Sheffield Hallam University
Centre for Regional Economic and Social Research

Travelling Through Trauma: Voices in Partnership, 2021-22

Service Evaluation

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Knowledge Applied

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1 Introduction

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, 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 Health and Justice NHS England in relation to 'The Strategic Direction for Sexual Assault and Sexual Abuse Services 2018-2023' policy document and the NCA Stovewood investigation. The service was commissioned in 2018 in response to the Jay report 2014.

The TRS is in its fourth year 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 pathways[1] for adults across the borough. The partnership approach sits within the Gold command structure of the NCA Stovewood investigation.

Its vision is to augment a systems wide approach to enable victims and their families suffering from CSE to be valued and understood and find services accessible and compassionate.

The Rotherham Trauma Network (RTN) 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 900 hundred practitioners from a range of organisations have attended a variety of training since the inception of the service in 2018, mainly 'Trauma Matters' day package. Also, numerous have attended CPD conferences and events[2] linked to deepening the appreciation of complex trauma within a safeguarding context. Numerous others have been trained in the TRS trauma stabilisation programme.

[1] See Figure 1

[2] For example, a study afternoon was held regarding Disassociate Identity Disorders, providing a developmental perspective.

In partnership, the TRS strive towards achieving a trauma informed Rotherham.

This evaluation builds upon previous evaluations undertaken by Sheffield Hallam in 2018-2020, the First Year Evaluation and 'Travelling Through Trauma'. This report 'Travelling though Trauma: Voices in Partnership' whilst providing an update, primarily focuses on the survivor voice and experience, consulting with survivors who have benefitted from the work of the TRS.

2 The Rotherham Trauma Network

The Rotherham Trauma Network is a collection of services that have had involvement with the TRS through training, consultation and commissioning. It is growing into a community of practice that is developing via specific projects and more informally through individual attendance at one of the CPD events. It has been developed organically is inclusive, and attracts participants from within Rotherham, the county and nationally. Its boundaries are permeable and flexible.

There has been considerable expansion of the Rotherham Trauma Network and Survivor Pathway[3] in terms of the availability and variety of support offered and in the range of services that have become and are becoming trauma cognisant and fluent, and also those that work in partnership to broaden the reach of the Trauma Pathway (such as via CAMHS).[4]

The TRS structure and its development, as illustrated in the previous two evaluation reports, provides a blueprint for exploring the transferability of the model and the development of trauma networks elsewhere. This would enhance nationwide provision to meet the needs of the considerable population of CSE survivors (and their families) who greatly need and deserve compassionate, holistic and appropriate support. In addition to treating survivors of CSE (and other traumas) with the sensitivity, empathy and understanding they are entitled to, the TRS approach also has a cost benefit. Its work can significantly mitigate the multitude of barriers that mean hard to reach cohorts[5] face so they are able to approach and access support which recognises and responds to their trauma, providing them with choice, control and capacity.

2.1. The Author

The research has been designed and carried out by Rebecca Hamer, a PhD candidate in the final part of her programme who has been kindly supported by her supervisors from Sheffield Hallam's CRESR. CRESR, the author and her supervisors are passionate about working in research to support marginalised populations with complex needs, redressing social injustice and informing systems change.

3 Referring to the voluntary and sector relationships developed by the TRS to embed pathways for CSE survivors and to the range of options available to survivors for support and community of practice.
4 Please see Figure 1 for illustration of this relationship and others.
5 Such as those involved in the criminal justice system, suffering domestic abuse and others with multiple unmet needs.

2.2. The TRS VLOG

An illustration of the partnership narratives can be viewed on the link below:

https://youtu.be/jXAtbAbC-VA

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Literature Review: Trauma, Adverse Childhood Experiences, Child Sexual Exploitation and Rotherham

3.1. CSE in Rotherham

In 2014 the Jay report declared that between 1997 and 2013 over 1400 young girls in Rotherham had been sexually abused and exploited by predominantly British-Pakistani men. CSE in Rotherham is predominantly characterised by two 'models'. The 'Boyfriend' wherein victims are targeted and exploited by a (usually young) man offering emotional, practical and material inducements and manipulations including bribes and threats. And, 'Organised Sexual Exploitation' where survivors are passed and/or traded around networks of perpetrators. Within Rotherham, the two models operated symbiotically as ''Group Localised Grooming' (Mooney and Ost, 2013).

This widespread, on-going sexual exploitation of children and young people has received significant public, political and media attention. It is now often at the forefront of the public and professional mind where pervasive, hidden and insufficiently tackled repeat sexual traumatisation and abuse of children is concerned. As cases of CSE continue to be bought before the courts and similarly widespread and harrowing networks of abuse are uncovered nationwide, the spotlight very much remains upon the professionals of Rotherham (Whitehouse, 2020; Dearden, 2019). Often this can take the form of a quickness to attribute blame or levy accusations of shortcomings, perhaps a legacy of the allegations of professional blindness and neglect that accompanied the Jay report.

The Jay report (2014), which the TRS was developed in response to, detailed the extent of the horrific abuses suffered by children in Rotherham. It also revealed how the marginalised backgrounds of a significant proportion of the survivors rendered them especially vulnerable to these types of abuse.

> *"In just over a third of cases, children affected by sexual exploitation were previously known to services because of child protection and neglect. It is hard to describe the appalling nature of the abuse that child victims suffered. They were raped by multiple perpetrators, trafficked to other towns and cities in the north of England, abducted, beaten, and intimidated. There were examples of children who had been doused in petrol and threatened with being set alight, threatened with guns, made to witness brutally violent rapes, and threatened they would be next if they told anyone. Girls as young as 11 were raped by large numbers of male perpetrators."*

As a result of these horrors, among many other tragic consequences, children and young people suffered pregnancies, miscarriage's and terminations; some had children removed under care orders and so suffered further trauma as contact with their children was terminated (Jay, 2014: 43).

As noted, a proportion of survivors already had vulnerable backgrounds marked by struggles with adversity and lack of support from services. Consequently, the Jay report noted that the majority had 'multiple reported missing episodes', that addiction and mental health issues were 'common themes' and that 20% and one third respectively had experience of parental addiction and mental health problems. Furthermore, these experiences commonly resulted in barriers to accessing mental health support and counselling, with Jay noting there was 'little specialist counselling or appropriate mental health intervention offered to child victims despite their acute distress' (Jay, 2014: 30, 43). The report recognised that there were a number of cases where survivors expressed a need and want for such specialist support yet were unable to access it because of long waiting lists and gaps in services. There was also a lack of understanding of the symptoms of PTSD and the consequent impact upon survivors' engagement with services when they were available; for example, if a child missed their first mental health appointment they would be discharged from the system (Jay, 2014: 56). The CCG commissioned a specific service within CAMHS bridging with adult mental health in 2014 to address this issue and an innovative consultation service reduced thresholds, increased accessibility, and developed a managed approach to CSE referrals.

The TRS service has since built upon this success, incorporating the recommendations of the accompanying Department of Health (2015) report 'Tackling Child Sexual Exploitation' and advocating to ensure services understand the roots of engagement difficulties in trauma and find ways to address them.

Following the exposure of historical deficits across the Rotherham CSE landscape the local authority was placed in special measures. This was followed by the resignation of the leader and chief executive of Rotherham Council and eventually, following Home Office pressure, of the council's director of children's services and the Police and Crime Commissioner for South Yorkshire Police.

Given the severity and repetition of the terrors inflicted upon survivors, it is vital that the CSE service provision landscape and associated services are informed by knowledge of: PTSD, ACE, developmental and complex trauma and understand the devastating consequences of trauma upon physical and mental health, personality development, subsequent relationships and presentation and ability to engage with services.

The 2014 Department of Health Independent Inquiry estimated that victims might number around 1400. However, survivors of sexual abuse and violence, especially those of CSE and grooming, face great obstacles in self and perceived societal stigma, in addition to internalisation of guilt and shame as a result of trauma. Due to these impediments to self-identification, it is likely that numbers of survivors may be in excess of this. This is certainly seeming to be the case as the NCA and TRS continue to discover further numbers of survivors as their work progresses (Dearden, 2019). The National Crime Agency's Operation Stovewood has had contact with over 1500 survivors. This is the largest national investigation of its kind and represents a landmark in criminal and societal approaches to the grooming and sexual exploitation of vulnerable children and young people. Court cases continue to progress and the need for survivors to be supported during these especially traumatising experiences is critical. COVID-19 has resulted in a backlog of cases in courts and so survivors have been under increased stress as their wait justice is prolonged.

A key aspect of the TRS' role is to support survivors during the court process and beyond, whether or not convictions are achieved. Developing a strong, evidence-based trauma aware/informed professional network is an essential aspect of this. The TRS Trauma Pathway clearly evidences the existence and operation of this professional network and is leading the way in transforming the landscape of CSE service delivery.

It is also crucial to acknowledge that CSE is not just a local issue. With 19,000 children having been identified as victims nationally, the more evident it is that the Rotherham experience cannot and must not be viewed in isolation (Dearden, 2019). The danger of this is that there is a very real risk that other boroughs and cities then fail to recognise the same problems in their vicinity. Thus, it is vital that work such as that of the TRS is not seen as a quick fix but as part of an essential, wide reaching and permanent shift in the way the nation perceives and responds to CSE and complex trauma generally. Furthermore, the learning and work of the TRS can serve to inform similar efforts on a nationwide basis to address the devastating impact of the realities of CSE across the country.

3.2. What is Trauma?

Developmental Trauma

'Developmental trauma', 'relational trauma' or 'attachment trauma' are often used interchangeably to describe the impact of trauma that can emanate from profound relational experiences in the early years of life.

