedly in such a short period of time to avoid the survivor feeling pressurised. The survivor whose case study stands alone also went through periods of fluctuating stability and wellness, and while her desire to add her voice to the research was consistent, her ability to do so waxed and waned as she worked through various struggles. It is the unpredictable and inconsistent nature of trauma and of the human condition itself that a longitudinal project will be better poised to capture, charting the shifts in survivors' lives and the years needed to engage and build trust with the hardest to reach survivors.

5 Findings

Some survivors do not 'tick the boxes' for what it is often **presumed** a survivor will 'look like'. This research mostly spoke to survivors who are outwardly 'well' and are not just coping but succeeding, or at least did not meet the typical assumption of an abuse survivor in services as somebody in visible crisis. It is important to recognise that there is no representative or typical survivor, but that the presentation of trauma often varies, influenced by a myriad of factors including survivors' prior levels of social and practical capital, the accessibility and quality of professional support available to them, the presence of further threats and their health and quality of life.

The higher levels of coping shown among the survivors spoken to in this research attests to the more subtle but nonetheless insidious effects of trauma, where some survivors are better able to 'mask' and live outwardly acceptable lives. However, this does not mean the effects of trauma upon them are not significant. These survivors experienced debilitating anxieties and often had difficulties with letting down the protective walls that allow them to appear 'well', meaning their relationships with their children, friends, family and partners could be superficial, they were unable to place true trust in these people and so while often in company, were frequently alone. Furthermore, the effort of masking can be debilitating physically and mentally, too, and at some point this is no longer sustainable, when crises may emerge, betraying the suffering and agony that the survivor has been wrestling with for decades beneath the surface.

Many survivors are more overtly struggling and experiencing chronic complex unmet needs, including mental health crises, substance use problems, housing instability and homelessness, anti-social behaviour, criminality and loss of custody of children. Alongside these difficult experiences, there is often regular involvement of services that can increase trauma (such as social services and police). Such survivors' experiences are comparatively few in this report for two reasons:

1. As demonstrated in this research report, building relationships with survivors takes time, whether professional, research or personal, and survivors who have experienced lifelong trauma and adversity need time in which to build trusting relationships. This was not possible with this project but is the intended focus of a longitudinal bid that will target more complex survivors with higher needs over 7 years to explore how their ability to trust and engage develops and (likely, given the non-linear nature of trauma and trauma recovery) fluctuates.
2. Because of the greater level of need and complexity of this population of survivors, they were less likely to meet the inclusion criteria of this research; primarily, that survivors must be safe and stable and have benefited from trauma-informed support to enable them to be in the best place possible to take part in research. A longitudinal research project that could have an 'open door' for such survivors could have more potential to engage with harder to reach survivors in a safe and ethical way, as well as further attesting to the role that long-term availability of professional support may have for certain groups.

The demographic captured in this report is an illustration of the importance of time and patience in being able to engage survivors who are perhaps most in need of support and whom the TRS make focused efforts to engage and represent; survivors' circumstances and timelines vary with the individual, and the greater the length of time, the greater the capacity of research to follow these journeys.

Because of the supremacy of time in multiple ways (in building relationships, accepting change, charting outcomes and in the severity of trauma) and this must underpin trauma-informed support and systems development if it is to be seriously committed to and expected to see results.

1. Even the survivors who were successfully masking and present as high functioning needed lots of time and a sensitive approach from professionals that a) allowed them to engage and disengage when they were overwhelmed/ their window of tolerance was threatened,[5] and this be understood as a natural part of working with trauma, not a sign of disinterest, incapacity or an unsuccessful intervention. Crucially, being able to disengage before imperilling the window of tolerance also avoids survivors suffering more, due to the unhealthy coping strategies, unbearable distress and return of intrusive thoughts and feelings (Hershler, 2021); b) did not expect 'hard outcomes' within rigid timelines; c) understood that trauma damages survivors' ability to trust and thus to connect and engage with peers, family and friends but also professionals. This trust must be established first before any work can begin, and this reflects Judith Herman's three-stage trauma recovery model, wherein safety and stabilisation must precede any work looking to the past, to help the survivor tolerate its impact on the present.
2. For survivors who may have experienced repeated traumas throughout their life course or have had less by way of protective factors and resilience and may have co-current needs such as problematic substance use and homelessness, their ability to trust is especially tarnished; consequently work to engage and support these survivors should be expected and understood to take a long time, and this should be acknowledged in expectations of services. For survivors, these difficulties could present as a greater reliance on services including professionals holding a more central role in survivors' lives, meeting unmet relational needs where survivors have been unable to develop friendships or have had absent or traumatic experiences with family. (See 5.1.)
3. Bringing services into a trauma-informed network also takes time, and the professionals I spoke to have been involved with the TRS model for years, so have undergone a journey themselves involving an expansion of their way of thinking and working that has naturally also involved overcoming their own challenges.

5.1. Case Study, Survivor M

Before presenting the main report findings, which focus on the higher functioning survivors who comprise the majority sample of this research, the below case study sets the scene for the complexity facing survivors and systems, and of the vital insight provided by trauma-informed approaches.

Survivor M's story is set out as a case study because her experiences involve long-term connections with a network of services and illustrates the importance of trauma-

[5] See Hershler, 2021; The Window of Tolerance describes the threshold in which individual can tolerate stressors and challenges; this varies according to the individual, and for traumatised individuals, may be more easily breached.

informed collaborative working. It also raises important points about the nuances and challenges of supporting survivors who have experienced lifelong trauma. Survivor M was described by the several professionals I spoke to, as very well supported and able to access that support, as well as being skilled, resourceful and often very strong. However, she has also experienced multiple traumas throughout her life from her earliest years and has experiences of trauma that can be described as multidimensional, including interpersonal experiences, isolation and rejection in the community and experiences of services that have felt punitive to her.

For this Survivor, I felt I needed and I was able to have my own trauma-informed clinical consultation by using some of the interviews with other professionals to explore my reflections, thoughts and feelings about some of Survivor M's words. This is a somewhat meta-form of research as I took my trauma-informed approach to the next level by utilising one of the core functions of the TRS, the clinical consultation, for myself, to support myself but also to further apply a trauma-informed approach to my data. As a result, this case study is interspersed with reflections that have been sense checked by and explored with clinicians to get a deeper understanding of the impact of trauma upon this survivor's experiences.

The clinical consultation gave me valuable insight into the role that this function can play in the Trauma-Informed Network from a professional perspective. I found the opportunity an ineffably valuable space to sense check and sound out my reflections upon the data from my interview with Survivor M, drawing upon what I had been told about this survivor by other professionals in her network and my own impressions and understanding of trauma. By exploring this with clinicians with unique specialist knowledge of the psychology of trauma and of this survivor, I was able to get a deeper understanding of the data but also to mitigate against any impact of my own vicarious trauma. For example, my I realised post-interview with Survivor M that I had not asked about her positive experiences of trauma-informed support. I had a strong desire to re-interview Survivor M to pick this up, despite it not having naturally emerged in the interview. We considered that this reflected the strong sense of responsibility and urge to provide care that was triggered in many professionals when working with Survivor M. On reflection, the absence of this topic from the interview despite it taking front and centre in all the other interviews also reflected where Survivor M was in terms of her 'selves'; professionals spoke of her alternately as being both capable and very much in need of intensive support. In more difficult times, it seemed that Survivor M would 'default' to her inner child, being hyper vigilant for and extremely reactive to perceived lack of care, of being seen as not important or in need enough to be given support and attention. I spoke to Survivor M in an especially vulnerable time, when she was in hospital under a mental health section and being observed every 15 minutes following an NFA (no further action) verdict from the National Crime Agency and her very supportive relationship with a voluntary sector professional having been drawn to a close. As a result of this, the Survivor M I met and that comes across in much of this case study is a survivor who felt very let down, was analysing every aspect of her environment and interactions for signs that she would be failed or overlooked, and who was focused on 'filling the void' her younger self suffered in terms of the lack of a present caregiver. It is unsurprising, in this context, that we did not explore her strengths and positive experiences, and that while Survivor M did respond positively to writing to me about this, I did not hear back from her. In her stronger times, professionals described someone who was very capable, had provided support to other survivors as a peer, who was fluent in trauma-stabilisation, had been very successful in her studies at college and who had a clear future and goals ahead of her.

> *Everyone I spoke to said that she was really capable, but was also really, really isolated. So in terms of family support, Survivor M has next to no family support. She has a Nannan, which is pretty much the only support she has. She's in contact with a mum and dad, but her mum has been neglectful and emotionally*

abusive since Survivor M was about six.So she's been in and out of lots of services, sort of through childhood, but never officially taken into care. But she was homeless, I believe around 14 and went into different sort of support living accommodations.

Because of Survivor M's childhood, she was sort of lost. She didn't really have much papers, weren't sure which was supposed to be doing, was never really given any guidance on sort of like your day-to-day living. (Professional K)

Survivor M has been 'in the system' for much of her life, and all the professionals spoken to attested to the level of support and the strength of the network around her. She is fluent in navigating the trauma network and can access support appropriately when she needs it.

So M understands what our service does really well and does use it when she's in crisis, when she's experienced self-harm and suicidal thoughts. She's used it prior to her admission, she uses the emergency department if needed attending there… In that moment, she's obviously got something very robust around her. She's got therapeutic intervention and support from lots of different services. (Professional M)

Having a network of services around her, especially those which come from a trauma-informed perspective and collaborate accordingly, meant that as well as having a high level of support, Survivor M was also receiving bespoke care that tailored responses and prepared services to meet her needs on an individualised basis. This was especially pertinent for services whose remit means they engage with survivors at their most distressed moments, when their need is felt greatest and yet where the service can only engage briefly.

In her previous experiences, before a management change in the NHS crisis team, Survivor M had experiences that she had felt invalidating and showed that professionals weren't taking her seriously or recognising how urgent her situation was.

I felt like they weren't listening to me or that it was questioning about what medication I was on, or they told me to go to the GP the next day… before I got admitted to here, so I was really suicidal. I was sat on the stairs like with a ligature around my neck kind of thing, and they want to stand the ambulance down. I felt like I didn't matter to them. Like, that I weren't important enough like to go to hospital to get help. I felt angry in a way. So I'm like, how can you possibly want to stand down an ambulance that's potentially going to save my life? (Survivor M)

What stood out here was how focal validation and being worthy of care and indeed, worth an emergency, was to Survivor M, and how carelessly chosen words or the text of routine procedure can be heard by survivors as harmful messages. Survivor M instead chose to phone her voluntary sector support worker and counsellor who talked to her on the phone and arranged for a mental health ambulance to attend, which provided her with the intervention and validation she felt she needed.

Luckily I got compassionate ambulance people and it was like the mental health ambulance vehicle which is vital; probably in Rotherham, which I think we need more of… they're trained paramedics within the paramedic service, and there's been mental health training... they came and they took me to hospital. They were really compassionate, making the hospital where of how serious it actually was. And I think the nurses in the hospital was understanding. I think if I got different nurses, I might not have been admitted… I've had experiences in past where like I've had nurses call me attention seeking… I've had ambulance staff call me

attention seeking before. And the nurses that have like put me in a hospital, made me sit there for hours. Not even notified the mental health team. (Survivor M)

Survivor M describes a pilot service that has been trialled in a few localities, where a mental health ambulance aims to provide interventions to keep people safe in the community where possible and to free up 'mainstream' ambulances. For Survivor M, the understanding and kindness that these specially trained paramedics showed and their ability to emphasise to other professionals the urgency and importance of her need was reassuring and soothing. To the contrary, previous experiences have been very destabilising, triggering negative emotions (e.g. anger and suicidality), due to experiences like the criminal justice system returning No Further Action verdicts, professionals describing her as seeking attention, or Survivor M feeling abandoned by the system, these all carry the message that she is not worthy or cared about.

I'm probably the only person that is glad to be on at Section 3 because it means I get section 117 for life. It means I get mental health service care for life when I'm out of hospital. They can't just drop me through the system like they have in the past. Like, oh, we can't help her. We can't do this. We can't. We can only offer what we're offering. (Survivor M)

Survivor M also expressed relief and a sense of security now that she had been sectioned, stating it meant she would now be eligible for mental health care in the community for life, meaning she would always be a priority and services could not disregard or dismiss her. I wondered how much this reflected her experiences as a childhood victim of group grooming. When taking this to clinical consultation, we reflected upon this remark and what it signified in terms of Survivor M's reliance on professional input to try and compensate for the internal insecurity and emptiness that began in her childhood neglect, as well as the absence of caregivers which was exacerbated by the horrific pain caused by her abuse and the lack of response to that. As one TRS clinician commented, wanting to be sectioned in a mental health hospital really speaks to a desperation for contact:

Because being in the hospital is horrendous, being in a mental health ward full of really ill people is also not a nice place at times, so there's something driving that need for care so strong and then I linked it to a reassurance that they'll always be there. They'll always be there. But then I thought about the word reassurance and I thought, short lived because I think what happens is that for that moment, for that time, for that section, her pain will ease. They will have to be here now. They will have to be here.

But it's short lived and then the void comes back , and even when she has these professional encounters, the big void that she's got doesn't get very full. It fills up a little bit, doesn't it? So then it gets emptied again, and then it's, you know, you're feeling empty. (Professional Q)

The concept of the 'void' left by childhood abuse and neglect and amplified by experiences of violence and abuse where again, nobody responds to or shows awareness of the survivors' pain. Many behaviours described in this case study are indicative of Survivor M's attempt to fill this void. Her scrutiny of interpersonal and professional interactions to screen out threat or to test trustworthiness demonstrate her need to have safe caregivers. Her coping strategies such as compulsive shopping and a desire for the guarantee of consistent, on tap care 'for life' are all indicative of the need for regular comfort. These are illustrations of one survivors' attempts to fill the vastness of that void, which provides some insight into the challenges services face when working through how to support survivors to face the void and address it proactively, in collaboration and then independently.

I was enormously struck throughout at how hypervigilant Survivor M was to the slightest (but to her, glaring) signs that somebody was not hearing her, not noticing her pain, or not caring about it, and the overwhelming presence this had in her life. The centrality of feeling validated, heard and being seen as a person whose life was worth saving felt intertwined with her awful experiences of abuse, that professionals have described as 'sadistic' and 'depraved'. This suggests strongly that when working with trauma survivors, an additional layer of specialism is required. Enormous care needs to be taken over words and actions, and following processes and procedures reappraised given the potential for survivors to be injured by feeling overlooked.

Survivor M described how when she had not been listened to by the NHS crisis team before, she was able to tell them to speak to her voluntary sector professional who 'made them listen' and take her to hospital. This revealed the strong relationship Survivor M had built with this professional who had become her advocate, somebody who people would have to listen to. Bearing this in mind, it is perhaps no wonder that the ending of this professional relationship could be especially challenging. Furthermore, it perhaps indicates how and why trauma survivors may become reliant on certain professionals, as they finally have somebody through whom they can be heard, somebody who will protect them. However, this dynamic unfortunately unintentionally reinforced the message that Survivor M alone is not enough, that her voice solo cannot be heard, and she is defenceless if independent.

The importance of 'active listening' became apparent throughout this report, but especially with Survivor M, where the centrality of being heard correctly was so important. For example, after she had explained she could not get up to remove the ligature from the stairs, she was told to go to the GP the next day – she analysed this and concluded that the person can't have been listening to her properly or taking her seriously because how could she go to the GP if she can't even stand up on the stairs? This kind of analytical, logical processing of interactions shows how careful the approach by professionals must be and perhaps speaks instead to the value of simply listening and reflecting what is heard. Repeating and checking survivor's words could be an important cornerstone of interactions, as could taking time to consider how ones' responses could be analysed and interpreted, perhaps altering them accordingly, or clarifying true intent. Admittedly, this doesn't lend itself to current processes in, for example, crisis teams, where a sense of urgency is naturally underpinning interactions, where resources and staff are scarce and pressure is high. However, if this could be a valuable approach, perhaps it could be considered and explored as an unconventional but specialist way to engage trauma survivors in particular. Being heard and being considered worth listening to properly was such a dominant theme that arose in this research that it seems reasonable to conclude that it is so for survivors, and this is a cornerstone of truly trauma-informed approaches. Also, this example speaks to the impact trauma can have on how survivors hear and experience seemingly meaningless or neutral interactions with services. Survivor M demonstrates hypervigilance, intensely analysing what people say and how they say it, or don't, looking for evidence that she is not being heard or listened to but also testing whether people really care and will really protect her. This is attested to by a TRS clinician when we reflected on the above incident in our consultation:

> *Let's see if you care for me and I can list some of the ways that I can (subconsciously) test to see if you're a trusting, safe person and the only way that she knows whether somebody possibly can be trusted is if they do the thing that she says she needs. And sometimes that's from that's coming from a different perspective to that professional of what she needs, like that crisis call, where the crisis call professional thinks the thing that she needs to do is to remind herself that she can take care of herself. She can undo the ligature. She can take autonomy and power. You know, they might have been coming from a place of thinking that's going to get her back into her sense of, you can do these things for*

yourself. You can make a choice to look after yourself . But Survivor M is then saying I can't make any choices. I need the ambulance. I need the crisis team to come in and do this for me. I'm relinquishing my own control and my own power, and I'm giving it to you. And then she's met with a message of the crisis team or whomever, saying we're not going to take that power and control off of you. We're going to try and empower you, but that must feel incredibly, abandoning and rejecting at that time. (Professional O)

This really speaks to the complexity of working with trauma survivors and the conflicting forces that can be at play within the self and even within professionals when trying to empower survivors and encourage resilience and independence. The changeability of this, as we see with Survivor M, who was described six months ago as being in a 'very different place', is also challenging for services who may not know the 'version' of the survivor they are going to encounter, and what kind of response may work best for them. This is another aspect of working with trauma which highlights the value of multiagency processes, including the Hub, where professionals can present a case and their thoughts and concerns to a range of other professionals from various sectors, including TRS clinicians.