Humans are born ready to attach to a primary caregiver (Slade, 1999), which is imperative to their survival and development. The way this caregiver interacts with the infant becomes wired into its developing brain circuitry (Van der Kolk, 2015). Initially, a baby's communication repertoire is limited to "emotional expression" to signal its needs to the mother (Bowlby, 1979). The mother or primary care giver in 'ideal' development responds appropriately on the majority of occasions, thus providing 'good enough care' (Grolnick, 2002). From a psychoanalytic perspective "healthy development" is based around the child developing the capacity to distinguish between his internal and external worlds (Şar, 2017). When a child develops and grows in an abusive or mis attuned environment, they may develop an insecure attachment style and be in a pervasive state of fearfulness, often developing altered states of consciousness in relation to the limits of their minds and bodies where reality, imagination, memory, and knowledge are not integrated in the usual form (Herman, 2015).

As a result of emotional abuse, neglect or physical abuse, or indeed compromised relationships as a result of substance misuse or domestic abuse, an infant or young child might grow up in a family atmosphere that is characterised by peril and unpredictability. The resultant mix of emotionally un-digestible experiences, if not mitigated by a caring and thoughtful adult, can have a profoundly damaging impact upon the core of the developing personality of the child and growing individual. We know from substantial research that such experiences render individuals and families vulnerable to a host of emotional difficulties intergenerationally (Fonagy, 2018; Frewen et al., 2015; Van De Kolk, 2014).

Where the attachment relationship has been profoundly disrupted or disturbed by abuse it usually leads to children experiencing a constant need to stay alert to environmental triggers of impending attacks and of finding ways to survive and adapt in an ever changing, unstable environment (Herman, 2015). For an individual who has never had an internal sense of security and safety, it would also be challenging for

them to distinguish between safe and unsafe or dangerous situations, potentially increasing their vulnerability to harm (Van der Kolk, 2015).

The Consequences of Developmental Trauma

One survival strategy that children and adults who have experienced developmental trauma adopt is dissociation, the disconnection between mind and body in the face of overwhelming stress and trauma. It is thought that children can learn to dissociate on cue (Herman, 2015). Children and adults who feel a pervasive sense of numbness may also engage in risky or dangerous behaviours to enable them to feel real or alive (Van der Kolk, 2015).

Regarding personality development, it has been illustrated that the ability to form "emotional bonds" i.e. relationships, in both caregiving, and receiving roles is a central feature of "effective personality functioning and mental health" (Bowlby, 1979). The experience of repeated or multiple traumatic events breaks down the structure of the personality in adults, and de-rails the development of the personality in children (Herman, 2015). During adolescent development, the brain goes through another phase of re-wiring which again is transformative and imperative to personality development (Van der Kolk, 2015).

The development of insecure attachment style and/or early childhood abuse leaves individuals with a vulnerability to serious psychological difficulties following the experience of further traumas in life (Van der Kolk, 2015). It is thought that a child's attachment style accompanies them throughout their life course, providing a 'blueprint' of relating to others (Bowlby, 1979). Bowlby suggests that this becomes internalised, meaning the child repeats it or "imposes it" on novel relationships, in differing settings. And so, people repeat the patterns of their past and of their past traumas.

Insecure attachment style can also be transmitted intergenerationally, through families. Fraiberg et al. (1975) refer to children being "burdened" by their parent's upbringing and the tendency of people to repeat the events of their childhood (Fraiberg et al., 1975). Similarly, Wallin proposes that people are "unconsciously gripped by the need to repeat habitual patterns of relating, feeling and thinking" (Wallin, 2007). However, as Fraiberg et al. (1975) and others suggest, parents who acknowledge their childhood distress are more likely to break the cycle of repetition, while those who do not are more likely to be trapped in repetition.

Whilst every person's experience and background will differ, a significant number of those who suffered from CSE came to the abuse with prior vulnerabilities, often with a foundation of developmental trauma. Among the Rotherham survivors it was not uncommon that this led to a number being looked after within the care system, adding another layer of vulnerability. The subsequent experience of being manipulated or groomed into an attachment relationship at a tender age, on the cusp of or in early adolescence, with someone who turned out to be a perpetrator of abuse rather than a secure and attuned attachment figure adds yet a further layer of developmental trauma.

When planning services, it is important to be cognisant that when thinking of CSE victims we are never speaking about the impact of a single trauma but for many a lifetime of experiences that, unacknowledged, can disable an individual and prevent them from leading a settled and contented life.

3.3. Adverse Childhood Experiences and Their Impact

A not insignificant aspect of the lifetimes of harmful experiences suffered by a proportion of Stovewood survivors include traumatic incidents in childhood known as 'Adverse Childhood Experiences' (ACE). A significant proportion of survivors

experienced multiple other ACEs such as prior emotional and physical abuse and neglect, growing up witnessing domestic violence and with parents or carers with substance misuse and mental health problems (Larkin et al., 2012).

From the 1990s medical researchers at the Centre for Disease Control (CDC) partnered with Kaiser Health Plan to assess a cohort of over 17000 adults and the correlation between their ACE and negative health, behavioural and social outcomes (Anda et al., 2020; Felitti et al., 2010; Larkin et al., 2014, Larkin et al., 2014). The ACE study illustrated that ACE often co-occur and that there is a strong 'dose-response' relationship between ACE scores and social and health problems that occur across the life course (Felitti et al., 2010; Larkin et al., 2012). The consequences of ACE are broad reaching, encompassing health, criminal justice, and social domains. The below table illustrates the summary findings of the CDC-Kaiser ACE Study and the outcomes associated with ACE (Larkin et al., 2014: 265).

TABLE 4.1OUTCOMES ASSOCIATED WITH ACES

Outcomes associated with the ACE score	
Prevalent diseases	Ischemic heart disease, cancer, chronic lung disease, skeletal fractures, sexually transmitted diseases, liver disease
Risk factors for common diseases/poor health	Smoking, alcohol abuse, promiscuity, obesity, illicit drug use, injection drug use, multiple somatic symptoms, poor self-rated health, high perceived risk of AIDS
Mental Health	Depressive disorders, anxiety, hallucinations, panic reactions, sleep disturbances, memory disturbances, poor anger control
Sexual and reproductive health	Early age at first intercourse, sexual dissatisfaction, teen pregnancy, unintended pregnancy, teen paternity, foetal death
General health and social problems	High perceived stress, headaches, impaired job performance, relationship problems, marriage to an alcoholic, risk of perpetrating or being a victim of domestic violence, premature mortality in family members
Problems from the longitudinal follow-up of the study cohort	
Prescription medications	Total prescriptions, prescribed multiple classes of drugs, psychotropics, bronchodilators
Diseases	Chronic obstructive pulmonary, autoimmune, lung cancer
Mortality	Premature mortality, lung cancer

Many of the aforementioned consequences affect survivors of CSE, and these factors serve to complicate and exacerbate the difficulties suffered by sufferers of PTSD, resulting in complex PTSD.

Post-traumatic stress disorder

Although the effects of the horrors of war upon combat veterans had long been established it wasn't until after 1980 that it was recognised that post-traumatic stress disorder also occurred among women who had been physically and sexually abused, and that 'the hysteria [1]' of women and the combat neuroses of men are one', namely the symptoms of Post-Traumatic Stress Disorder (PTSD) (Herman, 2015: 32).

The consequences of exposure to extreme, actual, or perceived violence and abuse are individual, social, and economic and transmitted across generations. Experience of trauma has been illustrated to produce poor physical, mental, and emotional health outcomes, consequences of which range from suicidal ideation and attachment

difficulties to emotional regulation and problem drug use. Therefore, the root of many 'social problems' can be partly identified as the experience of chronic traumas.

3.4. Models of trauma

The Operation Stovewood CSE survivors are predominantly female, and many have been repeatedly exposed to severely traumatic events, so it is imperative that individuals and services endeavouring to support these women are aware of corresponding models of trauma.

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) PTSD the criteria for PTSD is outlined as follows:

- Criterion A – the person was exposed to death, threatened death actual or threatened serious injury or actual or threatened sexual violence, as follows:
  - Direct exposure.
  - Witnessing in person.
  - Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
  - Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

The DSM-5 designates a criterion of four clusters of symptoms including.

- Intrusion symptoms.
- Persistent avoidance of stimuli associated with the trauma.
- Negative alterations in cognitions and mood that are associated with the traumatic event.
- Alterations in arousal and reactivity that are associated with the traumatic event.
- These symptoms must also be.
- Present for more than one month.
- Manifest as significant symptom-related distress or functional impairment.
- Not due to medication, substance, or illness.

According to Herman (2015) clinical symptoms of trauma are broadly organised into the following three categories:

- **Hyper arousal:** involving hyper vigilance, poor sleep, irritability and being easily startled. These all indicate the constant state of anticipation of further threat and violence.
- **Intrusion:** entailing reliving the traumatic event(s) in sleep and while awake, and the intrusion of memories of the event(s) that may resemble the 'memories of young children' in their absence of verbal narrative. Intrusion may also result in survivors exposing themselves to further risk through re-enactment of events, such as forming relationships with older controlling men, which may lead to

experiencing fresh traumatic incidents in addition to being trapped in the abuse of their childhood.

- **Constriction:** 'the numbing response of surrender' (Herman, 2015: 34) which may present as disassociation, detachment, trance states and the pursuit of numbness and oblivion.

In addition to involuntary mechanisms of thought, memory and the subconscious, other strategies through which traumatised people may attempt to manage their symptoms of trauma include use of drugs and alcohol, defensiveness, aggression and restriction of their practical and social lives.

Complex Post Traumatic Stress Disorder

Repeated exposure to traumatic events amplifies the impact of PTSD, known as the 'dose-response' curve (Choularia et al., 2014; Felliti et al., 1998). This repeated, prolonged, and severe exposure to trauma has resulted in the expansion of the conceptualisation and definition of PTSD to include 'Complex PTSD', or Type II Trauma. The symptoms of this 'include denial, psychic numbing, self-hypnosis and alteration between extreme passivity and outbursts of rage' (Herman, 2015: 120).

The International Classification of Diseases (ICD-11) includes a diagnostic category for Complex PTSD (CPTSD), which incorporates the symptoms of PTSD plus difficulties regulating emotions, feelings of guilt, shame and/or failure, and interpersonal relationships blighted by conflict.

Of great significance to the Stovewood survivors, Herman (2015) attests that adolescent girls are especially vulnerable to the trauma inflicted by rape. This chronic trauma compromises three of their normal adaptive tasks in that stage of life: the formation of identity, the gradual separation from their family or origin and their exploration of the wider social world. The NICE guidance (Greenberg et al., 2018) attests that CPTSD manifests in children in a similar way to adults but may also include physical symptoms such as stomach aches, bed, and heightened anxiety when away from parents/adults and re-enactment of the trauma through play.

Therefore, as Rotherham survivors were often subject to multiple assaults and exposed to on-going cumulative terror at vulnerable stage of their development, it follows that many may meet the criteria for CPTSD. A proportion of the survivors also experienced trauma as children and so CPTSD may have manifested in their lives from a young age.

Attesting to the importance of multi-disciplinary, holistic care for complex PTSD survivors, evidence and best practice guidance has recommended 'psychological, sociological and pharmacological (McFetridge et al., 2017). In order to be trauma informed, this support must be informed by the phased trauma recovery model, discussed below.

3.5. The Three-Stage PTSD Recovery Model

Judith Herman's (2015) pioneering work on trauma advocates a three-stage model wherein recovery is attained via a process entailing the following.

Firstly, Stabilisation must be attained before the traumatic events and memories may be attended to. This entails establishing stability and safety within the domains of an individual's physiology, psychology, and social needs. Stabilisation requires a holistic approach, addressing basic needs/ such as housing, finances/benefits and childcare then moving on to the establishment of structure and routine, including eating regularly

and sleep hygiene. Co-morbidities such as substance misuse issues are also considered at this stage, as well as the teaching of individual skills to regulate their mind and body. The latter may be attained through periods of psychoeducation supported by strategies such as grounding and emotional regulation. Management of symptoms such as nightmares and panic attacks may be further abetted as therapeutic relationships develop.

Following a period of stabilisation, work may be begun to confront and process the trauma or traumas that the individual is wanting to work on. This phase is also known as 'Processing' and is achieved via various therapies through which the 'story' of the trauma may be pieced together. Herman notes that it is important to remember that the 'story' may change over the course of therapy as missing or dissociated pieces are uncovered, and that this fragmented recall is a symptom of PTSD. It would be expected that a logical narrative of 'what had occurred' would be more accessible to the individual following the processing phase once the pieces had been assimilated, rather than when the memory is still in its fragmented state. The imperative to acknowledge and act on this when supporting survivors throughout and around the decision to or not to engage in the criminal justice process is discussed further in this evaluation.

Finally, Reintegration follows coming to terms with the past, wherein the survivor begins to re-build their future whilst confronting fears, learning to speak up for themselves and fundamentally, reconnecting with their self and others.

The above is described in a linear fashion, although it is well known that in clinical practice individuals may progress through the stages in a cyclical manner going ahead and then back a stage as they need (Palmer and Foley, 2017). It is also important to emphasise choice and some people may wish to work on the symptoms and some may want to gain meaning and make sense of their life and the story of their development.

This process, or stages of it, results in the restoration of trust, autonomy, initiative, competence, identity, and intimacy, and thus it is evident why and how trauma must be addressed for the quality of life, wellbeing and justice of survivors, families, communities and society.

3.6. Resilience

The concept of resilience refers to the ability to 'bounce back' from adverse experiences, and regarding posttraumatic resilience 'refers to a complex repertoire of behavioural tendencies' including 'extraversion, high self-esteem, assertiveness, hardiness, internal locus of control and cognitive feedback (Agaibi and Wilson, 2005)'. It is critical to build resilience in survivors in order to lessen the harm of any criminal justice proceedings or other threats. This can be facilitated through the development of coping skills, support networks and self-efficacy. Supporting survivors to understand their experiences of trauma as natural responses also builds resilience, improving their self-esteem and ability to manage hardships.

A resilient personality might be one that can draw upon emotionally attuned and reliable attachment relationships from their past or existing in the present day. Therefore, having professionals who are reliable, trustworthy and show positive regard and empathy can be a great asset in resilience building, especially where secure attachment figures have historically been absent.

In order to help build resilience then it is fundamental that services throughout Rotherham work together to empower survivors in the development of positive, supportive relationships with professionals, family and the community.

3.7. The Impact of Child Sexual Abuse/Exploitation

The repercussions of CSE for individuals, families and society are significant and wide ranging. Associated physical health problems include injuries from violence, pregnancies and terminations, sexual health problems and drug and alcohol misuse to name a few. Correlating mental health problems range from depression, anxiety, and low self-esteem to the various and severe symptoms of PTSD and CPTSD. It is estimated that half of CSE survivors suffer a range of psychological problems directly related to trauma, while 85 per cent have self-harmed or attempted suicide (HM Government, 2015).

In attempts to manage the significant impact of the trauma of CSE, abused children's adaptive attempts commonly include:

- Dissociative defences.
- A fragmented identity.
- 'The pathological regulation of emotional states' (Department of Health, 2015).
- In adulthood the survivor's sense of self, sense of trust and safety in the world and others is greatly damaged. Their cognition, memory, and ability to act autonomously and use initiative are also significantly harmed.

Herman (2015: 32) describes the coping strategies that often result:

> *'Self-injury is perhaps the most spectacular of the pathological soothing mechanisms… abused children generally discover at some point in their development that they can produce major, though temporary, alterations in their affective state by voluntarily inducing autonomic crises of extreme autonomic arousal.'*

These can manifest as drug and alcohol misuse, bulimia, risky sexual behaviour, and compulsive risk taking.

The correlations between CSE and PTSD/CPTSD symptoms are evident. The Department of Health and Social Care's 'Transforming Services for Children and Young People Who Have Experienced Abuse' (DOHSC, 2018) concludes that 50-80 per cent of CSE survivors exhibit symptoms of PTSD that, in addition to the above, may include aggression and rage, disruptive behaviours and withdrawal. The severity of these psychiatric responses directly correlates with the number of traumatic incidents, meaning those who have suffered repeated victimisation are more prone to exhibit chronic symptoms of trauma (DOHSC, 2018). Therefore, it is crucial that services supporting CSE survivors are informed by an understanding of the presentation of PTSD in order to avoid misinterpreting symptoms of chronic distress as rebelliousness, aggression or a lack of willing/interest in support.

The report (DOHSC, 2018) also attests that in order to most efficiently identify and address the symptoms of CSE, multi-agency, coordinated, collaborative care across sectors must be specific to local needs, high quality and evidence based. CSE survivors thus need services that are both trauma informed and engaged in a network of information sharing, collaboration, and referral with a range of other professionals.

3.8. The TRS and Providing Evidence Based CSE and PTSD Support

The International Society for Traumatic Stress Studies (ISTSS) 2015 Prevention and Treatment guidelines are informed by a systematic review of the clinical research

literature on prevention and treatment for children, young people, and adults at risk of or suffering PTSD and CPTSD.

These guidelines conclude that psychological interventions are most effective when focussed on establishing safety, trauma processing and reintegration, reflecting Herman's phased model.

The ITSS have assessed and agreed upon early (within three months of exposure) and later treatment guidelines for PTSD, including trauma focussed interventions which incorporate relaxation and stress management. These are being delivered to survivors through the TRS' partnership with the voluntary sector, though the TRS stabilisation programme.

NICE (Greenberg et al., 2018) guidelines for the 'Stabilisation' phase advise that interventions should include 'psycho-education about reactions to trauma and strategies for managing arousal and flashbacks.' Furthermore, such interventions must be delivered by 'trained practitioners with on-going supervision' (Greenberg et al., 2018). Thanks to the trauma training provided by the TRS, professionals are now able to acknowledge the trauma and its impact upon survivors and equip them with stabilisation techniques to manage the symptoms.

A fundamental element of trauma support for CSE survivors is that survivors are able to tell their stories and to be listened to and believed by professionals, friends, family and by society. The work of the TRS in helping individuals and professionals understand the symptoms of trauma that may be misinterpreted and have previously led to the survivor being doubted or depicted as unreliable is a vital part in facilitating this. Their ongoing development of relationships and trauma awareness throughout services including schools and early intervention family workers among others, increases the availability of professional services where survivors may safely share their stories and be appropriately listened to and supported.