She stated she had not had a care coordinator in her borough for over a decade, and that without the Trauma and Resilience Service and her ISVA, she would not be here. Survivor M acknowledged the important role the TRS and voluntary sector partners played in advocating for and supporting survivors who greatly need but struggle to navigate a complex network of services.

She (ISVA's) been quite helpful in the sense of, like, she's constantly being there trying to fight my corner with services and trying to get me the right services and I think if it weren't for the Trauma and Resilience Service in place then I think many people would of just fell through the net, all those survivors.

An important part of the trauma-informed network is the collaborative work between services sharing information to develop bespoke solutions for survivors, illustrated by Professional M below.

So a lot of the work I'm doing at the moment is around how we make the interventions matter because we are only involved for such a short period of time, so how can we make those interactions better? So we'd asked her ISVA through the MDT, the professionals meeting, to maybe think about that with Survivor M and give some suggestions which are helpful to the staff, so getting that prior knowledge is really helpful because quite often people are told to ring us with no expectation and obviously we've got to understand who that person is, understand what they're going through.

Ask lots of questions which might not be helpful to that individual, but if we don't know them, that's what we've got to do. We've got to determine mental state and risk, whilst establishing rapport, enable someone to feel comfortable, so any preparatory work where we can understand that individual and make that interaction better is gonna be really useful. (Professional M)

The result of this work was that while Survivor M expressed dissatisfaction to a different professional about her experiences with this service in the past, after this work was instigated by said service and carried out between professionals , the next time Survivor M was in great need, she had a positive experience that helped stabilise her.

Unlike survivors who are harder to engage with and reach, who may be excluded from support, or survivors who have only been able to build trust with one service and professional, Survivor M is very engaged in the system. However, this presents its own

problems in terms of how she is able to manage endings and the extent to which she can pursue independence, which must be a daunting prospect as it would mean losing the 'robust' network around her and many of the regular social communications and sources of validation, support and care that have punctuated her life over many years. Furthermore, Survivor M has not experienced the early developmental care and positive relationships with a caregiver that form our earliest attachment styles and our understanding of our place in the world and our value to others. Because of this, relationships with professionals, not peers, have become her world and the challenges of forming relationships that are reciprocal are something that her professional network felt may be a significant barrier to her independence.

Where endings of relationships with professionals coincided with destabilising experiences where Survivor M again felt devalued and unheard, this triggered serious crisis and a relinquishing of control on behalf of Survivor M: Twice, despite her perpetrators being sentenced for similar crimes, and the intensive evidence giving process Survivor M had bravely committed to for years, she found out that no further action would be taken. This, alongside the withdrawal of a trusted and central professional caregiver, led to Survivor M eventually being hospitalised due to suicidal ideation.

> *Interventions do come to an end, and with Survivor M given she's got so much in place, I can imagine that there will be a destabilisation for her, I think, Rebecca. I don't think it's a coincidence that I think that her ISVA was stepping out, the NCA was taking No Further Action and then we've got a hospital admission.*
>
> *Obviously from a historical perspective, something very similar happened last time. (Professional M)*

This raises questions about the extent to which it might be important for some survivors to be able to have ongoing access to professional support in some form or another, perhaps on a permanent basis until they are able to withstand setbacks and traumas *and* to have developed healthy, reciprocal social relationships to buffer these independently. Service delivery is often predicated upon achieving recovery or certain outcomes that will lead to endings, exit and independence . However, for survivors like M who get so much from professionals but struggle to make the step to self-reliance and independence, or for survivors who are facing a very severe constellation of traumas and disadvantages, is there currently lack or even absence of commissioning and service design to provide and accept lifelong support if needed?

Alternatively, Professional K described Survivor M has withdrawing from services and engineering her own endings when she felt misunderstood or not listened to or cared about by professionals. However, this could be less a sign of services no longer meeting needs (as these are services who M has used for extended periods of time and who she revisits) and more of a sign of Survivor M's need for particular kinds of support and her fear of independence.

In consultation with clinicians, we discussed Survivor M's experiences, especially with the crisis team wherein she presented with very particular needs, to be recognised and treated as an emergency, as a life worth saving, and for the crisis team to demonstrate this according to Survivor M's unspoken (and possibly unknown even to herself) criteria.

> *Let's see if you care for me and I can list some of the ways that I can test to see if you're a trusting, safe person and the only way that she knows whether somebody possibly can be trusted is if they do the thing that she says she needs. And sometimes that's from that's coming from a different perspective to that professional of what she needs. The crisis team thinks the thing that she needs*

to do is to remind herself that she can take care of herself. She can undo the ligature. She can take autonomy and power.

They might have been coming from a place of thinking that's going to get her back into her sense of, you can do these things for yourself. You can make a choice to look after yourself and she's saying I can't make any choices. I need the ambulance. I need the crisis team to come in and do this for me. I'm relinquishing my own control and my own power, and I'm giving it to you. And then she's met with a message of the crisis team or whomever, saying we're not going to take that power and control off of you. We're going to try and empower you, but that must feel incredibly, abandoning and rejecting at that time. (Professional O)

Certainly, Survivor M had intensively engaged with and benefited from a plethora of general and trauma-focused support and interventions in the past, however there were repeated patterns of intensifying demand and feeling unheard or rejected followed by cycles of re-engagement and help seeking elsewhere. This suggests that there is something in Survivor M's embedded distrust of others, her internalised system of evaluating the safety of others, and the conflict between her empowered adult self and her vulnerable, powerless past child, that trap the system and Survivor M in an unfulfilling cycle.

She's worked with lots of different services, so she's worked with therapists, she has done trauma stabilisation, she's worked with other sort of local community groups, with a residential and day care centre for vulnerable adults that do some quite intensive support. And she's had a lot of support off them through the years. But she kind of falls in and out of services mainly because she feels as though they're not providing her with what she needs, and then she kind of pulls back the service, takes that as though she's disengaged. They will close her, and then she feels that she's ready to re-engage and it becomes a never ending cycle for her. Professional K)

When I spoke to Survivor M she was in a somewhat precarious position given her historical experience with endings; her voluntary sector worker had closed her case as she was no longer able to support her and Survivor M was under section in a hospital out of area.

Like 'cause, I got no further action she has had to close my case now. She closed me yesterday. It feels like I don't know. I'm a bit scared a minute, but I'm in like a hospital, so I've got staff to talk to. I think if I was at home I'd probably feel like I've got nobody.

Survivor M did not have relationships with her family in Rotherham and wanted to emphasise that councils and housing departments in particular should be mindful of this for survivors. Survivor M wanted to move out of area to where she was under section as she has no family or connections at 'home', and also her perpetrator was due out on license and because of her case being marked 'No Further Action' was not eligible to any protection from him. He had threatened her and so she is naturally frightened about reprisals from him. However, councils do not recognise friends as local connections to justify moving, but for Survivor M, she feels the friend she has in the area and the opportunity to move away from the area of her abuse, the reach of her primary abuser and to be in an environment closer to nature would be hugely therapeutic for her as a trauma survivor.

My best friend for 25 years, lives out here… so I've got somebody, just, hopefully the Council can see trauma as much as other people. the hospital and my ISVA has done me a letter in support. 'Cause a lot of councils want local connection,

which I think's a bit wrong again, I think needs to change. Because some people don't speak to their families.

It felt like this next step could be pivotal; whether the council would approve Survivor M's move, then whether she would be able to secure suitable support there (she was unable to look into this without having housing in place) and whether this would live up to her expectations remains to be seen. This desire for relocation could also be understood in terms of her trauma manifesting as her search for 'perfect' or 'complete' care and validation, which the TRS clinicians and myself reflected seems to characterise a lot of her interactions with services.

People who've had Survivor M's experiences can go to a fantasy, a striving for a hope that there will be perfect care that exists. And I can just force it or access it by moving around , changing systems, changing locations and find this perfect care that's just out of my reach. I might be able to control somebody into giving me perfect care. I might be able to do or say the thing that will mean I can finally not have to just be with myself, that somebody else will literally kind of embody, will be with me to provide that closeness that didn't happen as a baby didn't happen as a child. (Professional O)

This quote from a TRS clinician emotively reveals a more compassionate interpretation of survivors' behaviours that can be accessed through a trauma-informed lens, that might otherwise be experienced by systems as frustrating or perceived as manipulative or unfair. Viewing Survivor M's symptoms and self-professed unmet need through this lens can also lead to a more compassionate, perhaps more appropriate understanding of this case study. Survivor M's perpetual search for the inner security and fulfilment she was denied in her developmental years, first by her mother and then, which was sadistically exploited by her abusers.

Survivor M primarily wanted to speak to me to share some of the indicators she had shown that she was in crisis that she felt professionals should be aware of in survivors that often go overlooked or treated singularly, with the symptom seen as the problem, not the root trauma. The commonality between all the indicators we discussed was that they served to soothe, provide a distraction, sense of hope and/or dopamine rush, which makes sense as a coping mechanism when experiencing unbearable trauma.

I can get quite needy and like in the past, then just phoning up all time and also I can get pretty distant, so it's like warning signs there like. There's also kind of like spending, buying things that I don't need and hoarding…the buying part of stuff has happened since COVID like to make me feel better. I need to buy stuff. Oh, it can you get more intense when I'm poorly. Or it could be like for some people, drugs and alcohol… that's another thing I know my friend depends on that, and then she's not alcoholic, but she she kinda drinks a lot, but when she drinks, she drinks to cope, and takes drugs to cope. But when she's seen A&E or something, they think that she needs help because its' the booze and stuff that's causing it. But it's not.So basically they're looking at like, oh, she's been drinking and she's took drugs and then self harmed rather than the deeper thing. The trauma there. But they're not looking at the trauma being there.

Here, Survivor M vividly describes the obfuscation of trauma that the absence of a trauma-informed perspective, especially in primary health care, can cause; where symptoms are problematised and survivors feel overlooked or treated as problems in themselves rather than seen as responding to trauma. This speaks to the value of a trauma-informed approach throughout voluntary and statutory services where a collaborative approach in which organisations share knowledge to work towards a shared vision in which trauma is recognised as the problem.

Survivor M also felt that crisis points could be avoided through community support which recognised the symptoms she described and used their presentation as a reason to investigate with trauma in mind. Professional K noted that if she were thinking about developing in-community support for Survivor M, she would be mindful of finding ways Survivor M can 'fill the void' herself, with professional support playing a supplementary role in supporting and facilitating this.

Indeed, there is a supplementary way of interpreting the above, enriching understanding with a clinical trauma-focused perspective – this does not discount the initial observations, but provides greater nuance. Through case consultation, I explored an alternative way of understanding Survivor M's description of her warning behaviours (compulsive shopping) as indicators professionals should look out for. We discussed the survivor's self-awareness and her ability to identify behaviours that meant she was struggling and her recognition of what that provided for her. We also acknowledged the strong network of support around Survivor M who she would ordinarily be able to approach for support and/or to draw upon trauma stabilisation strategies that she is fluent in to be able to respond to these warning signs herself. This triggered a really enlightening discussion about the two dominant 'selves' of the survivor, and how when in difficult times, she often reverted to the passivity and helplessness of her inner child, who was looking for others to demonstrate her worth and ensure her safety by taking full responsibility for her welfare.

> *It's so painful for somebody like Survivor M, who has not only gone through and survived all of the things that she's survived. She's left with this often conflicting message as an adult about who's responsible now, for things getting better and I feel like she moves between those positions of, well, other people have to do this to do more, other people have to do better and in a different way. And I'll reach out to housing, can improve or crisis team can treat me better or this person can just do something that will see the what's happened to me as a child. And no, I can't fix this.*
>
> *And then the other part of her that when she does feel gently, carefully supported to see herself now in that kind of adult role that goes OK whatever's happened to me is absolutely not my fault. But now the things that I choose for myself are about how can I build up that self to self, that sense of worth, that sense of value.*
>
> *And that when something feels really distressing for her, her core Survival Instinct is to hand over that to somebody else because you will feel emotionally very young inside. (Professional O)*

I thought about how helpful this insight could be for professionals in a group setting when thinking about Survivor M and reconciling their different experiences of her and their understandings and expectations of her vulnerability and capacity, and why and how that might change. Certainly, in the case consultation we also spoke about how sometimes professionals could feel overcome with an urge to step in and take control to help Survivor M in any way they could, assuming the role of the caregiver and protector that had been so markedly absent in her most vulnerable, developmental years.

Another recommendation Survivor M made was for greater recognition to be given to the therapeutic potential of emotional support animals; her dog has been a critical form of support, especially where relationships with others are absent, and her dog plays an important role in helping with her social anxiety and difficulties going outside. While the UK is nominally a 'nation of animal lovers', there does seem to be a gap between this status and our use of animals as partners in healing, as sources of protection, compassion and safety.

When I struggle with like social anxiety and different things then I've got to get it (shopping) back and I've got to leave the dog. Well, the dogs hopefully becoming an emotional support animal. That's another thing that I want to see more emotional support animals. Because my doctors won't write me a letter but the psychologist here has wrote me a like really good letter.

If we think about the role Survivor M's dog could play in terms of meeting her needs outside of the system, dogs can provide a constant and non-judgemental source of love, and for Survivor M, provide one of the few possibilities in her life for her to take on a care giving role as well as receive reciprocated care. However, her dog was unable, as perhaps everybody else is ultimately unable, to fulfil Survivor M if/when she is seeking 'perfect care', and she had to leave her dog to go into hospital. This highlights the shifting sands of the survivor as strong and capable and relinquishing control and embracing passivity that can be an ongoing battle for both the survivor and those working to support them. Perhaps when Survivor M is able to be more self-sufficient in 'being with' herself and accepting a degree of a 'void', she will be more comfortable in staying with her capable adult self, drawing upon the resources and care around her and eventually being able to move on and add non-professional sources of validation and love into her life in the community.

Finally, very topically, Survivor M wanted the scale of the group grooming CSE that has occurred to be known; not for retribution via a criminal justice organisation or the profiling of offenders, but so that services are alert to the symptoms and impact of trauma, and who carry compassion in their work.

I'd like to see more training on like how big the abuse scandals were and the grooming and stuff like that, and how much trauma it can cause to a person 'cause, I know that's what's happened here in this hospital. They didn't realise how big the grooming scandal was.

Returning to both these revelations before clinical consultation, I thought about Survivor M's compulsive self-soothing through shopping and her feeling that the scale and the importance of the group grooming scandals were not sufficiently known about. During the consultation interview, I reflected upon whether these might be part of the 'void' caused by Survivor M's traumatic developmental experiences, demonstrating when she is in a more vulnerable place, her deep desire to feel comfort and validation, to be recognised and to feel seen and important. We explored the parallels Survivor M mentioned between her shopping and other survivors' drug or alcohol use and the comforting role that both can play, providing oblivion or numbness from 'the void', albeit a temporary relief, meaning behaviour is repeated and compulsive. We also reflected upon the feeling of being 'seen' and recognised as a trauma survivor for the first time that Survivor M will have experienced at the hospital, which is in a new location where nobody knows her. It was remarked that if she had been in hospital in Rotherham where professionals are familiar with her, she would be unlikely to have been under a section three and seen as in urgent need of protection and support. This was a very sad and poignant illustration of the two 'pathways' available to Survivor M when she is under great stress. On one hand, the familiar option to default to her passive, helpless 'child' whose needs must be governed and met by a matriarchal caregiving figure (or professional/s). Or alternatively, to take the less familiar, more daunting route of the adult who is embedded in a network of supportive professionals who have seen her in her strongest and weakest moments, who can encourage her to draw upon the strengths and strategies that they know she has in her toolkit. It was recognised that it is understandable that Survivor M often opts for the first, more comforting and easier option, and that this dichotomy and splitting really captures some of the complexity of the world of survivors but also of the professionals around them, whose responses can be similarly split.

6

The Impact of the Trauma-Informed Network: The Creation of Rotherham's Multidimensional Trauma-Informed Community

The sections in this report explore the ways in which the Trauma-Informed Network is affecting understanding of trauma, symptoms of trauma and its legacy among individual survivors, the community (including intergenerational transmission of trauma and alternately, of resilience, safety and trust, and survivors' ability to engage with and contribute to the community) and systemic factors (ways systems and services can contribute to or alleviate the incidence of trauma).

Findings are presented under headings according to the different dimensions of trauma; individual, community and systemic, but these forms of trauma do also overlap and intersect, and for some areas, are presented as overlapping. These are not definitive combinations though, different types of trauma frequently overlap and interrelate, for example, in deprived communities there is often a higher level of need where services may be under-resourced and struggle to meet that need. This may place particular stress on professionals and impact their ability to respond compassionately to service users, increasing their levels of trauma due to feeling stigmatised and excluded.

The findings were also analysed thematically, according to the core principles of trauma-informed practice; Safety, Trust, Choice and Control and Empowerment. This approach has woven a golden thread throughout my research exploring trauma, embodying and reflect not just the work being done by professionals but survivors' own needs, challenges and successes. Each principle is discussed relating to different dimensions of trauma, but it is important to remember that just as forms of trauma overlap and intersect, so do the benefits of the different aspects of trauma informed principles. This is exemplified below by a quote from a professional, who encapsulates the complex and far-reaching impact trauma has on the worlds of survivors but also the far-reaching impact that work done to alleviate these symptoms can have:

> *I think it was incredibly important to have that trust for her to trust in me because of the experiences that she had had within the family, but also outside the family. I think that she found it very hard to make connections and trust in relationships with people. And obviously for her to share her experience, be able to be vulnerable but also feel safe, she really needed to trust that there was no judgement. That what I was saying was authentic and genuine. And I think without that, without that trust, I don't think that we would have made the connection, so I don't think that the work would have been anywhere near as powerful.*

The above quote brings to life how trauma can tarnish survivors' ability to trust; with people they are already close to, strangers in the community (including potential new friends, employers, even, e.g. shopkeepers) and also professionals who they might voluntarily or involuntarily need to engage with. Rebuilding trust is complex, and entails safety primarily, so survivors are able to let down their guard without feeling under threat. To have choice and control in how and when they do this is also crucial to the maintenance of safety and the building of trust. Choice, control and trust then builds independence and empowerment, through relationships successfully built, hurdles overcome and debilitating fears and beliefs being deconstructed within this. So, behind each interaction or story described in this report, a multitude of transformations, shifts and connections have occurred that have similarly complex and broad-reaching effects on survivors, the wider community and the systems and people within them that are working to safeguard and promote the wellbeing of communities and individuals.

6.1. Safety

Individual

Trauma's symptoms and the coping strategies that survivors used in the absence of alternatives are significant for all survivors, in various ways. This included internalisation of anger and self-harming, disordered eating, mental health crises including voluntary and involuntary sectioning and inability to form relationships: all deeply damaging to one's wellbeing and sense of self as an individual as well as loved ones and the wider community.

Here, Survivor C describes the painful symptoms of her trauma but also the impact of being equipped with a toolkit of strategies and techniques to manage her symptoms:

> *But over time working with (worker) I've learnt stuff to help me not get to that stage, I know how to deal with it before it gets to that point, so I don't get there any more. I still get physical flashbacks where I can still feel it, but I know how to manage it better than pacing up and down crying. Or stuff like in terms of self-harm, I used to be really, really bad with that but now I've learnt different ways, distraction techniques or what to do. I'm not saying I don't do it any more but I don't do it near as I used to so that's definitely helped as well.*

Survivor G also described how being able to recognise when she was reaching her window of tolerance, when her trauma symptoms were becoming overwhelming, she can now use strategies to avoid becoming subsumed by anger and sadness.

> *Whereas before, I kind of just let it take over a little bit. It's helped me find in the moment when I'm going out of like the window of tolerance and realising that, yeah, I do need to move away, take a breath. I think that's been really instrumental for me, knowing when I'm upset or I'm angry and thinking, yeah, I can go away and take some time. (Survivor G).*

Other symptoms that are increasingly recognised as related to trauma include the physiological responses of the body, especially chronic pain and fatigue and stomach and bowel issues such as IBD (Glynn et al, 2021; Schnurr, 2022; Van der Kolk, 2014).

For example, survivor D had suffered digestive problems as a child, coinciding with her abuse, and as an adult when she was triggered she noticed these stomach problems re-emerging; through counselling connected this physical response to her trauma. Other survivors spoke of chronic fatigue and chronic pain that were also related to their traumatic experiences and which were alleviated or aggravated by their experience of triggers and ability to be resilient in the face of challenges.

Several survivors described negative experiences with GPs, a concerning finding due to the relationship between physical health symptoms and the experience or triggering of traumatic memories. GPs are often the 'first port of call' for people seeking help and so the lack of awareness of healthcare professionals and the general public of the link between sickness, pain and trauma suggests the need for further advocacy, research and training to address this. While there is a need for GPs to be able to recognise and investigate the link between certain physical symptoms and trauma histories, it is also important that they are able to do so sensitively and without triggering survivors, for example by demanding unnecessary details, as seen in this report, some survivors felt GPs showed prurience and a lack of compassion regarding their trauma.

Currently, trauma-fluent workers in the voluntary sector in Rotherham are playing a valuable role in helping survivors to make the link between their physical symptoms and their traumas; survivors are seeing improvements in both as a result: indirectly through benefits from stabilising and processing their traumas, and directly through being able to advocate for themselves to receive support by confidently articulating their pain.

> *I think what was really helpful is that my therapist was really, like cognizant of the other things that I have going on, like chronic pain and stuff, and she was very open to talking to me about how they're so interconnected, a lot of the time. So I think that kind of intersectional, outlook of it, was really helpful for me like realising that things don't live in a vacuum. (Survivor G)*

Survivor G is now receiving specialist chronic pain support and having that intersectional knowledge of her trauma and her pain helps her to choose strategies that soothe her trauma symptoms such as meditation and breathing techniques which also alleviate her physical pain.

Findings suggest that there is work underway in the Trauma Network that is addressing physical health symptoms in tandem with the psychological impact of trauma through the voluntary sector's understanding. The impact of this for survivors is notable, and examples of this include survivors being better able to be present for their loved ones, able to pursue interests and passions and to consider their future, less hampered by debilitating pains. For example, Survivor G is now pursuing her interest in creative writing, taking part in a group and has resumed her education too. This illustrates the multidimensional benefits of this; although this finding is categorised as a safety related impact because it is improving survivors' health and wellbeing, it has multiple other tangential effects, especially in the community, as it is vital that citizens are empowered to be as healthy and strong as they can if they are to be expected to engage in and contribute to their communities, however that might look.

The Criminal Justice System - Systemic Traumas and the Individual

For many survivors, the criminal justice process by its nature, can be an enormously destabilising, retraumatising and unsafe time; it can often take many years, involve revisiting and confronting traumatic memories and experiences multiple times, often in settings that are not trauma-informed and compassionate. It can also involve disappointment, where despite survivors' years of working with the criminal justice system, providing evidence and making statements often to many different professionals, and facing their abusers in the court room, No Further Action (NFA) can be declared. All of these aspects of the court process were traumatic and represented a significant threat to survivors' sense of safety and stability . Voluntary sector professionals drew upon their understanding of trauma to be especially vigilant during particularly gruelling stages of the court process including evidence giving and examination, or great disappointments and feeling let down and disbelieved, such as in cases of NFA. Several professionals described their recognition that these

experiences were profoundly risky to survivors and anticipated to trigger mental health crises, substance use relapses, self-harm or suicidality.

Here, Survivor A speaks movingly about the vital role trauma-fluent professional support played during an especially challenging time in her journey.

> *And it were nice to have somebody, I found I didn't have much family support so it were nice to know that in that moment through court if I needed someone to just go offload to, even if it weren't owt to do with it and I just needed to go and have a cry or just a rant, or just to talk about summat different, I knew I had my worker to be able to do that to, so that were really, I don't think I could have done it without having that someone to help me stay afloat, help me keep my head above water whilst going through that really rubbish time. (Survivor A).*

However, by providing trauma focused support, and in recognising the inherently traumatic nature of the criminal justice process for historical CSA/E (child sexual abuse/exploitation) survivors, professionals were able to mitigate against these huge risks and stood by survivors to help them withstand these challenging experiences. For example, professionals offered more frequent, intensive support to survivors during these experiences, ensured survivors were accompanied by supportive workers during court attendance (for example, ISVAs) and worked on embedding strategies so survivors could ground themselves and self-soothe in healthy ways.

6.2. Systemic and Individual

Boundaries

For the safety of survivors and professionals, it is important to establish and maintain clear boundaries around relationships. Trauma survivors have frequently had tarnished experiences of social engagement and may develop inappropriate attachments and perceptions of relationships with professionals because of this, and because of a historical absence of caring figures in their lives. Equally, professionals may be deeply struck by survivors and have strong desires to protect and care for them which can lead to them overstepping professional boundaries. While these blurring of lines come from positive intentions and wishes, the impact can be hugely detrimental. For example, survivors feeling betrayed and manipulated, or developing a stifling dependency upon professionals. Within an unhealthy co-dependency such as this, professionals may inadvertently restrict survivors' empowerment and independence by taking on an untenable weight of emotional and practical responsibility, attempting to perform roles they are not capable of or qualified to do.

> *I knew the boundaries around it, I knew she's not me friend, I know that, she were very, very professional, but were able to make me feel so comfortable and able to, be able to be me and that were really nice. (Survivor 1)*

Survivors spoke of boundaries around their relationships with trusted professionals without being asked- in speaking warmly of the comfort and care their encounters with staff provided, they were also clear about the limits of that relationship. It was evident that the professionals I spoke to and was signposted to speak to by survivors were pivotal figures in their lives and with whom they had close, transformative relationships. In these relationships they were able to feel safe, realise and establish their sense of selves and share their needs and hopes in an unencumbered way but crucially, underpinned by a clarity of the nature of the relationship and that it would necessarily end and that, whilst ending might in some ways feel bittersweet for both parties, would ultimately signify a triumph, an important part on the survivors' journey.

6.3. Community

Community Housing

The crisis in available affordable, appropriate housing is not new, and it is hoped that suitable investment in the sector will provide greater options. It remains, however, pertinent to remark upon the impact of this crisis for trauma survivors, who for many reasons may be unsafe or in a permanent state of anticipation of threat in their current housing but unable to move away and thus on. For example, Survivor C had given up custody of her children to her sister because of her concerns about her own mental health and ability to safeguard them. This decision was praised by her worker who viewed it as the survivor exercising choice to look after her family in a way her own mother had been unable to with her and thus breaking a cycle. However, Survivor C still wanted and maintained a relationship with her children but was unable to take this further because of a lack of housing. More concerningly, her current housing was the site of an extremely traumatic incident, but due to shortages and the associated strict rules regarding social housing, she was currently trapped in that environment.

> *She might never get them kids back home, she'll say I don't know if I'll be able to do it, now she's got the challenge herself of is it the right thing for kids as well cos they are stable where they are and that's why she wants to be nearer to them but there's no housing coming up where her kids are so it's really hard for her. She's with them now, she spends time with them in holidays, she sees them every weekend, she'll sometimes go and stay over when her sister and bloke want to go out but it must be heart-wrenching for her….The house that she's in at minute, I have visited her at home and she's got pictures of kids up and stuff like that and that was their family home so she's surrounded by triggers and I do believe, don't quote me on this, that that is the same house where she was sexually assaulted as an adult, actually quite horrific physical injuries as well…. (asked about moving) It's not as easy as that, you can't just move and if she accepts somewhere and just moves she'll not be able to move again, it'll need to be right. (Survivor C's Voluntary Sector Worker)*

That said, within this conversation, the worker did think more about the Survivor's housing situation and decided to see if there was a way she could support her to change this, with the recognition of housing, and move to a safer environment. However, the state of the housing sector also meant that workers tried to avoid having much to do with housing beyond making referrals, because of the complexity and huge risk of 'getting it wrong' in an increasing climate of 'voluntary homelessness' decisions.

> *[Asked about involvement with housing] as little as possible because it's just a minefield. We support women with applying for getting on council registers, things like that, looking at different options, but no, in my experience they're not always very helpful because they haven't got houses to put people in. (Survivor C's Voluntary Sector Worker)*

However, housing was identified as a core issue for many survivors, with the dangers posed in local hostels being especially concerning, illustrating a great need for a trauma-informed approach to housing for survivors that prioritises their physical, psychological and cultural safety.

> *But a lot of women that come to us do have housing issues. We have a project that supports women that are on probation and a lot of them are no fixed abode or they've just come out of prison so housing is a big support on that project… It's dire. I supported a woman last year and she were in a hotel and she'd got a four year old, not ideal. It weren't even a hotel it's not ideal, for want of a better word it's where they put people they've got nowhere else, so you can expect people*

that are drug users, people that are alcoholic, not ideal at all. So housing, sore subject. I think they try their best with a lot of things but then at other times I could say they don't try at all, certainly not trauma-informed but they've got their guidelines and their restrictions in place, it just makes it hard. What we could do with is a few properties somewhere that have got, a bit like refuges, that these women can just go and get on with their lives, go and live there for a bit, but that's in an ideal world. We do have a refuge in Rotherham but I would imagine it's full. (Survivor C Voluntary Sector Worker)

Trust

Many survivors have had their trust betrayed, or have found that others cannot be trusted to protect them or believe them, on a multidimensional level- that is individually, in their communities, and in systems. The consequence of that is that their ability to feel safe, to connect and engage and to feel valued in experiences with individuals, in their day to day lives and with professionals has been deeply tarnished. This common reality is surmised by Survivor G's support worker below;

She didn't experience the amount of support and care that she deserved. And her the impact of that on her wasn't recognised. Family and school, the medical profession, missed a lot of the stuff that she was going through and so the foundation of having a trusting relationship, knowing someone's got your back, knowing someone's going to believe you, was not there for her. (Voluntary Sector Professional, Survivor G)

In this section, I explore the different components of multidimensional trauma and the vital role played by the destruction, absence or rebuilding of trust.

Individual

The quote below from Survivor A encapsulates many survivors feelings; although she describes her feelings when seeking support and beginning to engage with the voluntary sector, these understandable anxieties around trust effect survivors' relationships and ability to connect in multiple ways. This includes difficulties trusting people, anxiety around meeting new people, reluctance to disclose personal information and engage with people without fearing being exploited, betrayed or hurt .

It's not always easy to trust people so when I came into it I were very nervous, I find it hard to trust people. (Survivor A)

The experience of developing positive relationships with trusted professionals, where survivors were heard and believed gave survivors opportunity and space to not just revise their feelings about others, but their feelings about themselves. Through the strength of carefully and slowly developed therapeutic relationships, many survivors transformed within themselves. Through trust came self-exploration and recognition, building a sense of self. Within that, emerged an ability to understand themselves, have compassion for their responses and behaviours and to take control through coping strategies and using their knowledge to self-validate and affirm. In several survivors this developed through a process of trust, wherein their relationship with professionals initially provided them with reassurance about the symptoms of their trauma, their body and brain's natural responses, their lack of blame and their ability to manage symptoms and begin to discover themselves as people. Some survivors still depended on their trusted professionals for this validation and reassurance, whereas several others further on in their journeys had travelled from reliance on professionals to being able to find strength, soothing and resilience within themselves. Several survivors spoke powerfully about how they now recognised themselves as dependable experts, and could seek reassurance and understanding within;

consequently, their relationships with their self and their vision for the future improved as survivors recognised themselves as brave, caring, and capable.

Systemic

Survivors had often had negative experience in systems and services, including feeling disbelieved, betrayed, disregarded or treated dispassionately and increasing survivors' stresses through untenable expectations or demands of behaviour and achievement in services.

In contrast, the TIN (Trauma Informed Network), notably voluntary sector professionals, were able to demonstrate that professionals could be approached and trusted to provide appropriate support. The ability to provide support must be preceded by the establishment of a relationship, especially for trauma survivors who will often have protective walls up, or anxieties about professionals. This could be achieved in the TIN through the time, flexibility and choice offered when building relationships with professionals, which was crucial in building formative and eventually enduring trust.

> *Obviously that built up over time so it were never pushy, it were very led by me, it weren't this is what we're doing at this appointment, it were very going at my pace which were nice. So I didn't feel rushed, I were able to get that calmness before starting out a bit deeper. (Survivor A)*

Survivors' freedom to access support for longer periods of time than in statutory services, to repeatedly access interventions provided by different services *and* in different ways, and to re-enter treatment when needed, meant their experiences with their trusted professionals was refreshingly flexible.

The lack of pressure mentioned by survivor A was also attested to by many survivors as crucial in their building a trusting relationship with professionals. When asked if she was initially comfortable speaking to her worker, Survivor G advised:

> *At first, no, I think it took me quite a few sessions to open up. I think I got to like 7 or six sessions and my therapist was kind of very gentle and was like, you haven't spoken much about what happened. And I didn't even realise that I wasn't. (Survivor G)*

It is worth noting that Survivor G describes her therapist is bringing up her avoidance of the traumatic event as 'very gentle'; allowing survivors to build a relationship and gain trust is critical but professionals also understand that part of a trauma-informed therapeutic dynamic is the worker gently and carefully working with survivors to confront and realise in a healthy, safe way. This means that survivors are able to explore their traumas without feeling pressured, exploited or triggered but also, that their ability to trust and their relational experiences improve through the accretion of positive experiences of being vulnerable with and placing trust in others.