3.9. Vicarious Trauma

The risk of trauma transmission is not just intergenerational. Due to the impact of engaging with survivors' disclosure of traumatic events, workers' core beliefs (their sense of self, others and the wider world) can be damaged due to secondary or vicarious traumatisation (McCann and Pearlman, 1990; Sabin-Farrell et al., 2003). The consequences of vicarious traumatisation can include depression, anxiety, and other symptoms of PTSD such as intrusive imagery. Vicarious traumatisation can also directly impact upon professionals' capacity in their work, causing struggles to engage with survivors' accounts and mental and physical exhaustion[6]. These understandably affect the wellbeing and quality of life of staff and their ability to continue to support survivors (Ortlepp and Friedman, 2002; Bober and Regehr, 2006; Berger and Quiros, 2014). Sharpen's (2018) exploration of services for women experiencing multiple disadvantage noted the influence of professionals' vicarious traumatisation, with practitioners attesting to the need for services to 'recognise and respond to the impact of secondary trauma on staff'. It was also felt that a genuinely trauma informed service would understand the signs and symptoms of vicarious traumatisation and provide supervision and other specialised support to help minimise this. Consequently, the wellbeing of the workforce must be a parallel consideration when developing sustainable and effective support for survivors of trauma. Worker wellbeing and prevention/management of vicarious traumatisation can be supported through social support, supervision, and training for staff with a focus on recognising vicarious trauma and learning self-care and stabilisation strategies. This results in greater confidence,

[6] Also known as 'burnout'.

reduced isolation, and ability to recognise and act upon the manifestation of vicarious trauma in the personal and professional lives of staff (Bober and Regehr, 2006; Dane, 2000; Salston et al., 2003). The TRS provides consultation and support to professionals which educates them about the signs and consequences of vicarious traumatisation and is also vigilant for and responsive to the signs of workforce trauma in its day-to-day work.

3.10. The lived consequences and future risks of a trauma-blind approach

As discussed, the symptoms of trauma are devastating, far-reaching and can be lifelong. Symptoms can impact upon the safety, quality of life and wellbeing of individuals, families, and communities. Those suffering PTSD and CPTSD often struggle with complex physical and mental health problems, involvement in the criminal justice system as offenders and within social services as their parenting abilities are scrutinised. As a consequence of these multiple needs, survivors are often in contact with a range of services, so it is particularly important that these services are able to identify and work empathically with the symptoms of trauma.

3.11. Complex needs and the importance of cross-sector trauma informed practice

As discussed, survivors of CSE often experience the cumulative impact of severe multiple disadvantage (SMD[7]), partly as a result of their trauma and partly due to ACEs and developmental trauma in earlier life (in addition to deprivation and poverty) (Sharpen, 2018; AVA and Agenda, 2017; Sosenko et al., 2020). The 2015 Hard Edges England report mapped severe multiple disadvantage nationwide and concluded that 12,000 women in England are known to be experiencing several complex needs, often due to trauma in childhood, although the true extent of this is hard to quantify due to fragmented services, barriers to access and stigma (Sosenko et al., (2020).

Sosenko et al's (2020) follow up report, focused on SMD among women, demonstrates how the variety of adverse experiences among CSE survivors can entrench and exacerbate social, physical, and mental health problems. In women, SMD is indicated by four dimensions including mental health and psychological problems, problem drug use and experience of violence and abuse, a framework which encapsulates many of the adversities experienced by CSE survivors in addition to the trauma from their experiences of sexual exploitation in childhood. Secondary domains of multiple disadvantage among women are identified as loss of children to social services, poverty, criminal justice experiences, accommodation difficulties and isolation, all of which are also often prevalent among survivors (Sosenko et al., 2020; Larkin et al., 2012). This results in a chronic and complex level of need that, left unacknowledged and unresponded to, intensifies the marginalisation and social, spiritual, and material deprivation of CSE survivors.

Attesting to this, Golder et al. (2015) surveyed 406 women on probation in the US, creating subgroups of psychological distress to stratify their symptoms and found that 76.7 per cent of women in the High Distress category experienced symptoms of PTSD and were more likely to regularly drink alcohol to intoxication, use opiates, be more socially isolated, have experienced more frequent childhood mental abuse and adulthood physical, psychological, and sexual abuse.

[7] Severe Multiple Disadvantage (SMD) is a term utilised in the Hard Edges reports (2015 and 2020), although various anacronyms are interchangeably used in policy and research to refer to the co-occurrence of physical and mental health, psychological and social problems.

As a consequence of this complexity of need, as adults, survivors are frequently engaged by and seek support from a range of different services including drug treatment, the criminal justice system and social services. However, fragmented working and a lack of trauma awareness have been illustrated to pose significant barriers to people experiencing complex disadvantage accessing support (Sharpen, 2018; AVA and Agenda, 2017; Sosenko et al., 2020). Sharpen (2018) found that women experiencing multiple disadvantage often 'had a very real sense that what they had experienced did equate to complex trauma' and yet services across sectors were not able to meet their needs and recognise the impact of their experiences. Re-traumatisation was a common narrative among their experiences in services, exacerbated by siloed and fragmented systems where women are compelled to constantly repeat their stories of hardship and abuse to a revolving array of practitioners (Sharpen, 2018). A lack of flexibility and empathy, particularly in the context of symptoms of trauma and their impact on behaviours was also felt to replicate abuse by exacting control upon and expressing disapproval of women (Sharpen, 2018).

Research by Holly (2017) and Sharpen (2018) concerning the needs of women with multiple complex needs demonstrate the importance of genuinely trauma informed practice across services, many of whom will regularly work with identifying and hidden survivors of CSE. The evidence points to multiple barriers to access when services do not recognise and respond to behaviours and circumstances that are consequences of experience of violence and abuse. For example, the Hard Edges Scotland report (Bramley et al., 2019: 30) concluded that the strike system of appointments in mental health services 'could almost be designed to eliminate the chances of those with chaotic and unstable living arrangements from ever gaining access to the help that they need', illustrating the vital importance of the TRS' work in helping survivors of trauma receive support where previously they had fallen through the gaps inadvertently created by service bureaucracy. A wealth of recent research consulting both service users and providers has revealed the prevalence of trauma in the lives of women suffering SMD and how services that have a less nuanced, compassionate understanding and implementation of trauma informed practice often fail to engage women with SAMD, who are deterred from engagement and feel excluded, overlook and judged (Sosenko et al., 2020; AVA and Agenda, 2017; Sharpen, 2018; Bailey et al., 2019). Correspondingly, Bailey et al (2019) remark that although the evidence base suggests that problematic drug using trauma survivors benefit from trauma informed treatment that is tailored to address their drug use alongside their psychological trauma (as opposed to a siloed approach), the UK currently lacks services that do this. Despite the common co-occurrence of addiction and trauma in women, with 95 per cent of Bailey et al's (2019) participants meeting the criteria for PTSD, just two had received treatment. However, while the need for trauma informed practice is great, and the implementation of this across services working with vulnerable women is, as Wilton and Williams (2019) for the Women's Mental Health Taskforce assert, critical. This entails a rigorous, thoughtful consideration of the contextual needs of survivors, implemented by professionals with a deep understanding of trauma and with confidence and experience in trauma informed practice who also have the capacity to build these skills among other professionals from various backgrounds. A host of studies commend the suitability and efficacy of comprehensive, integrated trauma informed services for women, attesting to the need not only for trauma awareness but for the delivery and operation of this within localised, cohesive, and collaborative systems (Brown et al., 2010; Cocozza et al., 2005; Elliot et al., 2005; Purtle, 2020). Consequently, trauma informed practice must be delivered internally, and through a delivery that is influenced by local context and an ongoing feedback loop between deliverers and recipients in order to ensure practice remains tailored to the evolving needs of survivors and service providers. Such a system can only be achieved through relationships built between local services where trust, familiarity and ongoing

collaboration can ensure the continuous and sustainable implementation of bespoke, responsive trauma informed practice.

The importance of upskilling services across sectors to respond to survivors of trauma has been resolutely illustrated, in Rotherham and internationally, but it is equally important that this is undertaken systematically, sensitively, and rigorously, adhering to the principles of trauma recovery that emphasise the value of safety, trust and collaboration, and with the guidance and support of practitioners with clinical experience of PTSD. As noted in Sharpen's (2018) report, while trauma has become somewhat of a buzzword, comprehensive and nuanced understanding requires the input of informed and experienced practitioners. This is exemplified by one participant (Sharpen, 2018) remarking 'some people think that a trauma informed environment is putting a plant in a room!'.

3.12. Trauma, CSE and the Criminal Justice Process

Despite two decades of government policy concerned with ensuring the centrality of victims' wellbeing and experience in the criminal justice agenda, the related policies and guidance are yet to succeed. Ellison and Munro (2017) contend that this is due to a lack of appreciation of the impact of trauma upon the criminal justice process.

Symptoms of trauma such as avoidance of confronting the traumatic experience, dissociation and fragmentation of memory can present obstacles to reporting and testifying. Trauma can also 'mitigate credibility' as symptoms such as misremembering or difficulty remembering may be presented by the defence as evidence of unreliable witness testimony, when it is well known that disruption of memory processing is characteristic of difficulties of this nature. The process of the trial itself can also exacerbate trauma symptoms or retraumatise due to survivors often being required to face perpetrators and undergo cross examination which may further entrench guilt, shame, and negative self-image (Ellison and Munro, 2017).

Due to the proliferation of stereotypes and 'rape myths' that permeate structures, institutions and society, the account of the traumatic event and the details of a victim are subject to great scrutiny. This has led to some referring to a trial itself as a 'second rape' due to the power dynamics at play and the threatening and emotive nature of the process (Foley and Cummins, 2015). Further symptoms of trauma such as anxiety, depression and alcohol and drug use are also often seized upon by the defence as indicators of unreliability of the victim rather than symptoms of and attempts at coping with abuse and suffering (Brown et al., 2010).

The Serious Case Review into the suicide of 'Mrs A' illustrates the issues posed by historical sexual abuse prosecutions, whereby a lack of forensic evidence led to scrutiny of the behaviour, perceived validity and reliability of the complainant (Foley and Cummins, 2015). The implications of this attest to the importance of comprehensive support for victims if traumatisation and its correlating harms are to be avoided as a result of the judicial process.