Some survivors also changed their views of professionals and developed or rediscovered trust in them. In one striking instance, a survivor had been raised to fear and avoid social services and the police, but through her work building a relationship with her worker and reappraising her own upbringing and her desires and priorities in the present, she was able to overcome these fears to protect her loved ones, breaking her familial cycle.

> *She was fighting been brainwashed… she was very scared of any kind of authority. Petrified of police, petrified of social workers, and she's fought against that absolute terror in herself to try and make sure that she was protecting other people which were at the time her nephews and her children. (Survivor A ISVA)*

This shows the impact of survivors being supported to build trust not just on their own ability to engage with services and authority figures but also on the wellbeing and safety of those around them *and* the empowerment of survivors to take action to resist their own trauma in order to protect others in society.

Furthermore, during their journeys within the Trauma-informed Professional Community, survivors were able to break damaging cycles of inherited trauma, to safeguard and empower their children and to prevent the intergenerational transmission of trauma , exclusion and thus complex needs that often accompanies the families of traumatised individuals. This indicates how the rebuilding and development of trust has impacts on individuals, on systemic engagement and outcomes but also on the future of communities.

> *Her relationship with their children is absolutely inspiring, given what she's been through. She is the polar opposite of the person that she was raised by her and I've seen her in action with her, with the kids as well. Her children feel heard at all times. They know about safe grown-ups, they know about authority figures. They know about everything that she should have had as a child, basically. (Survivor A, ISVA)*

Community: Survivors' relationships and ability to be present with their loved ones was impacted by their trauma, presenting in the overwhelming effects of trauma symptoms including dissociation, emotional dysregulation e.g. panic attacks, avoidance, mental health crises, harming their ability to connect with the outside world and their family and friends

> *She's found it really difficult I think within school, she's gone to college, she's not been able to make connections with peers very well and she's felt quite different I think to others but she's worked so hard and she's had a lot of support from the ISVA throughout that as well. (Professional B)*

A multiagency network of professionals, bought together through the Rotherham Trauma Network, facilitated by the TRS, recognised that Survivor B's trauma had permeated around her and was also affecting her family including her siblings and parents. This was something they saw often in other survivors, where loved ones struggled to understand and respond to survivors' trauma symptoms and were experiencing their own vicarious trauma in response to the abuse. Below, a professional describes the bespoke provision of trauma-informed support to the family of survivors but also the need to formalise provision of this.

> *We've worked really closely together, so myself, the ISVA worker and we've had an early help worker as well to work with the family. What we did as part of that support is we recognised that there was Survivor B but we'd got other young people in our service that had experienced child sexual abuse, child sexual exploitation where the understanding from the parents, and I think they were finding it difficult in the home and the things they were learning around themselves and understanding and doing the trauma stabilisation would be helpful for parents to also understand that. (Professional B)*

Because of the flexible nature of the voluntary sector service, they were able to iteratively respond to needs they had identified and provide services creatively and responsively to support the world around the survivor also.

> *We don't get any particular funding to support parents or anything like this, but just because we thought it would be so beneficial we put together a group for parents and did the stabilisation that were aimed at the parents, at mums. (Professional B)*

The recognition of the vicarious nature of trauma and its ripple effect throughout families and potentially then into communities, triggered professionals in the Trauma Pathway to implement support to focus on providing trauma stabilisation skills and education around the impact of trauma to family members. For Survivor B, this had a significant impact on her relationships with her family and on the environment within the family home and collective wellbeing. Without the understanding of trauma and having a toolkit of skills to support the survivor and to manage trauma symptoms, the survivor's home had often been a place of emotional dysregulation, where everyone felt unsafe, uncontained and in conflict. As a result of trauma-informed support provided to the entire family, this changed to a place of compassion, recognition and stability and safety. The consequences of this for the family members' wellbeing and their ability to exist and engage in the outside world can only be extrapolated theoretically at this stage. However, in doing so, it seems pertinent to conclude that the impact this must have had on their own experiences in the community, among peers and friends, in the workplace and education can only have been positive and enhanced their own quality of life and that around them. This is indicative of the positive ripple effect of trauma informed practice beyond the individual and into their families and communities, reducing the collective strain of trauma that has, as with group grooming CSE, occurred on a mass scale.

> *So her mum attended that and Survivor B had fed back that she found that really useful because I think she felt that the responsibility had been lifted off her a little bit so it made it easier to communicate things to mum and mum had got her understanding of things that she'd been doing or recognising things in the survivor to help her through different skills….. I think there were a lot of times (before) where it was quite, everybody just got up to here (gestures) and there were a lot of screaming and a lot of crying and different things in the home. (Professional B)*

Another aspect of trust in the community was the enduring difficulties survivors have in motherhood, being challenged repeatedly by potentially risky opportunities for their own children that can trigger their fears and over-protective, stifling parenting. One voluntary sector worker remarked on this and how she expected it to emerge for one survivor with young children as they grow and reach certain milestones. This was an important reminder that survivors' challenges and needs are not vanquished but may re-emerge in response to the changes that occur across our life course. Therefore survivors may need to re-engage with support but this must not be seen as a 'failure' of services or the survivor but as the importance of working with survivors according to their own priorities and timelines and keeping an open door, understanding that as life fluctuates and shifts, so does trauma. Below, a professional describes how a survivors' trauma impacted her parenting as she was confronted with balancing her desire to protect her children from her own experiences and providing them with a fulfilling childhood.

> *Not really letting kids stay out at friends', certainly not sleepovers, uncomfortable about who she leaves her children with. think in future that might cause issues of letting kids be kids and do what kids do and let them go to prom or let them get on bus on their own. I have other women who don't let their kids get on public transport because they might be accosted by somebody, a perpetrator. She did used to say to me even leaving kids sometimes with her husband, she wouldn't always feel safe, even though she knows he'd never harm the children, but I think because of what's happened to her there's always that little element. (Survivor A voluntary sector worker)*

6.4. Choice and Control

Systemic and Individual

Individuals having choice in organisations about their treatment meets several needs that are especially important for trauma survivors: it gives them freedom, avoiding them feeling proscribed or dictated to (which may mirror and thus trigger controlling and coercive past experiences). It recognises the fluid and individualised nature of trauma where survivors have different needs that are contextual and changeable. It then also promotes flexibility for the systems that support them and control *for survivors,* a power transference that is empowering, bespoke and holistic.

> *I had quite a long period of time with (voluntary sector) and we did grounding skills which I found really helpful, I had a load of different ones actually, I were given different, when I asked for, that one's not working for me, is there owt else you can suggest, there were different things that were brought to the table. It were literally very different to anything I've ever done. (Survivor A)*

By being given choices, survivors were not just able to pick options that spoke to them and worked best for their preferences and personalities, but this choice also carried another valuable message; that individual difference is normal, one size does not fit all and that journeys to recovery, including coping strategies, look different for everyone. This is in contrast to the more restrictive approaches encountered in other services, who are more limited by remit, commissioning and resources, resulting in some survivors feeling unable to 'succeed' according to prescriptive, rigid codes and set 'packages' of support.

> *There were lots of different options and it were really nice to see that, it were very, not everything worked for one person, everybody's different, everybody deals with stuff differently and that were a nice to get that perspective to think then when you're doing it and you're in your own life or your own troubles it's really hard to get that mindset of everybody deals with things differently, you just kind of feel like you are doing everything wrong. With some other services it were very you're in this room, you're sat here, we've got a timer, this is exactly set, what we're doing, it's all in stone and this is it and we've got this amount of sessions… this is what we've got to do, all set out on a table, this is what we can help you with, there's no other way. (Survivor A)*

Coping strategies

Professional members of the trauma network in several core voluntary sector organisations have been trained in providing trauma stabilisation on individual and group levels. This has been significant for survivors in understanding the psychological and physical impact of their trauma, helping them realise that their responses are healthy, normal and their brain and body's way of protecting them. Although the concepts underpinning C/PTSD and the machinations of trauma are complex, often very clinical/technical and diverse, it was evident that the trauma stabilisation is delivered to survivors in a digestible, approachable way. This meant survivors were not overwhelmed and that the information struck a chord with them and facilitated self-knowledge, empowerment and self-sufficiency.

> *The trauma stabilisation talks you through how the brain works and the different effects of how trauma can affect you and the point where it can react in your body and stuff. Just to have that understanding of it were amazing for me personally because it just helps me to get it a bit more. (Survivor A)*

Trauma and PTSD are complex, daunting topics that can often feel 'off limits', inaccessible due to the technicality of language and concepts that describe it; by opening the door to survivors to be able to reach this knowledge, survivors can be empowered through understanding to support themselves, rather than rely on professional expertise.

Community - Family and Relationships and Making Difficult Choices

Professionals' understanding of the consequences of trauma and the importance of working with rather than against this also had implications for survivors' experiences with others and also in their communities that were challenging. Several survivors had complicated relationships with their family members or with partners, often struggling with the disconnect between the ideal of love, compassion and care that they longed for and reconciling it with their reality, where these caregivers or potential romantic partners were not able to meet the ideal. Often this looked like parents being disinterested, abandoning them or parents being abusive or connected in some ways to the trauma that survivors experienced. Survivors had struggled with this disconnect and their natural desire to have close, loving relationships with others, and professionals often played an important role in helping them work through these complicated feelings and the often traumatic and disappointing consequences of this. For professionals, this requires a nuanced understanding of choice; that while survivors may be attempting to form relationships with unavailable, risky or dangerous figures, it remains important that survivors exercise choice in their lives but are perhaps supported to do so while processing their wants and needs in the context of their reality.

> *There's been a lot of abuse in her life but I think what set this particular psychosis episode off was the unexpected death of her mum, obviously it were a shock cos nobody were expecting it… It's a difficult subject matter to be fair, only because her mum is linked to the abuse that she experienced as a child. Her mum was an alcoholic and used to take kids to pub with her and then bring men back to house and I think that's when some abuse has happened. So it were a difficult relationship I think. I've had very in-depth conversations about relationship with her mum actually and I think she had an ideal of what that should look like and it didn't look like that for her, but I think she still sometimes, why weren't it like that for me. (Survivor C's voluntary sector worker)*

Despite the lack of care that Survivor C had from her mum and her mum's connection to her abuse, she remained attached enough to the idea of a relationship and a profound sense of loss and unfairness, to the extent that her mum's death triggered an episode of psychosis. Because of the compassionate, trauma-informed approach taken by her worker, Survivor C could be supported by people who understood the origin of this disconnect between desire and reality, and the extremity of emotional and physiological response associated with this and its origins in trauma, and to work with Survivor C without judgement and with compassion. For professionals whose remit it might be to eliminate risks and triggers, e.g. in a mental health capacity, Survivor C's persistence on a relationship with her mum and the severity of her response to her death may have been frustrating and seen as a sign of a lack of willingness to 'do the work' and 'get better'. Conversely, a trauma-informed approach involves a recognition of the great complexity and the ongoing influence of developmental trauma in survivors' relationships and choices. This means that therapeutic relationships, which are so important for survivors in establishing the trust that is a prerequisite for any recovery journey, are not disrupted but maintained and strengthened. Consequently, survivors can be supported to appraise their hopes, expectations and relationships and the people in their lives as they explore their inner and outer worlds with the companionship and guidance of a trusted professional who understands the role trauma inevitably plays in this.

Balancing making choices

As survivors gained greater independence and confidence in their self they were able to differentiate between harmful symptoms of their trauma that they wished to work to overcome and areas where they wanted to define and assert their own boundaries. Part of this involved coming to know and accept their preferences and rights as valid elements of their personality.

> *I just noticed her putting herself out there testing the water and equally saying, you know what I'm going to say no to that thing because I don't want to do that. And that's just not me. And so it was really nice to see her have that balance, Incorporating areas that she had lost that she wanted, but equally not feeling like she had to take on everything that might be under the umbrella that some people would consider normal like. You know, not everybody wants to go out drinking on a Saturday night and that's fine. (Professional, Survivor F)*

Survivor F exemplified this dual process; in some areas, she had, with the support of her professional support, used graded exposure and grounding strategies to allow her to take part in activities and relationships in more present and involved ways. She had also acknowledged that she did not have to chronically 'people please' and that her preferences socially were not abnormal or unacceptable but completely within her right and control to assert.

Body image, priorities and eating disorders

An especially interesting finding emerged regarding professional responses from healthcare to (arguably but likely) symptoms of survivors' trauma with regard to either their disordered eating patterns or their choices and preferences regarding their own body. Both are understandable and natural responses we can connect to the experience of trauma in terms of having choice and control over the physical form. Four survivors had struggled with their body image and eating, and of these, two had received judgemental and punitive feeling responses from healthcare professionals that they felt didn't recognise their choice, their histories and their priorities.

> *She did speak about and this was about her size and being dismissed because of her size. I got a sense that she almost felt blamed because she didn't fit into the model that they wanted her to. She's a big advocate of body positivity and a lot of services, health services they don't embrace it in the same way. And I think she found that very difficult and talk about the conflict between wanting to really sit with her values, her belief in the right to be and look however you want to, but also society and services only accepting her if she would lose weight, if she would get a job, if she would do this. So I know she found that very difficult because she really wanted to stay with her core beliefs. But that meant, inevitably, she was feeling isolated and judged. I know she felt very dismissed, not heard silenced and not believed. (Professional, Survivor G)*

The above quote illustrates how services with different but perhaps more singular priorities that must be (due to commissioning and remit) focused on getting particular outcomes from people. These services may not be thinking about the impact of this on people whose presentation or behaviour (whether weight, substance use or conduct) may be influenced by their trauma histories.

They are not necessarily also encouraged to also think about how their beneficiaries' priorities might be different from the services and that it may be more important that they're able to hold on to the confidence and self-belief they have developed than to focus on a more medical model of , for example, what is healthy.

6.5. Empowerment

Individual Trauma

The empowerment of individual survivors can be understood in terms of the convergence and accretion of the other aspects of trauma-informed approaches, where safety and trust builds professional and personal relationships through which survivors are given choice and control to access knowledge about themselves and trauma which they can use to self-soothe and to achieve validation and self-compassion. The collective result of this is the establishment of a positive sense of self, an increase in wellbeing and in quality of life, all of which survivors become empowered to increasingly pursue independently as a result of being heard, held and supported to recognise the validity of their responses, their capacity to manage these and their right to life.

> *I felt very rubbish about how I were dealing with things, I didn't have much understanding of myself, whereas at the end of it I feel like I were able to go do you know what I'm a pretty resilient person and with this crap situation that I'm in I'm now able to see that actually you're doing alright. I feel like that were from the work I did at (voluntary sector) because it were having that voice, listening to me and then helping me to see how I was dealing with that situation, having somebody to go and openly talk about it once that relationship had built up, that were really nice. Then the trauma stabilisation work, that were a big one for me, a really big one. I feel like I didn't ever understand my own reactions and when I did the trauma stabilisation. (Survivor A)*

An important part of the development of empowerment is the recognition that survivors' thoughts, feelings and responses are healthy and normal, a realisation that undoes the self-imposed component of the isolation and othering many feel. As one survivor below describes, through understanding oneself as normal and healthy, it is possible to see the self more as a capable and potentially powerful individual.

> *It kind of made me realise that I'm normal, I know, what is normal? But it made me realise me reactions were normal and I weren't crazy or abnormal, it were just a response to what I'd been through. It kind of helped me realise some other things as well from stuff we spoke about in the trauma stabilisation, it made me kind of go oh wow, yeah, I get it and I took a lot from that I think when I left.*

The recognition of the normality of individual difference also helped survivors to balance the understanding that their needs and responses are normal and valid but also that they can differ from other people's without negating their importance and reality. Within the system, this recognition was provided through an offer that not only provided various options and flexibility but which emphasised the variety of response and need among trauma survivors.

> *So there were lots of different options and it were really nice to see that, it were very, not everything worked for one person, everybody's different, everybody deals with stuff differently and that were a nice to get that perspective to think then when you're doing it and you're in your own life or your own troubles it's really hard to get that mindset of everybody deals with things differently, you just kind of feel like you are doing everything wrong. This service helped me understand that everybody deals with things differently and trauma reacts in everybody's body differently and different strategies work for people differently. It made my mind a lot more open to how it is and how it works.*

From distrust to reliance to independence

Survivors often felt bewildered, out of control and ashamed of their brain and bodies' natural responses to trauma; the establishment of safety and trust with professionals was crucial prior to any work being undertaken to address this, but because of the qualities of the approach discussed above (taking time, demonstrating boundaried care, showing belief and hope and emphasising choice), this meant professionals became trusted sources of knowledge and clarity for survivors. For several survivors, their approach to understanding and managing their trauma paralleled the process of their relationships with professionals; once trust had been built, survivors sought answers and reassurance from professionals, a valuable stage in which, as we see, the normality and healthiness of their responses to trauma was emphasised, and survivors were encouraged to rediscover themselves and reassess their role in the world. Over time, this would progress as survivors became more self-sufficient, and gained the confidence and sense of self to seek that reassurance and validation from within. This is exemplified by Survivor A below;

> *I have a better mindset. I think I used to have a lot of negative thoughts and I didn't, I just looked to everyone else for my answers…it is nice to know that little me got help from me, along with all my little cheerleaders around me, which were (voluntary sector service) and my ISVA and police, it were people there supporting me somebody has said we're here for you and the biggest person who I never thought would drag me through it all is me, it were like I went back and I helped myself, I went back and I held my own hand and I dragged myself through it. (Survivor A)*

Another illustration of the journeys to independence survivors made was by Survivor A's worker who described the transformation that she had undergone:

> *I think maybe at some point there might have been, I don't want to say a reliance on services, but a bit of a what will I do if I haven't got summat in place. She always talked about ISVA service, she always spoke about support from us. I think she's come to the end of the support with (sexual assault service) but she could go back at some point if she needed to. Where we're at today, she moved area, she got a job, she's doing driving lessons, she's going to Disneyland twice, taking one child then another child because she can't do it all together. So she's doing brilliant things for herself and she's a very different person. (Survivor A Voluntary Sector Worker)*

Reconciling the past: Soothing the inner child and unleashing the developed adult

From an established trusting and beneficial relationship with a professional network, some survivors were showing that as they progressed, they were increasingly able to take the lead on their wellbeing and their course in life. As explored in the case study for Survivor M (hyperlink), many survivors must balance or reconcile two dominant selves. On one hand, the frightened, angry and powerless child who often was let down or neglected by familial or professional caregivers. On the other, the adult the Trauma Network is encouraging to blossom, who has drawn upon the support, skills and knowledge provided to them through a professional network and can now locate that security and safety, validation and care internally. This development is touched upon below too by a professional supporting Survivor F.

> *She would take something that we'd discuss in a session and come back having implemented it. And she was really especially towards the end, driving herself forward with challenges and those sorts of things it was. It was really good to see and I didn't see that side of her at the start where: I knew that she from her work*

that she clearly managed people. She was in charge, you know, she had that side to her, but that side became more visible in her recovery towards the end. (professional, Survivor F)

Whereas Survivor F had an 'in charge' side in her professional life, other survivors, for example Survivor M (hyperlink case study) have not had the opportunity to exercise a powerful self, and so their development of a secure and self-supporting adult has less to build upon and draw on, and so the process is more complex, drawn out and fragile.

Showing Courage and Seeking Justice

One of the profound outcomes of this journey from self-blame and helplessness to self-knowledge and confidence was the empowerment of survivors to face their abusers in court. Survivor C had gone from being so overcome by memories of her experiences that she would self harm, suffer physical debilitating flashbacks and be consumed by pacing to being empowered by her hard work with her support network to write her victim impact statement and deliver it to the perpetrator in court. This powerful moment illustrates her enormous progress but also her resilience and bravery.

In court I managed to stand up and read my impact statement out in front of the entire court room which was terrifying but because of the work I did with my worker and my ISVA it made me believe that I could do it and I have got what it takes to do that and I don't have to be scared, so I did manage to do that. (Survivor C)

Empowering futures

Furthermore, by being able to manage their trauma symptoms, recognise that they were not to blame for what happened and how they responded and respond, and rediscovering themselves as individuals with potential and possibilities, several survivors were also able to advance their futures. This involved survivors training for and successfully applying for demanding jobs in the emergency sector and voluntary sector, not only being able to manage their own traumas but contributing to their own sense of self-worth and power and to the good of others and the community.

But I got a job, so I work with the emergency services, so I managed to do that or I'm planning for the future now whereas when I first come to (the voluntary sector service) there was no future, I thought this is it. So (worker) really helped me to see that my life doesn't have to end because of this, there is a way forward. (Survivor C)

The transformation in survivors is encapsulated above by Survivor C, who describes an overwhelming hopelessness, lack of self belief and confidence and the debilitating impact of trauma prior to receiving any support to reaching a place where she is confident, defiant, resilient and actively pursuing and envisioning her future and her personal goals.

6.6. Community Trauma

The empowerment of survivors, through their hard work with the Trauma Informed Professional Community meant that survivors were better able to resist and offset symptoms of community trauma, which includes overcoming their relational difficulties, avoidance of going into and engaging in the community and their ability to support their children and loved ones.

Community Safety

Understandably, a common trait among survivors was fear of going out into the community, and this had had a debilitating impact on many survivors' lives. Several described being effectively house-bound over fears of seeing their abusers, or being triggered, or finding the stimuli and unknown and uncontrollable elements risked by leaving home unbearable.

The support provided to survivors was helping them overcome this in several ways; 1.) the positive impact of therapy or meeting their keyworkers became motivation to leave the house, and risks taken were reinforced when they arrived and had validating experiences with professionals to affirm this 2.) trauma informed support provided survivors with a skillset to soothe themselves and to bring themselves back down if their threat responses were over stimulated, so they were equipped to manage any triggers outside 3.) Work focusing on self-worth, confidence and assertiveness helped some survivors to 'stake their place' in the community, refusing to continue to hide or feel ashamed 4.) The development of a future vision and wishes for their future self-encouraged survivors who were further along in their journeys to engage in the community, motivated by a positive goal, which was then validated by their positive experiences in taking small steps to achieve this.

> *For so long I just didn't care about anything, I had no hope…but now I do have goals, I'm just working on making them actionable… Now I want to finish my university then I want to go into (career)… I've got other goals too I. just want peace. I think I just want a peaceful life. I want to move out. I want a cat. I want a job I enjoy. And I want I do want to share my life with people. (Survivor G)*

Survivor G had suffered with severe agoraphobia after her traumatic experience and often didn't leave the house at all for months at a time. Her trusted professional explained this to me from a trauma-informed perspective, revealing how traumatic responses manifest in behaviours and states of mind:

> *She would describe it as waking up in the freeze with the state that we identified as her freeze state, her low mood, her hypo arousal. And she would spend most of her time in there and then previous to our sessions, she had times where she would maybe attempt to go out in social situations, walk to a bus stop and just being around people, just the thought of people, of being visible to people would trigger the anxiety, the fight/flight, and then she'd go back home or cancel plans, then she would be back in that that shut down that self loathing that really dark place. (Voluntary Sector Worker, Survivor G)*

However, since positively experiencing support and therapy, this had motivated her to leave the house once a week and she had been increasing this as she and her worker set new challenges, and she had now resumed attending education and was meeting new friends there.

Fear of leaving the house is a common and understandable response to trauma, especially whereas with many survivors in Rotherham, their abusers and reminders of their abuse permeate their community. However, one impact of coping strategies, growing self-belief and confidence and the offset of self-blame was that survivors were becoming able to overcome their fears of the outside world and began reclaiming a place and role in the community.

> *I was experiencing quite a lot of agoraphobia at that time. Still am, but it's getting better. So I barely left the house and like when I started individual therapy, it started with me leaving the house to go to the therapy. So I think just that little step really helped because it got me out even if it was just to go to counselling.*

So they kind of like, encouraged me just to like, get out even like two times a week, even if it was just to the shop . So I started doing that and my goal at the minute is to go to like a thing on my own and meet new people. I haven't managed to do that yet, but I have managed to go back to Uni and I've met new people there. (Survivor G)

Above, survivor G shows the importance of taking a phased approach to recovery, realising the stepping stone provided by professional support and progressing towards goals in a way that is mindful not to overwhelm and overcome but that shows survivors change is within their reach.

Lesser-known symptoms of trauma

People-pleasing or an overwhelming desire to break the cycle when having children of their own could mean survivors struggled with looking after themselves, making time for their own needs and not being consumed by trying to do and be everything for their loved ones. While outwardly this might look commendable and give all the signs of being a 'good parent', the lack of ability to recognise their own needs and to moderate comes from a place of trauma-based anxiety. In supporting survivors to recognise the validity of their own needs, professionals achieved two goals- they helped survivors recognise themselves as worthy of care as individuals and also helped survivors safeguard themselves and avoid burnout.

I am making sure that she was supporting herself… she's got a family and she's very, very family orientated. It became apparent very early on that she was very happy to put her own needs aside and focus completely on what everybody else around her needed. So part of my role was to make sure that I kept pulling her back in to make sure that she was focused in on herself as well as everybody else because she can't pull from an empty cup. (ISVA , Survivor A)

6.7. Recognition and Response

Individual, Systemic and Community

In being heard and being believed, survivors' traumas across **all** levels were lessened, as their experiences in services, of building relationships and their experiences of socialising and of the world more broadly shifted. The survivor below shows how being seen and believed and treated as a trustworthy, valuable person can be transformative for people who have previously felt unworthy, rejected and denied by others. Being disbelieved and turned away often occurred for survivors in their interpersonal relationships, in their experiences with professionals and in the broader community, so countering these messages and demonstrating, through relationships with trusted professionals, offers an important way to begin to undo that exclusion and stigmatisation.

They played a big part in my journey of getting through that part in my life. It were first time, it was nice to have somebody who believed me as well, being believed were a big one cos I'd never been believed in my life with it before. So having somebody who sat there and didn't go 'you're a liar' were nice, were just really nice, to have someone saying yeah, it's rubbish what you've been through and we're here and we're hearing you. (Survivor A)

Systemic failure to recognise and respond

Before understanding their trauma, survivors often feel they are 'out of control' or 'going mad' (Hamer, 2022) and similarly, when services do not understand trauma symptoms, this can be replicated structurally by responses that exclude, discipline or

misdiagnose. This was explicated by Survivor G's voluntary sector professional who shared some insight on the very real consequences of this for survivors:

> *With other services that don't recognise trauma and what happens in trauma, fight flight is often diagnosed as either anger or anxiety or being unstable emotionally. Same with Freeze is diagnosed as depression. But actually when you when you understand, fight flight, freeze the trauma cycle, everything that goes off you realise that these are instinctual and natural responses to awful experiences. (Voluntary Sector Worker, Survivor G)*

Several survivors had disappointing and destabilising experiences with healthcare professionals due to a variety of factors including seemingly not reading survivors' notes to understand their background prior to consultations and not being cognisant of survivors' triggers and so needlessly asking retraumatising details. These experiences reduced trust in the healthcare system and had the potential to retraumatise survivors as well as deter them from seeking help in future.

> *I've actually recently had some really rubbish situations with my GP where I came out feeling worse than ever and obviously he were not trauma-informed and if they'd have even cared to look at me notes he'd have understood a bit more…With trauma obviously it can open up so many different doors to different things, one of things that I feel like one of my coping mechanisms were is I have two different eating disorders, I have binge eating disorder and I have disordered eating, but I've had that under wraps for a few year now. My GP commented on my weight, told me I were obese. I know I'm overweight but I weren't a few year back and I feel like I've spiralled so much and I haven't had a grip on that part of me, but he was so nasty, he made comments under his breath, he took me off my mental health medication and told me I can't go on it cos I need to lose weight and I just thought if you knew what trauma does to a person. (Survivor A)*

This account shows how siloed focuses on 'problems' rather than a whole person approach that recognises trauma histories and survivors' own journeys including their progress made and their own priorities, can trigger and exclude survivors.

Thankfully, due to the support she had received, the survivor was able to internally counter these harmful and hurtful comments, and to recognise her progress and strength so far. However, as she recognised, had this happened prior to her being better supported and more resilient, the effects could have been significant. This also raises the concerning issue of stabilising medication being withdrawn or used in order to prioritise weight loss at especially traumatising moments in a survivor's journey, in this case during the court process.

> *Luckily I were able to sit in that appointment and I was together, I didn't even cry, I were really proud of myself, and I were able to sit and say inside do you know what, you've had an absolutely rubbish few years, you've only just come to other side of it cos court weren't that long ago, you're allowed a minute and if binge eating is the worst thing that you've done, do you know what…but if you took me back three years ago, this were another thought I had with him, where I would have starved myself, I would have really took that and it would have really got me . Trauma hasn't helped my binge eating disorder, the last few years my mind has been everywhere and I've just been surviving it. The other thing were if he took me off my mental health tablets, which I seen another doctor two weeks later and they put me back on them because she said it weren't the right decision because she knew that I'd been through a rough time. But to say after I've just been to court, I've just faced summat I never thought I would face, to take me off my mental health tablets at such a strange time in my life were not the right decision (Survivor A)*

Recognition and Response

When services and professionals are truly trauma-informed, they can recognise and respond appropriately to trauma symptoms; not only does this mean that they are working from a place of genuine knowledge and understanding and so better able to provide support, but this also means *through recognition* and sharing recognition with survivors, symptoms can be reduced;

> *If you can understand that and if clients can understand that they can actually perceive and see their behaviours sort of differently and it can reduce the negative thought process that goes on with the shaming themselves. (Voluntary Sector Professional, Survivor E)*

Research attests to the powerful role that countering shame has in recovery and building resilience for survivors of child sexual abuse (Plante et al, 2022; Salter and Hall, 2022), and shame is countered in every aspect of the Trauma Informed Network/Community in Rotherham. Where survivors themselves, their families and loved ones and professionals who work with them are able to understand the symptoms of trauma and that they are natural and normal functions of a brain and body working hard to protect someone in the face of perceived and actual threat.

The compassionate understanding that professionals exhibited towards survivors also illustrates an approach that mean survivors can see themselves through the eyes of someone who understands their presentation, who can validate and normalise it while supporting survivors to better manage symptoms. I asked professionals what their initial impressions of survivors was and I was really struck by how positive and compassionate their responses were. This could be because their perspective was underpinned by knowledge of what the women have endured and are confronting, and of the nature and impact of trauma and the service's focus on promoting the women's wellbeing rather than controlling their behaviour. As this report demonstrates, survivors often find approaches from professionals judgemental and stigmatising, feeling dismissed and misunderstood, focusing on them as problems rather than people. By being seen instead as the people described below and treated as such, survivors' feelings of otherness and shame can be alleviated, and this is crucial to survivor's ability to build resilience, make positive change and recognise and build on the positive vision of themselves.

> *The initial impression I suppose of her is that she has had a lot of trauma and to be sat in front of me and conversing when there's been so much, I just thought how brave, I think she's brave, I think she's stronger than she gives herself credit for. (Voluntary Sector Professional, Survivor C)*

> *She's a wonderful person. I've worked with her from being a child to a young adult, so it was a long time. You know, you go into people's homes, you meet the family, you meet the dogs, you know, a little dog that they got while while I was working with her. It's kind of difficult because somebody like Survivor , who is so engaging, so endearing, such a lovely person. You want everything for them. You want her to go on and have because she deserves to have the best possible life. She deserves to have the brightest future and we've to talk about what her future would look like and how it's totally within her grasp to do it. She's so bright and she could completely have it all with self-confidence, with the things that the abuse took from her childhood. (Voluntary Sector Professional, Survivor B)*

> *My initial impression was how incredible she was. So bright, so intelligent, so articulate and very courageous. But I was also really aware of how that was the polar opposite of how she felt about herself and saw herself. And we talked about the fact that it was almost like. There were two different people in the room. There*

was the woman that I saw and the woman that she felt she was.' And she found it very hard to hear the positives that I would see. She I think it took quite a while for the trust to develop and for her to maybe accept and see the version of herself that she was experiencing was very different to other people's experience of her. (Voluntary Sector Professional, Survivor E)

It is critical to emphasise the point raised above, that this was not as simple as telling survivors positive things about themselves, but about building relationships based on trust over time before survivors were able to put faith in professionals' views of themselves and begin to dismantle their own negative views of themselves.

One of the core achievements of the TRS-facilitated Trauma Network, or Trauma-Informed Community of Practice, is the increasing reach and embedding of professional capacity to recognise and respond to trauma appropriately: this avoids survivors encountering the often common barriers of rejection from services due to conditionality or misinterpretation of trauma symptoms as disinterest, aggression or incapacity but also allows professionals to see beyond the surface of the survivor. Whether their exterior appears as aggressive, shut down, detached or easily distracted and lacking focus and attention, by being able to recognise these as symptoms of, e.g. dissociation, emotional dysregulation, hypoarousal, professionals can continue to work *with* survivors rather than exclude them or fail to see the whole. This is illustrated by Survivor C's voluntary support worker, below:

When she talks about her kids she'll say why don't I feel something and she'll cry and I'll say what do you mean, why don't I feel summat for my kids and I'll say but you're crying, you do feel something but maybe it's not what you'd think that you'd feel. She says I just feel numb and I say to her maybe that's a self-protection because she's not got her kids in her care, it were her decision to make that happen… we've talked about dissociation a lot, that maybe sometimes it's been too much for her to deal with so she's cut off so then that leaves you feeling numb sometimes. I do wonder sometimes, cos she'll just look at me and you don't get any sort of sense that, oh I see what you mean, she'll just look at me and listen to what I'm saying, how much of it she's taking in I don't know, I'm sure she is taking it in but I don't always get a lot back. (Survivor C Voluntary Support Worker)

Through trauma-specific support, Survivor C was also better able to moderate the ways her trauma affected her behaviour and presentation. While there is a way to go in some sectors in terms of recognition and appropriate response to trauma, by being helped to understand their symptoms' presentation and to take control of these, survivors can modify how they are perceived externally and reduce the chances of punitive responses from those who do not yet recognise the markers of trauma.