The consequences of trauma blindness in the criminal justice process are significant; without sufficient support, survivors may be reluctant or unable to bring perpetrators to justice, the process itself may exacerbate symptoms of trauma, or may trigger PTSD/CPTSD in survivors. Therefore, for the sake of justice and survivor wellbeing, trauma awareness is fundamental when bringing perpetrators to account.

4

Evaluation Aims and Objectives

This evaluation illustrates the progress of the TRS, the Rotherham Trauma Network and associated Survivor Pathway since 'Travelling Through Trauma' (the second-year evaluation) updating service development and the content and reach of service delivery. The first-year evaluation described the development of the service in its initial months and recommended the TRS continue to build relationships with various services and engage them in understanding the value of trauma informed approaches. 'Travelling Through Trauma' described the expansion of the Rotherham Trauma Network and illustrated examples of how it was working to support survivors and professionals. It concluded that the service had become established and offered outcomes where survivors could benefit from tangible results. The report recommended that working with survivors to seek their views would be timely and appropriate in the following year.

Consequently, this report '**Travelling though Trauma: Voices in Partnership'** whilst providing an update, primarily focuses on the survivor voice and experience, consulting with survivors who have benefitted from the work of the TRS and where this can improve. This evaluation focuses upon the experience of trauma interventions and the outcomes in relation to survivor's daily lives as a result of TRS voluntary sector commissioning and service design.

Each evaluation has been preceded and informed by an iterative and ongoing literature review to ensure that the research is underpinned by an understanding of the evolving evidence base concerning adverse childhood experiences, C/PTSD and their presentation, impact and the principles of trauma informed practice (Harris and Falot, 2001a and b).

4.1. The Survivor Roadmap

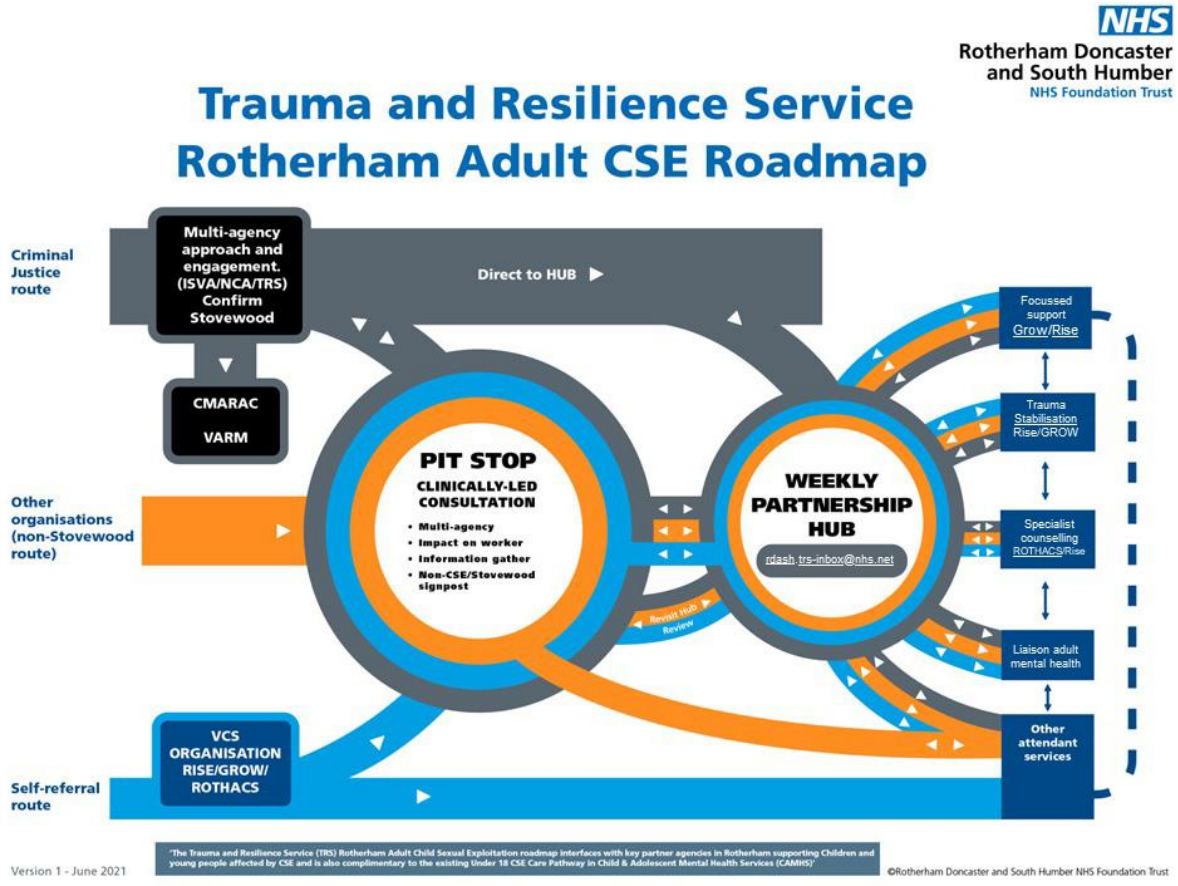
The survivor roadmap illustration depicts its circular, multi- interface pathway, as opposed to more traditional linear pathways. Survivors and those who support them can access and then re-access according to their situation and needs.

Key:

- **TRS**: Trauma and Resilience Service.
- **ISVA**: Independent Sexual Violence Advocates.
- **NCA**: National Crime Agency.

- **GROW**: Women's charity.
- **Rotherham Rise**: Domestic abuse charity.
- **Rothacs:** Rotherham Abuse and Counselling Service.
- **CMARAC**: Community Multi-Agency Risk Assessment Conference.
- **VARM:** Vulnerable Adult Risk Management panel.
- **Weekly Partnership Hub**: consists of TRS, GROW, Rise and Rothacs and builds a bespoke package of care.
- '**Pit Stop'**: Clinically led consultation service providing shared formulations, workforce support promoting coherent professional networks around victims.

Figure 1: The Survivor Roadmap



The Schools Pilot

The development of the TRS' relationship with schools is especially significant given the findings of this evaluation which reveal the need to support the children of survivors' and also of professionals to be vigilant to the presence of trauma among children and young people overall.

This is a funded ongoing initiative that began with four local primary schools. The initial participating schools were identified on the basis of their openness to and history of collaborative working, especially with mental health in schools service provision. They also operate a policy of 'pupil inclusion', where students who may be vulnerable or have complex needs are not excluded from equal and accessible education and support. The population of the four schools also covers many parents who are survivors and perpetrators of CSE whose children often attend the same school. The

ensuing encounters between families, such as at the school gates, were resulting in difficulties for staff who were struggling to manage the conflicts and the impact upon children and families. Intergenerational trauma was also prevalent among the families involved, and many were also below the threshold for statutory service intervention.

The TRS Schools Pilot has done the following:

1. Offered Trauma Matters training to all school staff, from front desk to SENS and leadership, including Youtube sessions delivered from a child and adult perspective, tailored to support children's' behaviour in school. The bespoke school training included information on the nature of anxiety and pre/post-natal attachment and trauma.

2. Provided ongoing consultation to schools so that staff can stop and think within the bustle and demands of the school environments. The consultations increase staff resilience, providing space for reflection on their experiences and on their workload and how best this can be handled.

3. Rather than providing training and an initial consultation then leaving, the TRS were keen to embed their work with schools. Accordingly, they host reflective discussion groups to develop and embed understanding of the relationship between ACEs and CSE. These groups are held by a child and adolescent psychotherapist with primary school teaching experience, in addition to that of working within CAMHS. The groups help staff realise the impact of parental well-being on their children's resilience and emotional development, and to recognise the difficulties CSE survivors face as parents.

4. The TRS and staff have put strategies in place to support the parent-child relationship in recognition of the role this has as the blueprint for all other relationships throughout life.

The Schools Pilot is ongoing and will be rolled out in key communities this work could be fully explored in further evaluations.

4.2. The Multidisciplinary Team Meetings

The MDTs were developed by the TRS to promote a direct pathway link to the Stovewood investigation for multiple agencies.

Attendees include the TRS, the ISVA team manager, Adult Care Complex Needs Team Manager and the National Crime Agency's (NCA) Safeguarding and Risk Management Team Officer. This facilitates a co-produced, centralised forum for multiagency consideration of cases in a reflective environment. Joint chairing is encouraged.

Meetings are held weekly, during which two cases are usually discussed, given 45 minutes each which allows sufficient time for each to be given due consideration and reflection.

They also give indirect voice to the survivor, for example ISVAs have quoted survivors when presenting their requests and concerns and letters written by the survivor have also been read out, giving them control to express their wishes and guide their case and care.

MDTs consider two cohorts of survivor:

1. Survivors on the ISVA 'red list', those with complex, high level of need who require particular consideration and intensive support.

   Where survivors are identified as high risk, the pathway allows the escalation of cases to MARAC or VARM (vulnerable adult risk meeting), ensuring their needs are prioritised.

2. Pre-approach survivors who are yet to have been approached by the NCA which, by necessity, involves 'cold calling' and so can often be retraumatising to survivors who are not expecting to be contacted and have past traumas revisited.

The NCA are typically focused on intercepting and investigating high level perpetrators of organised crime and so traditionally work by taking advantage of the element of surprise when calling. However, this approach was extremely disruptive and destabilising for survivors, many of whom find any unexpected knock on the door deeply frightening. In order to mitigate the potential for re-traumatisation and to allow for a trauma informed approach to be embedded into this and other stages of the criminal investigation, the MDT allows the NCA and other involved agencies to share information and develop a way to support the survivor through being approached regarding the Stovewood investigation.

Often, NCA officers have very little initial information on the survivor through the Caldicott report and so the MDT can be used to gather other professionals who may be involved with the survivor in different capacities, such as in housing or drug treatment, and to develop a broader picture of the survivor and any particular circumstances or needs to consider pre approach. This could range from the presence of children in the house during certain hours to the survivor experiencing certain mental health problems. For example, recently officers were due to approach a survivor with ADHD so received psychoeducation from the TRS on the presentation of ADHD and how best to work with the survivor.

Since its inception in March 2021 80 NCA officers have been presented regarding the availability of the MDT and increasing numbers are referring to it for further guidance and support pre-approach.

Beyond the witness approach, other elements of the criminal justice pathway are also potentially highly traumatising to survivors. While, due to legal necessity, aspects of evidence giving and the CPS must for now remain converse to trauma fluency[8], the MDTs and increased contact with the NCA has led to greater consideration as to how to make these processes as trauma informed as possible. One outcome has been that the investigation process is more considered and embedded within a partnership approach, for example through officers delaying contact until survivors are more stable, often through receipt of trauma stabilisation intervention.

The criminal investigation itself may also benefit from survivors having taken part in trauma stabilisation, as it provides survivors with coping techniques so they are better able to give interviews and evidence that can develop a strong case.

Below are two case studies that were discussed at the MDT meeting I observed, and which illustrate the different pathways of the multi-agency approach to supporting survivors throughout the criminal justice process of the Stovewood Investigation.

[8] As we see in the Recommendations regarding pre-trial access to therapy.

4.3. TRS Rotherham Adult CSE Roadmap Case Studies

Survivor A had not yet been approached by the NCA, but her name had come up in phone records as a person of interest as a victim/witness. Before approaching, the Caldicott enquiry revealed A may be experiencing mental health problems and so the NCA wanted to work with agencies who have more knowledge of A's wellbeing to think about how best to approach her safely and indeed whether to do so at all.

A's mental health workers advised she suffered paranoia and anxiety and had previously had problems with substance misuse (involving several hospitalisations) though this was felt to be more stable currently.

Her housing situation was precarious though, due to anti-social behavioural issues and financial exploitation. Because of this, at the last meeting the action plan included bringing in her housing worker (who was present at this meeting) so more attention could be paid to the pressing issue of A's housing situation.

The group explored A's support network and felt that it was lacking, especially as her previous care coordinator had recently left so there was concerns about approaching her during this period of upheaval. A had no ISVA but one could be made available.

The housing worker advised that A is in temporary accommodation and has had multiple placements. There have been complaints from neighbours regarding anti-social behaviour and due to this A is facing eviction. Housing and mental health are working together to try and support A during this. She currently has no further address and lots of housing won't accommodate her due to previous issues, so she is hard to place and not coping well with the stress of all this.

A's paranoia was particularly high and she often felt there were people outside (although it was acknowledged that there could be truth in this sometimes due to issues with neighbours). A's mental health worker was receiving lots of worried texts over the weekend and the move seemed to be the cause of lots of this stress.

A was not able to access many housing options that would support her mental health needs. One would not offer her another placement as she had already had 3, another wouldn't work with substance abuse, and another was unsafe for the survivor as it was near to an abuser. In order to address this, senior people in housing are going to meet and try to find options.

There was also uncertainty concerning her social care needs assessment which was stalled until A was accommodated and the level of provision that would offer could be taken into account.

A was identified as very keen for reassurance and companionship which could lead her to make poor decisions over who could provide this safely and appropriately. She is also described as a people pleaser and while she can articulate hopes and wishes, she can be derailed by negative social influences; for example, she may say the right things regarding using money for paying debts but then struggles to follow through and may spend it on drugs instead. Relatedly she was also vulnerable to people posing as friends and unable to focus on her best interests

Through the multidisciplinary meeting, there was a shared understanding that A was currently in a precarious, powerless place and feeling especially unstable as she was without secure housing, vulnerable to outside influences, ostracised from housing providers and experiencing flares of substance abuse. It was concluded that there was too much going on for A to have the pressure of being involved in an NCA investigation at this time as it could have been overwhelming.

A's mental health care coordinator made an offer to the NCA to work together so that when an approach is made this can be done jointly and so it does not happen in A's home but in a safe, neutral place.

The NCA agreed and decided to put A's case on the 'back burner' until she is more stable.

Support to help A work towards this place of stability was offered by the TRS who proposed networking with the relevant agencies and offering consultation to these in addition to providing A with trauma stabilisation and counselling when she is ready.

There had been three review meetings concerning A and communication would be kept open between housing and mental health professionals while the NCA would check back in a few months.

This illustrates how the Caldicott enquiry information, which only provides 'yes/no' answers is unable to capture the complexity of survivors' lives and so mobilising the relevant agencies into information sharing, consultation and action is critical in order to meet the survivor's needs. It was evident that due to the ongoing problems and instability in A's life, an unexpected approach by the NCA could have been significantly traumatising and sent her into crisis. Due to the information gathered, not only was this avoided but services were also engaged in working together to help A reach a place of stability where she could engage with the criminal justice process.

Case B

B was a young woman in her twenties, she was considered by all agencies to have very complex needs due to the post abuse trauma and associated heroin use in her adolescence. She struggled to engage with services who she generally distrusted. Nevertheless, she had engaged with an ISVA for over two years and had given video evidence as part of Operation Stovewood.

Her ISVA was present at the MDT and described a pattern of sporadic engagement and the need for a great deal of flexibility when offering services. The ISVA described how B needed to leave her current partner who was abusive towards her and struggled to gain her own tenancy for her and her children. She explained that B had family in Rotherham, however, she had memories of past abuse and links to perpetrators and former associates.

The ISVA described how B could be verbally aggressive to professionals and tends to appear explosive. Having worked with her for a long period of time and having received consultative support from the TRS to understand the depth of her difficulties in relationships, the ISVA had become familiar with Bs patterns of behaviour and could, as a result, manage and tolerate it.

The NCA officer and the ISVA had previously used the MDT to explore the decision that, after four years of work, they were not taking B's case any further. This was a disappointment to all concerned and there was great concern about the impact of this news. With the help of the MDT they decided to construct a letter to explain the situation to B, as it was felt that this would give B chance to process the reasons and properly take in the consideration that had been given to this event. They reported back to the MDT that although B had been very upset, she was able to digest the information and accept the reasons for there being no further action, and though she had been saddened she did not react adversely.

B had expressed the loss she felt at having to say goodbye to her ISVA as a result of this decision and together the meeting constructed a transitional package: the ISVA

would stay involved for an agreed period of time and would support the move through to the TRS voluntary sector hub partnership.

The presence of the Rotherham Adult CSE pathway and support options including trauma stabilisation support is especially encouraging here as it means B will be able to access support of her choice and continue to be recognised and responded to as a survivor of trauma, even after her case has been declared as 'no further action' and even if she continues to choose to reside out of the Rotherham area. This is important, for B had not met the criteria for previous mental health referrals, her drug worker had recently left, and the dual diagnosis nurse was no longer available except for crisis.

This narrative echoed other instances in this report, as B was living outside of Rotherham due to previous abuse and the TRS system approach did not disqualify her for support by them.

In conclusion, the ISVA and TRS clinical specialists decided to continue to work across the transition and proactively invite the new drug and alcohol worker to the next consultation meeting whilst pursuing a referral within the TRS hub. This would ensure Bs support did not become fragmented, and the narrative remained held.

This case demonstrates the complexities of supporting survivors during the variable outcomes of investigations. This this can be an enormously triggering and distressing time for survivors (and professionals) who have the stresses of evidence- giving and interviews but may be disappointed by the outcome of no trial. This highlights the importance of agencies working together to ensure an ongoing circle of support around the survivor so they do not feel rejected and abandoned further when they lose eligibility to ISVA support. That they can continue to be supported to manage their trauma and any disappointment regarding investigations.

4.4. The TRS Trauma Matters Training Package – A Recipient's Perspective

My research centre, CRESR (at Sheffield Hallam), was able to benefit from the TRS' bespoke 'Trauma Matters' training package, which was delivered to us with an added focus on how trauma might arise and should be approached throughout the research process.

The training itself provided a comprehensive and vivid understanding of the presentation and impact of C/PTSD that I, as a researcher now quite familiar with the worlds and language of trauma, found enlightening and which shed new light on my practice and approaches.

However, rather than discussing the specifics of what we learned, I will focus on illustrating the impact the training had on the participants and on our future practice as researchers and an organisation, as observed across the sessions.

- We realised that trauma was likely to be relevant for many of the groups we work with, for example homeless populations, those in the criminal justice system or experiencing poverty. The intersection between Adverse Childhood Experiences (ACEs), the onset of complex multi-faceted trauma (e.g. CPTSD) in childhood and adversities in adulthood really emphasised the importance of being able to recognise and respond to trauma when conducting research with vulnerable and marginalised populations. This was not something that had been recognised on a departmental level before or that people had begun to acquire the skills to be able to address.
- We thought about the ethics of trauma informed research and the importance of justifying asking potentially triggering questions, of allowing people to tell their

own story and to emphasise their freedom to disclose or not. We also recognised the value demonstrating how research can be validated by its benefit to survivors/participants, such as in systems change and individual empowerment. The research the centre undertakes is often contracted by external funders and the sessions allowed us to think about how we can meet these goals while also being sensitive to and even empowering the populations we are working with.