She's made it easier in a way for me to express how I feel a bit better and a bit more calmer cos sometimes I'll speak a bit like I'm shouting but I'm not. It's like I go on the defensive and get very animated in the way that I talk about my trauma and stuff like that…. I feel more confident in doing it in a calm way than what I previously have, like headstrong before, I've gone mouth first without putting me brain into gear. (Survivor C)

Survivor C has had experiences with social services and mental health crisis teams, among other services, and her previous way of communicating when feeling confronted or trigger, by being loud, forthright, gesturing and emotive, she could have been viewed as aggressive and less capable and rational than she is. By improving her ways of communication and social resilience, her ability to maintain positive ways of communicating even when feeling challenged or triggered, Survivor C is better able to have beneficial and pro-social experiences in the community, in systems and with her loved ones, a tripartite improvement that benefits everyone.

Recognition of trauma and its impact is more complex than it might outwardly appear. While being trauma informed is now commonly mentioned in services' strategies and in sector best practice guidance, the specifics of the reality of this are not broadly known or implemented. Some less identifiable manifestations of these 'on the frontline' are illustrated below, exemplified by Rotherham's Trauma Network. Currently, there is a lack of systemic understanding of what trauma is and how it can appear and impact individuals, communities and professionals but there is also a broader lack of understanding of the lesser-known, less obvious indications of trauma.

For example, Survivor F had triggers that were unrelated to what had happened to her- her trauma manifested in being terrified of having people behind her, which meant she was hypervigilant and avoided crowds, even avoiding walking around supermarkets 'against the flow' and avoiding social occasions where she wouldn't be able to plan in advance how to sit with her back to a wall. However, this had 'nothing to do' on the surface with the traumatic event, and so may not 'make sense' in the more normative sense to people whose understanding of trauma is more cursory.

Other indicators of trauma that may not be picked up on or recognised as related to trauma that emerged in the research include survivors whose presentation and symptoms are less severe and who outwardly appear to be high functioning. Several survivors had always worked in skilled professions where they were performing roles taking care of and protecting others, they had successful and harmonious relationships and were outwardly capable, loving parents. Survivor F felt uncomfortable and almost guilty about seeking help with her trauma because she felt she didn't appear to others as in need of help.

Survivor D was described by her trusted professional as outwardly very competent and successful, working in a profession where she was very 'clued up' on trauma and safeguarding issues; however, she had been unable to 'take that hat off' when it came to her own experiences and their impact and had been managing all these years by maintaining a carapace or 'masking'.

> *I think if anyone was to meet her, I think they'd be very surprised if she had trauma history. There were no issues with her social life, she has a family herself, is very much family oriented and she didn't score highly on the generalised anxiety disorder diagnostic tool…there wasn't any element of risk… she was able to engage really quite well but as she progressed it emerged that she emotionally wasn't engaging with those close to her, especially her husband. (Survivor D's voluntary sector professional)*

Survivor D's professional mentioned that masking is quite a common strategy for survivors who for various reasons are more able to suppress their trauma and dissociate long-term, and that his often appeared as maintaining an emotional distance in relationships. This was the case with Survivor D who, similarly to Survivor F was seeking support to help her take down the protective walls she had built up and be able to connect emotionally with her loved ones.

These examples illustrate how trauma survivors can still be in need of support even without more, overt 'chronic' symptoms of crisis, and that though they may be skilled at masking, the less overt symptoms of trauma such as emotional detachment can still have significant effects on the lives of survivors, their families and their engagement in the community. For example, Survivor D and F were able to build better relationships with their partners and children, breaking intergenerational cycles of emotional neglect and developing more supportive, trusting connections with their husbands meaning they were able to express their needs. This newfound ability to communicate in times of stress or low moods and bring their loved ones in and let them know how to help them was very empowering for both partners, meaning they were able to recognise

and mitigate against symptoms of trauma together rather than low mood, irritability, dissociation etc. causing divides and conflict.

Survivor G, through therapy, came to realise that her emotional distancing from family and friends was rooted in feelings of guilt and shame about her trauma and not wanting to 'be a burden'.

> *So I think I struggled to kind of like let people in a little bit, I guess because of my own internalised shame, and because it's a very heavy topic to talk about, I didn't want to, I don't know, put it on people. (Survivor G)*

Several survivors described feeling guilty about the impact of their trauma on others and would avoid people out of feeling responsible to 'protect' other people from their traumas and the symptoms of them. By having a safe place and person in professionals to speak about their trauma, survivors are able to relieve themselves of the burden of carrying their trauma in silence. They are also able to approach social relationships without being weighed down by feelings of responsibility for others and debilitating desires to protect others by staying away or only engaging superficially. The availability of a relationship in which survivors can dedicate themselves to exploring their trauma and its effects, without being impinged by responsibility for the other person or fear of how it will impact their relationship, not only benefits survivors themselves but also their loved ones.

Responsibilisation vs compassion

Individual

A really powerful development for survivors was their development of self-compassion, and their recognition that they were not to blame; in forgiving themselves they were also able to recognise their resilience and strength and within that, overcome even further hurdles, including being able to self soothe, advocate for themselves and envision themselves in their future as active, positive, powerful actors. This is not to say that recovery or the impact of this compassion and understanding is linear and remains at a peak, survivors invariably may struggle due to the very nature of what they have experienced, but the support being provided and the skills they are given appears to be equipping them to withstand difficult times and recover from setbacks more easily and to be more self-sufficient and make choices they are proud of.

> *She had no confidence and when I say confidence, I don't just mean sort of confidence to walk down the street. I mean sort of like the core of who she was. She said that nobody should ever believe a word she said…. she's a completely different person to what she was when I first met her. She still questions herself constantly. She's still struggling with her own confidence, but she's definitely now got some core confidence. I'd say she knows that she's made the right decisions. She knows that she Nine times out of ten will act in the best interests of other people.*

Systemic

Compassion approaches to supporting survivors can include avoiding perpetuating notions that survivors are faulty, flawed or in need or correction rather than in need of building and experiencing trust, developing coping strategies for what are understood to be normal responses and the restoration or establishment of a positive sense of self and others. Below, a survivor describes how previous experiences in services had (inadvertently) reflected her vision of herself as needing fixing rather than recognising the source of her problems as a natural response to a traumatic incident/s that were not her fault but that she can be supported to become resilient to and overcome.

There was a few where I've been in past and I think you go in and I kind of went I need somebody to fix me and they never really looked at me and went we can't fix you and it's not about fixing you (SA)

Within delivering interventions that emphasise the survivor's strengths and capacity, a compassionate response also recognises survivors as whole people with issues and interests beyond 'doing the work'. Giving survivors time and space within interventions to be able to explore and talk about other parts of their lives within the therapeutic relationship emphasises the survivor's wholeness as well as giving them control and choice.

I think it's obviously so many sessions that you do the trauma stabilisation and if one week I came in and summat else came up that I needed to talk about I were able to do that, so it were like were like we could come back to that. It were still very much we're doing it so it's meeting in a point where it all makes sense together but I still had the space to be able to, it were just it were led by me which were really nice.

Statutory services have limited, restricted remit and creativity and greater flexibility of third sector can mean they can consider the whole person and move beyond treating symptoms and 'surface problems'. One survivor had been under the care of a psychiatric doctor during a period of voluntary admission, and felt that the care provided therein was mostly focused on symptom management and fire-fighting rather than getting to the root cause of problems, or viewing 'problem behaviours' in the context of an entire person with needs, fears and aspirations.

She mainly wanted to talk about my eating habits and me sleeping habits which aren't fantastic. I've always punished myself through my depression with food, I've always withdrawn it cos I've not wanted to eat. I'm not saying she didn't do a good job, she got me on the right tablets and that but it just seemed that once she got me on the tablets what seemed to help to keep me head above water, that were it, she were just you're alright now. (Survivor C)

7 Rotherham and the Trauma-Informed Professional Community

7.1. Seeing the whole

There are various illustrations of the importance of a holistic vision and understanding of survivors in this report, including being able to address multiple complex needs, effecting multiagency collaborative working and understanding and planning around survivors' life course.

The sections below describe some of the key ingredients than enable the Trauma Network to adopt this Whole Person approach, but before exploring these further , and the multitude of other benefits of the TRS supported approach, the relational impact of being treated and understood as a whole person must be recognised. Every survivor spoke movingly about the warmth, interest and genuine care their trusted professionals showed them and described being 'seen' as a whole person with a life, goals and interests beyond what had happened to them. The quotes below illustrate how important this is to survivors whose experiences with professionals may often be reduced to a focus on their 'problems' or rather problematised elements of their lives, and whose social experiences and ability to trust people are often hindered by trauma which naturally leads to suspicion and aversion.

> *She's wanting you to talk not just about your trauma but everyday stuff and your interests as well, the good stuff that you can concentrate on while you are going through all this mental health stuff. (Survivor C)*

Here, Survivor C touches upon the boundaried but friendly relationship she had with her worker where she was given the space to be more than just her trauma, and to devote time to acknowledging the person she is outside of her struggles, which provided respite and relief but also demonstrated the value of the survivor and her relationship with her worker.

Trusted professionals and the space to exist without expectations of pursuing outcomes or demonstrating progress also provided survivors with crucial support and the opportunity to speak freely, where this was absent from their social circle, or where they found their family and loved ones incapacitated.

7.2. Collaboration and information-sharing

A huge benefit of information sharing relationships and collaborative working practices for survivors was the avoidance of potentially re-traumatising retelling of their story to multiple different services. Sharing what has happened to them be a source of great anxiety and potential disruption and upset for survivors for several reasons. Firstly, the fear (and sadly often common experience) of not being believed or not being properly

heard is an obstacle it takes great courage to overcome- past experiences and apprehensions about what has happened to them and their validity as victims can be hugely challenging in taking these steps in good faith. Secondly, the very act of talking about what has happened involves survivors revisiting memories and excavating potentially destabilising and dangerous triggers. By being expected to repeat this multiple times and in multiple places, the risk of re-traumatisation and the harms (including relapse of substance use, mental health crises, self harm, agoraphobia etc.) and of developing complex PTSD through the act of repeated exposure to reminders, is amplified. Here, a survivor sums up the powerful support provided by the Trauma-Informed Community of Practice in Rotherham:

> *My worker worked with lots of other services, my ISVA , school, early help, , other voluntary sector services, all that. And it makes things easier because I'm not having to communicate everything to each individual person because she says it in meeting and things. (Survivor C)*

If we think about the severity and impact of the symptoms (prior to trauma stabilisation support) this survivor describes suffering, that could be triggered by reminders of her experience, the importance of streamlining the processes wherein survivors need to revisit the past is evident.

> *Early days after I went to the police I used to get, I still get them but it's nowhere near as bad cos I know how to manage them, I used to get a lot of physical flashbacks, so I used to be able to feel it, I know that sounds nuts cos you can't feel it… But I used to be able to feel it. So when I used to be able to feel that I used to pace up and down hours crying cos I didn't know how to deal with it cos it felt like it was happening. (Survivor C)*

As attested to by Survivor D, survivors are entire people with whole worlds inside and outside of them, and with this comes the need for a holistic approach- often the origin and impact of trauma means that many aspects of their worlds have been affected, resulting in complex needs. A professional below describes the recognition of and attention to collaborative working and a whole-person approach, including checking on client's overall wellbeing and needs regularly, and liaising with other services to support this.

> *It isn't just one thing, although it's (the abuse) a huge thing that's happened to them. It isn't that it's just housing problems or problems with partners or ex partners or children or their mental health… there's all sorts of other things going on in the background for these people…So sometimes you know it's establishing what those things are. How can we help? You know, we're not housing workers. We're not therapists. We're not mental health workers, but we can refer on and signpost on to other agencies and organisations that could possibly help along with us in that sense. So that's establishing throughout their needs. You know what they would want from us, how we can best help them and for some people it's a monthly welfare check. How's everything going? Do you need anything? Have you got any questions? (Professional, Survivor B)*

This collaborative way of working has been a key aspect of the Trauma Network, as embodied in the Hub meetings described in the Trauma and Resilience Service (TRS) Evaluations (2018-2022), where professionals from a variety of backgrounds involved in a survivors' case convene to hear a 'presentation' of that survivor's current need and collaborate, under the supervision of Trauma fluent professionals, to design a multiagency, bespoke response. The Hub meetings and the TRS approach to uniting services in a support network around survivors have become more embedded and informal ways of working that operate organically now. Several professionals I spoke to described their regular contact with other important services in survivors' lives and

how the establishment of lines of communication in this way meant that they could feed back to other agencies about survivors' needs from a trauma-informed perspective, and help those services work more compassionately and effectively.

> *We've got some very good relationships with different agencies in, in Rotherham. It's sort of we recognise and we have to recognise, we can't be everything to everybody. You can't save everybody, you can't do everything for everybody, and it took me some time to get my head around that and think actually, that's right because I'm not, you know, I'm not the all knowing.*

The recognition of different professionals that a multi-agency approach was better for all involved and would mean that each professional could bring their own vital expertise into the room when developing a survivors' care also meant that relationships between professionals in different sectors were able to develop with fewer of the boundaries that can stifle collaborative working including territorialism.

By working with other services, professionals are also able to alleviate some of the strain and remove some of the barriers survivors (especially those in an earlier stage or at a difficult point in their journey) encounter in accessing support.

> *'So it's contacting the other services that are much better at that sort of support; we can attend meetings with people you know to ensure that they're not overwhelmed by information like that and we can then liaise with those different agencies to say, actually, can we just chase this up? Can we kind of find out what's happening with, you know, if you've got situations where somebody wants to move house, things like that? They (survivors) don't always have the capacity themselves, although .we try to encourage where we can people to do things on their own. (Professional, Survivor B)*

7.3. Flexibility and creativity

The professional components of Rotherham's professional Trauma Network are able to work with greater flexibility than statutory services or others constrained by time limits or specific conditions limiting the clients they are able to serve. This means that they are able to work with the reality of trauma, where experiences and their impact may not be realised until years after events and where the journey of realisation and recovery may involve peaks and troughs, setbacks and withdrawal and revisiting.

Adult survivors of CSE

Many survivors in Rotherham have only recognised themselves as such in adulthood for various reasons such as awareness raised by changing attitudes to consent, coercion and exploitation, or publicity from court cases that have made them aware of similarities with their own situations and triggers in adulthood.

Survivor F didn't feel that her childhood trauma was affecting her in adulthood until a friend confiding in her about a triggering similar situation which exacerbated her symptoms to the point that she decided to seek help. Survivor F's story illustrates the importance of survivors being able to access support for their trauma regardless of when it happened.

> *I never really felt that I needed to have any discussion or support about what happened to me, and I felt that actually it didn't impact me I suppose a few years ago something happened with a friend in her family and that did impact me more than I ever thought it would. Because, although because that experience in actual fact didn't impact me at the time personally, I found myself being quite angry and not coping well generally. I could go to work and do everything that I felt that I'd*

always done but found that I over thought it and potentially held back from my relationships in terms of the love I showed to people and how I responded to my children. (Survivor F)

Survivor F also illustrates how symptoms of trauma may be more insidious than we expect and may not necessarily have the huge visible consequences such as chronic mental health crises, suicidality or agoraphobia.

As captured in Herman's 3 stage trauma recovery model and touched on in TRS Evaluations, trauma recovery is not a linear journey and part of making overall progress includes facing setbacks, feeling overwhelmed and needing to withdraw or lash out, and the understanding of this in services who could recognise this as part of trauma meant they were able to work more flexibly and compassionately. This is illustrated by a quote below, which showed that the ISVA was able to stick with the fluctuations in the survivors' moods and progress and to recognise that this was part of the natural process. Rather than responding to this by becoming frustrated or pressurising the survivor, this compassion and allowance of time and space contributed to what, upon reflection, struck the professional as a remarkable transformation.

It was not plain sailing by any stretch of the imagination in the sense of, everything got better and better and went upwards. Trauma doesn't work that way, does it. We'd have some really positive visits sometimes, but then I found initially when I would first meet with her, she would be quite upset or quite angry or quite frustrated, about the things we'd spoken about in the previous week. You know, a previous time it would be almost like we'd never had that conversation. So in terms of lifting her confidence in herself, you know, we'd have our visits that would be sometimes two hours at a time. And which at the end of the visit, things would be really quite positive and things like that and then I'd see her again and we'd gone down a fair few steps. And so it was sort of building back up from that support again. So it's certainly over the time she, I saw her evolve. But n terms of strength or emotional strength , she grew massively, from this very quiet, shut down child to the absolutely amazing, incredible person she is today. (Professional, Survivor B)

Progress by survivors may also not 'look like' that which is expected or even demanded by statutory programs, for example in drug treatment or social services, whereby a set number of sessions or weeks is allowed during which 'success' is measured by performance outcomes such as employment, cessation of a coping strategy and the complete and successful establishment of new coping strategies. The flexibility afforded by the voluntary sector and the creative application of this freedom and responsiveness that their trauma-informed approach provided meant that they were able to offer a more accessible and suitable form of support that did not exclude or exacerbate trauma.

There is a lot to be said about that taking your time with people which statutory services don't allow that, they expect you to be at a certain point to be able to do bam, bam, bam and off you go. Sometimes some of these women when they come to us and they'll come for trauma stabilisation and actually they're not ready. (Survivor C Voluntary Sector Worker)

Being able to invest more time and having greater flexibility in terms of relationship building meant that the Voluntary Sector also found that women would return to them and were able to either complete trauma stabilisation where they hadn't been able to within the limited sessions offered through the statutory route, or were able to attend in the right frame of mind and at the right time to engage and benefit. By being able to work over a longer period of time, and to drop and resume the relationship according

to the survivors' needs, Voluntary sector professionals are able to provide transformative support that otherwise survivors might have been unable to access.