- The attendees agreed it was important to build awareness across staff of the need to be aware of systemic re-traumatisation and the possibility of our research contributing to that.
- The impact of trauma on recollection, speech and behavioural patterns led us to consider how we can be vigilant to the signs of trauma in research participants and how we can help mitigate the risk of re-traumatisation and to support participants if they are showing signs of being triggered, such as through dissociation.
- The importance of safety and stability also informed our discussions on how to undertake trauma informed research, from considering the environment fieldwork is undertaken in to using grounding techniques prior to and after interviews.
- Vicarious traumatisation was also noted as a real risk for researchers, especially where contractors may require multiple interviews on difficult subjects to be conducted in a short period of time. We thought about how we could avoid burnout and advocate for ourselves while being able to be fully present for each interview and how this could be beneficial for the research contractors as well as ourselves and the participants in terms of quality of data and being able to access otherwise hard to reach populations.

In summary, the Trauma Matters training directly impacted upon not only the way the University would approach their research but also upon this evaluation and how these factors were taken into consideration when interviewing survivors.

4.5. Survivor Voice Focus - Evaluation and Findings

This year I felt survivors were sufficiently supported to be able to benefit from sharing their experiences of the TRS' work. I decided to interview survivors and the professionals in the voluntary sector supporting them to explore their experiences, needs and how the development of the Survivor pathway and Rotherham Trauma Network had benefited them.

Research Design

In the first evaluation's Next Steps I proposed a focus on the survivor voice. However, this was deliberately delayed until this year due to an evolving understanding gained throughout the evaluations of the readiness, capacity and needs of survivors and the service delivery landscape, ensuring both were supported and stable, and in accordance with Herman's (2015) Trauma Recovery model[9], this was delayed until this year.

In Year 1 the evaluation focused on the initial design of the service and its early steps in forming relationships and beginning to deliver appropriate interventions.

Next, 'Travelling Through Trauma' explored the continued development of the Trauma Network, (community of practice across Rotherham) demonstrating the considerable

[9] which advocates stabilisation (and thus the establishment of experience, confidence and security in services and thus survivors) as the critical first stage.

expansion of the trauma pathway and the impact of the expansion and embedding of trauma fluency across a broadening professional landscape.

Both survivors and services have now been able to benefit from the development of the trauma pathways through the support, security, knowledge and confidence they provide. Because of this they could be safely and sensitively be engaged in research highlighting the individual's experience.

To capture both the *empirical* expansion of the trauma network and *the richness and complexity* of the benefits of this for survivors and service providers, the Year 3 Evaluation is informed by mixed methods research. I use both quantitative data on service development and expansion, and qualitative interviews with survivors and voluntary sector staff the TRS commissioned and supported; these findings have underpinned this evaluation's illustration of the progress, outcomes, and next steps of the TRS.

This evaluation, we must also contextualise the TRS' work against the backdrop of COVID-19, a global, deadly pandemic that has resulted in a series of lockdowns in the UK during which, at various points, people were ordered to stay at home, schools were closed, and many services had to shift to virtual delivery. The impact of this has been suggested by the literature review that informed this evaluation to be significant in terms of people's mental health and service delivery. This is explored by this evaluation, acknowledging the challenges this may have presented for survivors' wellbeing, progress and access of services and for services' delivery.

It is important to note that the evaluation does not capture all of the data concerning the TRS' development as it is mainly focused upon the interface between the voluntary sector and TRS in relation to the TRS commissioning projects. In doing so it has only touched lightly upon some other projects and has not fully mentioned the myriad of other projects under way. Examples of this include internal contribution to the transformation of mental health services, social care project, schools project etc. However, the overarching purpose of this research was to highlight the creative partnerships between the three voluntary sector organisations GROW, Rotherham Rise and Rothacs and the Trauma and Resilience Service. In doing so, we provide a snapshot of the work being done but the survivor quotes are indicative of the success of the whole-systems approach the TRS is employing.

4.6. The Interviews

Voluntary Sector Interviews

The decision to focus on the professional experiences of the voluntary sector services who are partly commissioned and funded by the TRS was justified according to the following factors:

- The intensity of their work with the TRS means they have benefited most in terms of being able to directly deliver trauma specific practice and to advocate on behalf of survivors to link them with other services.
- Their close, regular work with survivors in connection with other parts of the Trauma Network means they have in-depth, rich knowledge of the needs and lives of survivors and can also provide further detail of survivor's journeys from an objective perspective, enhancing the subjective narrative of the survivor's world.
- The TRS' commissioning arrangements permits this close working with the voluntary sector and is quite a progressive arrangement; exploration of the functioning and impact of this relationship may inform future working relationships between the statutory and voluntary sector. Through such partnerships survivors

can receive optimal support from multiple agencies working in collaboration to holistically meet individuals' various needs.

The voluntary sector workers' interviews focused on two main themes; the workers' experience of applying the trauma knowledge and related skills they have learned from the TRS and how they have seen the lives of survivors and their families change in relation to this.

They were also asked about developments they would like to see in the support provided by the TRS in future, for example concerning delivering trauma stabilisation interventions and how this could further benefit survivors.

Finally, they will be asked about the challenges presented by COVID-19 and how they and the survivor responded to this. Voluntary sector staff will be asked about this whereas survivors will not. This is because the concern regarding COVID-19 is its impact on service delivery and how this has been adapted and could respond to any similar events in future. Asking survivors about the impact of COVID-19 directly could also require discussing traumatic events when a sufficient understanding of the impact of the pandemic can be gleaned by asking workers.

Survivor Interviews

It was critical when designing and conducting interviews with survivors to prioritise their safety, comfort and the maintenance of the progress made in managing their trauma and rebuilding their lives thus far.

Therefore, the design of interviews and the sampling process was done in collaboration with the support of the voluntary sector workers and TRS clinicians who are trauma informed, most able to provide support and are most familiar with both the Rotherham landscape and context and the survivors as individuals.

This was undertaken as follows.

Sampling

It was agreed to approach only survivors who were suitably supported and stable in their journey, and who were felt to be empowered by sharing their experiences and potentially interested in informing future service evaluation and development. This was done collaboratively with the voluntary sector and the TRS who combined their specialised knowledge to ensure that survivors interviewed were able to be supported, participate in and to benefit from involvement in the research.

Finally, it was important that survivors had benefited from as many of the services who had partnered with or benefited from the work of the TRS as possible. Because of pre-trial guidelines it was also vital to ensure survivors were post-trial, if relevant, so as to minimise the risk of evidence contamination. It is also crucial to note that interview questions were solely focused on experience of services and needs, and very deliberately avoided discussion of the abuse itself; in doing so, I actively avoided re-traumatisation and to remain focused on the purpose of the evaluation.

Interview Design

My own research experience involves interviewing women with histories of trauma and who often had multiple unmet needs and faced barriers in accessing appropriate support in services, so I felt that a similar approach would be suitable for this evaluation. Namely, this involved a semi structured interview focusing on hearing the survivors' narrative of their experiences of and needs from services, comprising a more informal discussion focused on a topic rather than a series of interview questions. The

emphasis was also on survivors' perception and interpretation of their experiences as it is the subjectivity of experience that it is important to understand, so services can appreciate how survivors encounter obstacles to engagement, and how these can best be countered.

The guide for the interview structure was shared with TRS and voluntary sector workers who made sure that survivors were not asked for too much and put at risk of re-traumatisation.

It was crucial to ensure that the focus of the interviews remained on survivors' experiences of services (including barriers to access, positive changes and wishes for further development) and indirect experience of the TRS' partnerships and work with other services, such as through the provision of stabilisation interventions, advocacy for interventions involving other agencies and support negotiating support.

It was gently emphasised to survivors that the interview was not about their experiences of abuse but their experiences of services generally and how their voluntary sector worker has supported them in improving their wellbeing.

Interview Topics

The focus of the interview was on the survivors' journey and how the TRS' work indirectly (and the progress of the Trauma Network) has influenced their wellbeing, empowerment, understanding of and ability to manage their trauma. Accordingly, interview topics were as follows.

Survivor Journey

Survivors were asked about *their journey*; how their life had changed since receiving support and how that looked day to day. This included the development of a sense of confidence, safety, stability, self-esteem and positive relationships.

The *Trauma stabilisation* interventions provided through the TRS may play an important role in enabling survivors to progress in their lives, to rebuild relationships and to reintegrate into the community.

Accordingly, the *management of trauma symptoms* was also explored, to assess the extent to which survivors were able to use the skills taught by the voluntary sector to be able to ground themselves and be less afflicted and restricted by reminders of their trauma. To help inform the TRS process development, survivors were also asked about the timing and quantity of stabilisation sessions in order to assess whether survivors felt they would most benefit from stabilisation at a particular point in their journey (e.g., pretrial, during or post), and how important repeated sessions were to embedding grounding skills.

S*ocial support and connection* has been identified as a crucial part of trauma recovery and the mitigation of trauma symptoms, so survivors were asked about changes in their families' understanding of their trauma (including survivors' ability to articulate their trauma and advocate accordingly) and how their *relationships* with their family and their families' wellbeing has changed throughout their journey.

4.7. Analysis Themes

These are the themes which were used to guide the content of the interviews and to evaluate the data, keeping the core elements of trauma informed practice at the heart of the evaluation and of the exploration the survivor experience.

The themes have been developed to reflect the literature reviews that have accompanied each evaluation and to ensure the work is informed by an up to date understanding of the evidence base on trauma informed principles and care. (See Bibliography in Chapter 7).

4.8. Trauma Fluency

Trauma fluency can be defined as comprising both the ability to recognise and respond to the symptoms of trauma *and* the intersecting and complex challenges involved in supporting survivors' needs on an individual basis. This can be embodied in the shift from a 'What is wrong with you?' approach to one of 'What happened to you?'. It also considers trauma in both service users and service providers, acknowledging and addressing the presence and impact of vicarious trauma.