> *It took me a long time to do that work because she struggled a lot with her physical health but also her mental health, it took me months to do that work. We'd do a session and week after she might be ill or she might be struggling with her mental health so she didn't want to do that session, but it was a successful relationship between us and she got a lot from it when she completed it eventually. (Survivor C Voluntary Sector Worker)*

Voluntary sector members of the Trauma-Informed Community both recognise that progress is not linear but also may stall or difficult to realise and understand that some survivors have experienced lifetimes of trauma and so what they may be able to achieve and in what time frame, might not resemble expectations or the timelines of other survivors. Below, Survivor C's voluntary sector worker describes a stasis in her work in terms of outwardly measurable 'outcomes' but also acknowledges gradual improvement in a lack of engagement and connection and a lessening of emotional symptoms of trauma, which for Survivor C represent important and significant milestones.

> *We've had sessions where we've talked about maybe doing voluntary work, stuff like that, stuff that will help her with her mental health but she's at a big of a standstill with stuff like that and that's not changed, she still seems to be at that standstill. She doesn't get upset as much so that's changed. I think she engages a bit more with the session, that's probably because she knows me now, at first she would very much just sit and just look at me while I were talking and I'd have to prompt her to engage sometimes, but now I don't have to do that, she will talk freely about certain things. (Survivor C Voluntary Sector Worker)*

A staged approach to trauma recovery

Judith Herman advocates a three-stage model of trauma recovery including stabilisation and the establishment of safety in the present followed by processing of the past the reintegration, looking to the future. For survivors who are experiencing ongoing threats, whether from past abusers, new perpetrators or reminders of the past that they cannot tolerate, it is often not possible to be able to move beyond trauma stabilisation. This was attested to by Survivor F's Voluntary Sector worker, who recognised that Survivor F was somewhat rare in that her progress *was* staged and linear, as she had come to counselling in a comparatively stable place, with her traumatic experiences securely in her past.

> *'Depending on if they've got, if they've got something present in their life, something ongoing, you know if the if a person who's responsible for something is still very present in their life, then it's very common not to get beyond stabilisation because it's necessarily safe to go any further.*

This demonstrates the importance of the ongoing availability of trauma stabilisation interventions and the especially critical role they are likely to play for survivors who are in unstable and unsafe situations, for example due to domestic abuse, unsafe and inappropriate housing and environments or being exposed to the perpetrator in the community. It also highlights the importance of trauma-informed approaches only being implemented by those with understanding and skills- attempting to progress through the stages of a linear recovery model where it is inappropriate could cause significant distress and harm to survivors.

The holistic approach: Beyond problems and across the life course

Survivor C had been so desperate for talking therapies and to find somebody to connect with as a person and to share her experiences and feelings with that she voluntarily admitted herself to a psychiatric unit. However, she found there that staff were predominantly concerned with crisis management and addressing particular problematic behaviours, and that there was a noticeable absence of human connection and opportunities for counselling.

> *The time I were in (residential unit) for six weeks, it didn't seem that the staff were approachable. The only time that they ever did anything really is when patients played up, if you didn't play up they just left you to your own devices. There was no counselling or anything at all, which I thought there would have been… That were one of the reasons I volunteered to go in but you were just left to your own devices, fed three times a day.*

However, Survivor C found in the voluntary sector the care and concern that was absent in her encounters of statutory settings, and had, for her, the rare experience of knowing somebody did care for and about her and was interested in her life and how that had affected and was affecting her, and in supporting her to continue to receive help to address how it will affect her in future.

> *She just seemed to care and want to listen to you. At other times people have not wanted to listen to you or don't know what to say to you, I don't think they were able to comprehend why you felt that way, why you were in this situation to start with…. I've always said no matter what the experience is there's got to be some people out there that do give a shit and I've found one what does… I think doing the last few sessions on my trauma stabilisation and then we're going to, I think she's going to refer me for childhood trauma and neglect counselling cos that's one avenue I've never gone down and dealt with what happened when I was a child. Then an appointment to see if there's anything else that she can help me with.*

As encapsulated above, even when the voluntary worker's time with Survivor C was coming to a natural close, the vision of the survivor and of their recovery journey remained holistic and stretching across the life course, recognising the traumas that she had experienced at different stages of life and the importance of dealing with these at the right time and at the right pace. The collaborative working approach that underpins the Trauma Network is also evident in the worker's commitment to signposting and advocacy to help the survivor in any way she is able to, unrestricted by time period, symptoms or service remits.

This stands in contrast to Survivor C's previous experiences of care which, as we have seen, were problem focused rather than person focused, but which also for a set period of time that was insufficient to begin to touch on the real roots of the survivors' problems and needs. She also found that rather than future planning and actively connecting her to services to provide throughcare, she was signposted to services she had previously had traumatising experiences with and understandably, did not trust and thus would not approach.

> *After going in and being at absolute rock bottom, six stone wet through, not sleeping, not eating and then six weeks later you can just go. So six weeks later you've got a bit of meat on your bones, you are getting a bit of sleep but it's like you're just told to phone crisis team helpline and sometimes I've had really bad experiences with them. I don't know why they say cos most of the time it's go and make a cup of tea, at a time when you're wanting to commit suicide having a cup of tea isn't really going to work. I understand in a way that they're trying to distract*

you from what you're instantly feeling but I've had experience where they've laughed at me down the phone and it's like you're crying…you're wanting to commit suicide…why are you laughing at me? (Survivor C)

It is impossible to comment on the context and nature of the conversation this survivor had with the crisis hotline, but what is imperative is that she felt she was being laughed at and so, effectively, whether that was the intention of the worker or not, she felt laughed at, and this in itself was a fresh traumatic injury and piece of evidence that professionals and other people do not care and can't be trusted. Survivor C's experience of this encounter was harrowing and traumatising, and deterred her from accessing the mental health crisis team again, further excluding her systemically and socially.

When she laughed at me that stopped me crying like cos it were the shock, what the hell was she laughing at me for so that stopped me using that service. I'm like wanting to commit suicide, I'm crying, I'm screaming, I can't breathe and there's a lady on phone who's laughing. (Survivor C)

This excerpt stands to illustrate the opposite of trauma-informed practice; in the Trauma Network, professionals understand that stability, safety and compassion must come first and underpin all interactions, along with constant reflection and exploration to ensure trauma recognition and response persists as a golden thread throughout survivor's journeys with professionals.

Supervision and reflection

The Trauma and Resilience Service facilitates, guides and supervises the ongoing development of the Trauma Informed Community, and one of the vital ways they do this is through the provision of support to professionals that can include clinical supervision, multi-agency round table case discussions and action plans and providing space for reflection. This tripartite approach to supporting the professional community meant survivors were being provided with a more responsive, holistic and trauma-appropriate package of care that could evolve with their needs. Below, a survivor's ISVA describes the role the TRS Hub and clinical consultation has played in meeting gaps in service provision for young people, in providing timely support and maintaining connections with a range of other services to meet needs in a collaborative, whole-person way.

I've found it to be always very helpful, always very positive in terms of sitting down with professionals, presenting a case exploring what the best possible support for that person could possibly be and having those offers of support there as well. One of the things I find in Rotherham anyway is support could be very minimal, so when you get something like the hub and the TRS support, it's very positive because it's very quick acting, it's there almost within weeks for people as opposed to years or waiting for a person to turn a certain age.

So I've always found it to be really helpful just to be able to go back and forth, have that initial consultation with the team, with the hub and then for them to make suggestions offer different services and support. But then being able to go back if needs be. We've also been able to have consultations with a couple of the members of the hub in the past, you know, prior to actually presenting at the TRS hub itself, just to run it by them. So in my experience it's always been very positive with regards to that. (Professional, Survivor B)

The support of the TRS also allowed professionals to recognise active or live trauma and to tailor the support provided to avoid exacerbating this trauma. Survivor C's Voluntary Sector worker could draw upon her training to notice that a survivor was in

a state of shock and trauma and that proceeding with trauma stabilisation work would actually be dangerous and unhelpful. She was then able to follow this up with the TRS and draw upon their clinical knowledge to check and confirm her assessment, and to offer a different form of relationship and trust building and opportunities for therapeutic work that were appropriate and safe.

> *I had a service user that came one time, she was still in trauma and I recognised it, I thought I can't do this work with her, she'd just lost a child, how can I do this work with her, she's traumatised and I said I can't, I'm not doing this work with her, we'll have to wait. I saw her every week and I saw her for a long time and then we did the work. She'd lost a child, I don't think it were even a year before, she was still grieving the loss of that child so I can't do that work on her, it's not fair on her so I made that decision through support of TRS team and my manager and said I'm not doing this work with her just now, we're just going to have to do other stuff. So I just used to let her come and we'd do some mindfulness, art, stuff like that and just let her be and let her sit with what she'd got going on. So there's a lot to be said for being patient and allowing that time. (Survivor C Voluntary Sector Worker)*

Vicarious trauma

An often under-recognised but critical aspect of trauma-informed practice is the acknowledgement of and response to vicarious trauma, whereby professionals who regularly work with and hear the stories of traumatised individuals exhibit symptoms of trauma themselves. There is another layer to this also, which is the difficulties inherent in working with a population who can have complex needs and whose behaviours, circumstances and journeys can feel confusing or evoke other difficult emotions. This is another where the input of the TRS is proving crucial, in supporting professionals in their work with survivors and providing consultative support for their own trauma symptoms, providing guidance and companionship to support staff wellbeing.

> *Sometimes when I've got stuck, and some of these women are stuck and you can thrash that out with TRS team, yeah it has been helpful and the fact that you can take it back to hub as well so that partnership can discuss processes and next best steps or what might be on that pathway. So you're not on your own with it and that's important for me to feel that I'm not on my own, cos sometimes it has felt like that. (Survivor C, Voluntary Sector Worker)*

The professional above highlights a critical but often overlooked reality- that for professionals working with trauma survivors, work can feel very challenging, confusing and precarious, feelings that may mirror survivors' own trauma and that also reflect the emotive and demanding nature of working in a trauma network itself. In offering support that reflects that provided to survivors , namely, a space to be heard, validation and the opportunity to process and reflect, the TRS is also helping protect professionals against the impact of vicarious trauma.

7.4. Trauma-informed reform and priority support

The Criminal Justice System

It is increasingly recognised that elements of the criminal justice system and process are traumatising, and there are significant obstacles in terms of the law and the professional duties and remit of other professionals (including the police, legal professionals). Whether and how this can be made more trauma-informed to make the court process less traumatic for survivors of sexual abuse is an ongoing discussion.

However, there were systemic incompetencies that suggested the lack of regard professionals in the court system had for the professionals supporting survivors contributed to failures that amounted to enormous setbacks. Preparing for court is an arduous, intensive experience that is hugely testing for survivors; hearings themselves are critical events and anticipation and preparation for these takes a toll on survivors but also forms part of their recovery timeline and journey. Being let down last minute and having these changed could have had potentially calamitous impact on the survivor, and fortunately, the worst of this was mitigated by the survivor herself and her supportive professionals. However, this raises questions about the relationship between court professionals and those outside the system and how this can be built upon to focus on the survivor.

> *The basics of it was that the judge couldn't continue with that trial because they weren't going to be there… The long version of that is that is I had queried multiple times with the officer in charge of the case and gone to them and said this case is listed for three days. Based on prior court experience and speaking with other ISVAs, will that be enough time to hear this case from the jury selection at which point they said, Yep, it's fine. I think it was three or four times throughout about a 12 month period from that date being set, I kept querying it and it kept being told. Yeah, it's fine. On the day that the trial was due to start the judge looked at the case or looked at the overview of the case and said I will not be able to complete this case, so we cannot go forward with this case. ..so then it would have been two years, but then it was postponed, which made it three years, almost 4 by the time it was done. Then add sentencing on to that. I think we were at. Nobody at first said held their hands up and said, yeah, I'm really sorry, , this is on me. I did query it , I did chase it but I think we're just not seen as integral… The police sort of do see the (ISVA) role as important, but I think they're very dismissive of any time we talk about court procedures or anything like that. (Survivor A ISVA)*

Inaccurate comments or opinions made by figures in authority also effect survivors; the power held by police must be wielded carefully and responsibly as survivors keen for a successful trial and to be heard and believed can make monumental decisions based on glib or uninformed remarks. Survivor A was so keen to receive justice that she was unable to disregard the inaccurate advice of a police officer to not take advantage of protections for abuse survivors when testifying, and so instead went through the more traumatising, arduous option for fear of not being believed.

> *When she reported to the police, they mentioned to her options for giving evidence if he did go to court, and one of the special measures is a Section 28 pre recorded cross examination which is quite well known now. Lots of people do it. We recommend it to people because they are vulnerable witnesses and an officer at one point said 'Oh no, you don't want to do Section 28, you need a jury to be able to see your face.' And there was no reason given for it. We even looked at statistics of like you can do a Section 28 and it doesn't affect the outcome of the case. So when the trial was postponed in, the judge apologised and said, oh, she can do a Section 28, she can do that now and then her part in it is done.. So it could have been a much quicker process but there was no convincing her., I got my hands on every piece of information I could and gave it all to her. None of it made a difference to her because the comment that the officer had made years earlier had stuck. (Survivor A ISVA)*

While one survivor did mention a very positive experience with a policewoman which she described as 'very trauma-informed', several survivors mentioned concerning and likely uninformed rather than intentionally judgemental or harmful approaches from police on the ground. All participants in this research felt that any service that worked on the frontline with vulnerable people in crisis situations needed trauma training embedded into the professional development, throughout every level of organisations.

The evidence in this research endorses this, indicating that some individual, community and systemic trauma could be avoided and even offset by trauma-informed approaches and knowledge permeating throughout the criminal justice system from bureaucrats to frontline officers. However, this is something that is not mandatory or embedded , despite the potential positive impact of this on Rotherham.

> *Another one, police, definitely. I've had this from horse's mouth, so that doing any sort of trauma-informed training is, it's optional within police, it should be mandatory I believe. I have put that forward myself when they delivered something not long ago around sexual exploitation and I put in an email that maybe trauma-informed practice should be made mandatory, they should do the training, it should be mandatory and not optional and it is voluntary at the moment whether they do it or not which, to me, is dire. (Survivor A's Voluntary Sector Worker)*

However, survivors are being supported by other services throughout the currently potentially retraumatising criminal justice process due to the Trauma Network. The trauma stabilisation work and support of their voluntary sector workers during the court process had an enormous impact on survivors, making something that was potentially unbearable and enormously risky in terms of survivors' mental and physical health (including suicidality, self-harm and other relapse behaviours) tolerable and thus safe.

> *She's supported me through court, through the police investigation, how to deal with that and manage it in a way in which I'm not going nuts. My worker come to the sentencing with me, so she supported me through it. I don't know where I would have been without her to be completely honest because if I hadn't got the strategies that I know how to do I wouldn't have been able to cope with it. (Survivor B)*

Survivor C's supporting police officer withheld the possibility that her abuser could be found not guilty until the morning of her court case, which understandably had a huge impact on her and meant she was almost unable to deliver her victim impact statement, an achievement she and her support network were understandably extremely proud of and which marked a milestone on her recovery journey. By withholding this information, the police officer denied the survivor control and choice, and broke any trust she may have placed in the police.

> *Then the day before the sentencing she come to see me and said I just have to tell you there's a chance that he could get a suspended sentence and I was like this entire time you've told me that he's going to go down. I was so petrified cos I knew I was going to go to court, I was going to stand up, I was going to read my impact statement in front of him and his family and everyone knowing that there was a possibility he could be going home, and luckily he didn't, but she didn't pre-warn me about that. (Survivor C)*

Survivor C also had her emotions diminished and was admonished for expressing very natural distress during a traumatising process; this lack of trauma recognition and a compassionate response only made the survivor's experience of evidence-giving and the court process more anxiety-laden and stressful.

> *I know that they have to keep distance, they can't connect to the cases obviously because it's work for them, but I don't know, for me it just felt like she could have been a little bit more empathetic or a little bit more understanding on how I was feeling because I was really distressed and she was like there's no need to be that upset or there's no need to be like this and I was like I'm upset because I'm scared. (Survivor C)*

While the importance of a fair trial and the opportunity for defence is undeniable and a rightly enshrined part of the justice system in this country, the techniques permitted by defence barristers towards survivors of VAWG and sexual abuse cannot remain unquestioned. The deliberately scornful and dismissive mannerisms of the barrister in Survivor C's case added needless trauma- survivors can be cross-examined without eye rolling.

> *Then when I did my evidence his barrister was very I don't believe you and it was very hard for me to sit there and be asked these questions, did he do x, y, z, did this happen or how did this happen or when did this happen and when I'd get upset, cos I was sobbing the whole way through, he'd roll his eyes at me. So I had to sit there and relive that knowing that the perpetrator's just behind that, he's watching and he's probably getting a kick out of seeing me upset. (Survivor C)*

A final element of the criminal justice process where the support provided by the Trauma Network was especially needed post-trial, regardless of outcomes. following a period of intense involvement from professionals during evidence giving and court , the impact of this remained with survivors and they struggled with how to move on with their lives and how to reconcile their feelings about the verdict. Survivor C described this stage as even worse than pre-trial, a finding that surprised me but that really attested to the value of the work being done by the voluntary sector and ISVA service in their trauma-focused support.

> *I found it very difficult in the lead up but the after was worse for me. It was horrific, the lead up, the verdict was absolutely horrendous, but after, knowing that he'd gone to prison, there was no real support from court and police after. So after he'd been found guilty and he'd been shipped off to prison I really struggled with that and there was no support from them, it was (voluntary sector service) and it was my ISVA. (Survivor C)*

Healthcare

Healthcare professionals were identified as a group who would benefit from trauma-informed education and support, due to their frontline role and level of contact with the general public and the detrimental experiences many survivors had.

> *I do think GPs, if they could be more trauma-informed because I think they're the first point of contact for a lot of people, other people don't know there's different services you can either self-refer or be referred to, they go initially to a GP and if that GP doesn't know how to handle it or doesn't understand trauma and how it works and how it can be in a person and how it's different in every person, then can they actually do right by that individual. (Survivor A)*

> *I had to go to the GP for that, so the GP, he wanted to know everything that had happened to me but I said I don't want to explain it because I was looking at my medical notes on the computer and it said certain things so I was like why do you have to ask me certain questions, but it was really graphic, in detail questions that he asked me and I was like why do you have to… I remember when I left I was so retraumatised by it and triggered, I had a nightmare that night, it was horrific because there was no explanation on why he had to ask me them questions or how it was relevant because it wasn't relevant towards how it affected me mentally, he wanted to know what exactly had happened and who this person was and I was like is for your gain or for mine? It was really bad. (Survivor C)*

Survivor D's voluntary sector worker had previously worked in hospitals and explained that there is an urgent need for trauma-informed care in these environments, especially in emergency care where there isn't often time to explore patients'

backgrounds. The following examples attest to the potentially retraumatising impact that life-saving healthcare interventions may when administered without a trauma-informed underpinning.

> *To give you an example, there was a particular patient we had that was ventilated for a long time, on loads and loads of drugs and would hallucinate. When we bring him off the meds to check his cognitive assessment and all of that to check if he was able to come off the ventilator. Quite often he was just seeing things or hearing and couldn't respond properly. And but it turns out that he was being triggered by the sight of blood, he had a cannula in for all sorts of regulating and that would be a trigger. He'd been a train driver and someone jumped in front of his train. And this would be really helpful information to have for when we were taking him out of sedation and off the ventilator to avoid triggering him like this. (Voluntary Sector Professional, Survivor D)*

She also cited examples where people with histories of physical and sexual abuse were disorientated, 'screaming they were being raped' when hospital staff were removing cannulas or holding patients down to perform medical interventions.

One suggestion to avoid this, to pre-warn staff when they are working with patients who have survived trauma is to develop a way that (with survivors' consent), was for handover to provide information. A related idea that I hope to explore in future research is the development of a 'trauma passport' that accompanies survivors across all services and is shared upon referral as a matter of course. This would provide a 'need to know' synopsis of survivors' triggers and a 'flag' to alert that these are related to trauma; therefore, without disclosing sensitive information about survivors, professionals could be prepared and better able to understand and approach service users/clients compassionately, from a trauma-informed perspective and avoiding triggering.

Social care

Social services were another sector where survivors had historically struggled; social services are notoriously understaffed and overstretched and facing increasingly chronic and complex levels of crisis and demand in communities. This goes some way to explain the traumatising way in which some professionals within that sector worked, but regardless, the experience of Survivor C speaks to a lack of compassion, sensitivity and general understanding of trauma and triggers. By improving their knowledge of trauma, their approach towards survivors of abuse and their connection with other services, social services may be better able to perform their role as well as better safeguard and engage their clients.

> *Social services is a big thing. After you go to the police social services get involved to make sure you're safe at home and everything and I remember I'd just gone to the police, just disclosed it, social services turned up unannounced at the door and they come into the house, I was sat on the settee, and they basically told me, it was two women, basically told me I have to tell my dad everything that happened, which I didn't want anyone to know. I remember the way in which they did it, they didn't explain anything or they did it so that it was by textbook, not you know like caring or like I was someone other than just another kid that they're dealing with. They come upstairs, they barged in my sister's bedroom to check that we had beds and stuff but they didn't explain what they were doing. They weren't very helpful in terms of getting in touch with other services or giving me any help towards dealing with what was going to happen next or what had happened or how to process any of that. It was really bad, I was already scared, petrified of everything that was happening then to be told you have to tell your dad and you have to do this and do that, it was just too much. They were only involved for a*

little time, they come to see me in school I think twice and then they just left, but there was no explanation or no further support or advice on how to help me deal with what I was going through or anything.

Survivor C's traumatising experience of social services may have been mitigated by the presence of professionals and systems that were trauma-informed, and able to invest the time, provide the holistic, wraparound care and support network and demonstrate the care and compassion that was otherwise absent. This suggests that the operation of a trauma-informed network may counterbalance the (unintentional) harmful impact of services who, whether for reasons of organisational trauma, lack of capacity or misalignment of remit, are not able to provide appropriate support.

Social workers were also identified as a professional group who would benefit from trauma-informed education and guidance on how to apply this. Currently, it was felt that organisational culture meant that some social workers were mis-understanding the trauma stabilisation support and using conditionality to coerce women into taking part, an approach that is apposite to the principles of trauma-informed care as it takes away women's control and choice and is motivated by fear, not by hope and strength.

Social workers, social care, I know they've done trauma matters to social care managers but I do think that it every professional actually should do some sort of work around that trauma-informed approach and the impact of trauma because not everyone does understand it. Social workers, I know they've got a job to do but sometimes it's about being a little bit more understanding, and I know system doesn't allow that sometimes, but it might be, even it just changes how they approach people that's a start… I know of cases where because women have been sexually exploited it's been used against them, it's been brought up and it's been well then you need to go away and do this trauma stabilisation in order to… so it's been written into social care plans where it's a voluntary relationship to start with and that's what happened several times, numerous times. (Survivor A's voluntary sector worker)

This is concerning and indicates a disconnect between the intention and main application of the trauma stabilisation provided by the voluntary sector and the approach taken by social workers on the ground. Trauma stabilisation has been illustrated in this research to have a powerful impact on survivors' trauma, community trauma and systemic trauma; however, by misusing the offer, relationships between survivors and professionals may be more distrusting and their stresses and feelings of loss of choice and control exacerbated. This speaks to a need to address this fracture between organisational cultures to ideologically and practically realise the benefits to survivors and to social workers and social services that the correct use of trauma stabilisation *and* trauma informed practice can make for survivors, their families and their children.

Families

The importance of providing trauma informed support to families emerged in the findings as important in two ways; firstly, so that families were able to support the survivor by understanding symptoms and being able to respond to them but secondly, in recognition of the transmission of trauma and families' need for support with their own trauma in connection to the abuse of their loved one.

I think families because I think when, cos trauma is so complex, families around you that obviously need to support that individual and if there's children, if they don't understand it, again, can they support that person, can they understand it? So that person's got best chance of getting through it. (Survivor A)

Although there was not a commission to provide these services, professionals in the voluntary sector were responding to need and using the knowledge and skills cultivated via the Trauma and Resilience Service to also provide support beyond survivors as individuals, to their families. By drawing upon what is known about Adverse Childhood Experiences and the adults that grow from these, the impact of providing whole family trauma informed support can be extrapolated to not just affect the family unit and the individuals in it but the community and society that these individuals and families will engage with and contribute to in future. Consequently, the greater trauma-informed support can be extended, the greater the possibility of early intervention and the mitigation of future physical and psychological health problems, disengagement and exclusion from education and employment, antisocial behaviour, substance use and community integration. The reality of trauma as a whole family effect and the recognition of the need for work to address this in the voluntary sector was attested to by professionals and the success of the interventions they were providing in response;

> *It should be accessible to parents so they can better understand their child that's experienced trauma and therefore they can support their child. I'm supporting somebody at minute, she's the sister of somebody that was sexually abused and that trauma happened to that family, the abuse happened to that individual but the trauma of it, the ripple effect of that happened to that family. I support the sister and we've delivered trauma stabilisation to the mum, so we've done like a wraparound service around that family. It's not always doable, like I said we don't necessarily offer that support package to parents but we did with a particular cohort because we've got quite a number of young people that were in our service so we delivered trauma stabilisation to the mums of these kids. (Survivor A's Voluntary Sector Worker)*

Publicity and awareness

The issue of awareness of trauma-informed support that understand and listen and can provide tailored, flexible, compassionate help arose in 2022's *Travelling Through Trauma*, and below, Survivor 1 sums up the impact and essence of the message that further publicising these services could hold for survivors who are currently suffering in silence.

> *If you go back years and years, years ago I never knew there were this many services around that can support and in such a gentle way, understanding way. It's very specific to each individual, it can change for each individual, so it's not just a set routine of this is what is there for everyone, it can change for them. I think if people know that's out there I think you'd have a lot more chance of people coming forward and from somebody who's now on other side of it, I want to get out there that people, you're allowed to tell people what has happened to you because it has happened to you, it is validated and you don't have to carry it to your grave. (Survivor A)*

It is crucial to acknowledge, however, that services in all sectors are struggling after sustained cuts to funding, increased complexity and level of demand and need, and greater competition for resources in order to survive. Therefore, it is important that raising awareness and increased publicity is bolstered by increased capacity in services to avoid survivors feeling disappointed and let down again.

Expanding services to increase access

While the reach of the Trauma Network is expanding and, as discussed above in terms of flexibility and creativity, can provide support that extends beyond and is longer term than that traditionally offered, provision and accessibility can be improved. This is not

a criticism of the services or the system, but a comment on the variety of needs within the survivor population and the sadly significant extent of need and demand.

For example, Survivor F had concerns about confidentiality and anonymity when seeking help due to her profession, and also avoided group/peer support because of these fears, despite feeling that this kind of support would be really beneficial to her. The stigmatisation of abuse survivors and the shame they feel as well as the requirements of professional boundaries and separation in certain professions mean that the opportunity to access peer support without disclosing one's identity is something that may increase accessibility for survivors who aren't able to or do not feel ready to 'go public' as a peer survivor. Survivor F had also felt unable to work through an offered trauma stabilisation course alone as she recognised this could be triggered and unsafe for her and, being unable to take up the group option, instead was referred to counselling. This was an effective option but, due to discrepancies between demand and capacity, waiting lists mean that counselling is a less readily available choice.

> *I couldn't do the course on my own and they talked about some group stuff. That's something that I felt I couldn't explore because of my work actually that wasn't for me, because actually I'd reached a point where that triggered. I felt that I couldn't explore that on my own, that it was actually a probably a trigger to do it and that worried me…. I felt that it would have helped. And I felt actually, I probably did have a need for that, but for me, I don't feel comfortable doing it within my own locality so that was always a bit tough. (Survivor F)*

The benefits of peer support in abuse recovery have been generally indicated by a body of research indicating the positive impact on psychological, physical and interpersonal wellbeing of survivors (Konya et al, 2020), suggesting that the mutuality and connectivity provided by these forms of support may have additional extra benefits for survivors who find it appealing. The development of a form of peer support that transcends localities and maintains anonymity, perhaps akin to online addiction recovery support, may be a promising area for future development.

However, there are more pressing large-scale concerns over capacity and demand that, given the scarcity of funding nationally currently, ought to be prioritised before more specific capacity issues are addressed. There are long waiting lists for the trauma-informed support on offer; for example, Survivor G spoke of being on a waiting list for a year before being able to access counselling; before she received this support, she had contacted mental health crisis teams in various localities when struggling with suicidality, though had found this counterproductive. Much can happen in a year for a survivor, especially where there only accessible support is experienced negatively by them/does not meet their needs (PICK PHRASE) and where events in life may exacerbate their trauma. For survivors with chronic needs and complex trauma, this could have very serious implications. The statistics revealed by the IICSA (Jay et al, 2022), statistics on sexual abuse and violence nationally and ongoing poverty, global crises and the difficulties in the face of austerity and increasing need in health care, legal and criminal justice, and other sectors mean that levels of trauma nationally are likely rising significantly (Esposito et al, 2024; Hoddinott et al, 2022 ONS, 2023;). Therefore this research, contextualised against current affairs, asserts that there is a pressing need for a large scale trauma-informed overhaul of systems and services, and the expansion of capacity to enable existing specialist services to reach far greater numbers. Without this, it is likely that the experiences and environments that inflict trauma will be amplified, further increasing the impact of trauma nationwide.

This is exemplified by the fact that when asked which services would benefit most from becoming trauma-informed, every participant remarked that 'everywhere' and

‘everyone’ should understand trauma because of the extent of its effects in and permeation through the population.

An untenable paradox: Increasing need, greater urgency and lack of resources

It would be neglectful to omit a recognition of the struggles systems, individuals and communities are facing, especially after over a decade of government that has retrenched welfare support, decimated public services and increased pressure upon deprived communities. The result of this is that levels of unmet need and complexity in health and social care and the criminal justice system continue to rise, while services struggle to meet the volume and severity of demand. This report speaks to the important work that can be achieved where commissioning and funding allows true partnership working, when services can share expertise and knowledge, collaborating to support one another as a network addressing an increasing burden. However, especially for survivors who are in greatest need and at their most vulnerable, they may be unable to engage with any pathway yet; these survivors may often present to the mental health crisis team, homelessness services, in drug treatment and are in regular contact with the police. They may be described or felt as ‘too chaotic’ to engage with, or indeed cannot be found or seen by services which rely on beneficiaries being sent to or coming to their doors. For these survivors, there is pressing need for an increase in funding to support services to invest in outreach, finding those in the greatest need and meeting them where they are, both in terms of place but also ability to even consider the first steps of a trauma recovery pathway. This may not be able to look like having a view to support survivors to stabilise their trauma or even to recognise their trauma. Instead, it may begin with understanding that challenging coping strategies such as substance abuse or violent, abusive presentation may be vital self-preservation strategies . Instead , by making efforts to engage with these survivors simply by making contact, providing something tangible or intangible, whether food or simply sitting with somebody, outreach services can demonstrate that someone cares to those who are most often excluded from services by their lack of readiness to engage. However, currently services that aim to serve those who are most at the margins of society and most often unable to attend other services are under-resourced and so there is a gap in provision for a population of survivors who are in great need.

Capacity to respond to crisis

Part of a trauma-informed system is its ability to respond to crisis, and as we have seen, many survivors have avoided crises through the supportive relationships they have built with trauma-informed professionals in the voluntary sector and the stabilising and grounding skills and validating and empowering knowledge they have gained through this. The case study below, of survivor M, describes a survivor who has frequently been in crisis and who has over time developed a strong network of support around herself to hold her through difficult moments.

However, as touched upon above, there are many survivors who are unable to engage at all with normative services and who are often in a state of permacrisis, and for these survivors, who may be frequently presenting in states of emergency at already overwhelmed and strained services such as hospitals or the mental health crisis teams, there is a gap in provision.

The crisis team especially is a service that is set up for and aimed at providing short-term support to those at their lowest and most in need of urgent support; however as advised by Professional M , they are also a service that is struggling in terms of capacity due to funding issues but also the level of demand and elements of misunderstanding as to what they can and cannot provide.

We're a 24 hour, seven day a week service but not staffed as well as people imagine. Sometimes we can have three nurses on duty during the day and at night. … we conduct assessments alongside that and we can hold people for a short period whilst we're implementing all liaison with other services that that's pretty much the main function of our service… people might think we can work with people for extended periods of time… if you're looking and around Rotherham, what you find is our numbers everywhere. If you've if you're in a crisis, ring the crisis team, but there's no explanation of what we're doing…So if we're thinking about, you know, managing expectations, being trauma informed, enabling people to understand what our remit is, we've got to get that out and explore that. (Professional M)

Professional M highlights two elements of trauma-informed practice that warrant further investment and exploration. Misconceptions about the crisis team's capacity and remit and an assumption among services and service users that they are able to provide intensive emergency support as opposed to performing short term assessments and triaging is unintentionally creating unfulfillable expectations of a service which only creates hostility and disappointment.

Primarily, a trauma-informed network must reach the very perimeters; as attested to by Professional M, there is urgent need for the system to be able to respond to and engage with the most isolated, hard to engage with populations who may only usually be 'seen' when in states of great emergency.

7.5. Conclusion

The report has focused on the voluntary sector partners of the TRS, in particular GROW and Rise who have provided invaluable support and has spoken to a small cohort of higher functioning survivors. It has provided a valuable insight into the transformative and broad-reaching impact of trauma-informed systems change, speaking to the mitigation and offset of trauma at individual, systemic and trauma levels by approaches that build safety, trust, choice and control and ultimately, empowerment in a multidimensional way.

As the Case Study of Survivor M shows, the work of supporting survivors and the pathways Survivors must navigate are complex and challenging, and hard to capture, but a trauma-informed lens and toolkit can provide collective insight to develop collaborative approaches to support everyone involved in this crucial work.

8

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