For services, the ultimate goal is for professionals to be 'united in delivering trauma practice collectively, to bridge the needs of all populations, seamlessly' (Kennedy, 2020). This includes adults, young people and children, and service users and providers.

Trauma Recognition

This includes the recognition of trauma symptoms and how these may intersect with survivor's environmental needs, the experience of ongoing violence and the impact of 'systemic violence'[10] (e.g., exclusion from other services, restrictive conditionality).

Trauma Response

This entails delivering support that address trauma survivors' symptoms and their barriers to recovery, including delivery of trauma stabilisation and advocacy/liaison with other services to enable survivors to access appropriate support. For practice to be trauma and violence informed, it is important that workers aim to reduce inequalities in terms of structural barriers to support such as lack of flexibility, conditionality of access and discriminatory/trauma unaware attitudes. For staff, it can entail providing opportunity and space for sharing difficulties and being supported by peers.

4.9. Safety

This comprises physical, psychological/emotional and cultural safety including the prioritisation of survivors' sense of security and safety in terms of service location, accessibility and privacy. Practical safety could also involve women being able to 'drop in' or 'test out' sessions to 'dip a toe in' before committing to anything and feeling confident in being able to opt out of or pause support. It also privileges the avoidance of re-traumatisation by protecting survivors from exposure to triggering experiences, building awareness of the specifics of survivors' triggers, and in eventually working with the survivor to establish grounding strategies in the event of re-traumatisation.

Emotional safety is fostered through the development of trusting relationships that are characterised by consistency, reliability, compassion, empathy and sensitivity.

Psychological safety can be fostered by ensuring that survivors feel valued, accepted and valid, such as through being centred as the experts of their experiences and needs, and by having their disclosures responded to with acceptance and sensitivity.

[10] A concept referring to harm done indirectly or directly by systemic and structural practices.

4.10. Trust

- As survivors have likely had their trust breached in some of the most invasive and traumatising ways possible, it is crucial that they are able to trust staff and services to prioritise their safety, needs and wellbeing and to respect their opinions even in disagreements. Trust must also be promoted through transparency and reliability, where workers are clear about what action will be taken and when, and then follow through with that.
- Trust is also established by services supporting survivors to engage with social connections in the community and family that are similarly based on 'mutual respect, authenticity, moral courage and empathy', and so empowering survivors to branch out their experiences of positive social relationship and of acceptance in the community (Kennedy, 2020).

4.11. Choice and Collaboration

This is especially important as survivors' traumatic experience(s) entailed them having their ability to choose and their power and agency taken away.

Due to this, services risk retraumatising and excluding survivors by imposing restrictions and conditions upon them in order for them to receive support, and by 'doing to' rather than 'doing with'. It is important therefore that services are aware of the importance of supporting survivors within their service and others to provide a range of options from which survivors can choose at their own pace and providing them a platform to express their wishes, needs and to take control in the design and delivery of their care.

There is also increasing recognition of the importance of involving survivors in co-production and collaboration of services, to facilitate the safe and sensitive prioritisation of survivor's experiential expertise in service design, delivery and evaluation. This evaluation has taken the first steps to explore this by ascertaining the level of interest and potential benefits of co-production among survivors.

4.12. Strengths based and Skills Building

Converging the previous principles, trauma informed practice is overall concerned with empowering survivors, addressing their trauma without pathologizing or disenfranchising and working towards building survivors' resilience, confidence and capacity to pursue their goals in a safe, accepting environment.

4.13. Key Lines of Inquiry

Choice, collaboration, trust and control are fundamental elements of providing trauma informed care.

Therefore, *the quality and development of the relationship with the worker* is explored, in addition to how difficulties or disagreements have been handled and whether the survivor feels the worker is sensitive and responsive to their trauma, willing to work at their pace and according to their needs.

Other critical elements of facilitating choice, control and collaboration include the service's recognition of and response to trauma symptoms and, by proxy survivor's capacity to manage their symptoms and accordingly advocate for themselves.

A key element of this is whether workers are empathic to and understanding of survivors' trauma symptoms and how these could impact their lives and ability to engage with services, and whether workers responses to this were compassionate and flexibly.

4.14. Service experience and access

To examine the (indirect) impact of the TRS' work upon survivors' journeys in the Trauma Network and other services, they were asked whether their ability to approach and access support changed since being supported in this way. This included exploring any difficulties with their trauma being misunderstood by services, such as noticing change in service availability or through barriers to support.

Survivors were also asked whether their worker had advocated for them with other services to help their needs be understood and met in the context of their trauma and how this advocacy meant they were able to access support that was tailored accordingly.

As an initial step to involving survivors in evaluations and service design in a greater capacity in future, survivors were also asked about what they would like to see change or develop in the future.

4.15. Methodology

Continuing the previous evaluations' incorporation of the Magenta Book guidance on evaluating complexity (Bicket et al., 2021), this evaluation has adopted an iterative, flexible design that both provides an outcome evaluation depicting developments, progress, outcomes and challenges and an assessment of these to provide process development, informing next steps.

In addition to being designed, conducted and analysed in consultation with professional stakeholders through a Project Advisory Group (PAG) and meetings with staff from various organisations, in Year 4 steps have been taken to begin to engage survivors in evaluation design. This will further centralise the survivor's voice in service design and delivery and provide an opportunity for empowerment where survivors can take control of their narratives, acting as stakeholders in the services they access.

4.16. Special Considerations

Because of the specifics of the abuse suffered by survivors in Rotherham there were particular considerations that had to be recognised in order to avoid retraumatising survivors by replicating aspects of their trauma.

In particular, while compensation is advocated for when involving service users in evaluation, especially those with histories where they may have historically been taken advantage of and exploited or suffer low worth, this was strongly felt by professionals not to be appropriate in the Rotherham situation. Because of the dynamics of the grooming experienced, offering incentives for the disclosure of sensitive information and expose vulnerabilities could trigger re-traumatisation.

Similarly, while the evaluation is now looking to involve survivors in co-production of future evaluation and process design, as there are survivors who are stable and may benefit from this involvement, usual recommendations for peer co-production do not apply. Often, peers may be recruited as fellow researchers or involved in data analysis, but, it could be argued, both would be risky and unethical in situations with CSE. Because of the grooming dynamics, involving survivors with other survivors could

potentially replicate the abuse and run the risk of re-traumatisation. Likewise, exposing survivors to interview data poses a significant threat of triggering trauma as experiences of abuse are re-lived through reading others' difficulties with services. It is fundamental that survivors participate but are not over-burdened or feel pressure or expectation, especially given that many are in the early stages of their recovery from trauma and due to the potential upheaval and instability caused by COVID-19.

All survivor names have been changed and their information anonymised.

The evaluation has been approved by Sheffield Hallam's Research Ethics Committee and so has been conducted according to the principles of ethical research and the GDPR. Due to the author's experience with the TRS and expertise in researching with vulnerable populations, an additional layer of ethical consideration is its trauma-informed underpinnings.

5 Findings

The interviews were conducted with six survivors and four members of staff who work in the voluntary sector organisations to whom the TRS provides a range of support. Findings are presented according to definitions of Trauma Informed Care and are only discussed separately with regards to Trauma Recognition and Response. This is because a notable finding here was that survivors were taking control and using the skills taught to them in sessions independently meaning survivors were applying the skills in a tailored, reflective fashion in their own lives and experiences on an iterative, every day basis.

Survivor quotes are highlighted in green.

5.1. Trauma Recognition and Response

The impact of the commissioning and support of the TRS and its partners is distinct and unique in that it provides staff and survivors with ways to recognise, understand and respond to traumas in others and themselves. As illustrated by the testimonies of the survivors herein, the interventions are especially powerful as they help survivors to take control and take action, which is practically and psychologically empowering. CSE survivors often feel powerless and helpless and being able to exert influence and manage their symptoms helps with recovery (Chouliara and Karatzias, 2014; Saha et al., 2011).

Eve referenced this empowering impact, describing the interventions as *'delivered in a different way', as 'something substantive in that I can do that to help and that is quite a powerful tool in itself.'*

5.2. Survivors

An overwhelming endorsement from survivors and professionals was that the trauma stabilisation and education sessions provided a 'lightbulb' moment where survivors could recognise and understand their thoughts and behaviours in the context of what they had experienced, and that their responses were normal and natural.

For example, Naomi:

> *'There's this window of tolerance with your arousal zone and hyper arousal zone and things like that and as she was talking about it, a lot of it made sense and I could place some things in my life, not just from the Stovewood stuff, but with my ex-husband who was also not very nice. So, it's made me realise things and why certain things have happened the way they have and why I've dealt with things the way I have, and a lot of lightbulbs came on!'*

The sessions gave Naomi valuable insight into her experiences, of CSE and other trauma, supporting her to develop knowledge of self and also the ability to interpret the behaviours of others in responses to herself.

This effect was observed by almost all the women who experienced the sessions. Eve, a family member of a survivor and also a professional in the field, noted that even though they may have been apprehensive at first, of all the many women she had worked with who had received the trauma support described it along the lines of *'the best thing I've ever done because it's helped me to understand why I make the choices I make, why I do or why I've done what I've done for a long time and it helps me now to understand there are things now that have a historical context.'*

This is a hugely significant outcome for several reasons; by being able to rationalise their thoughts, feelings and behaviours survivors can achieve a sense of normality and understand that they are not alone, nor deficient, or dysfunctional. It also affords them the skill to step back and analyse their responses before being consumed by their defensive responses. Finally, it locates the root of their trauma in something terrible *that was done to them*, not in some internal flaw or failing of their own. Therefore, these 'lightbulb' moments can both help survivors recognise themselves *as survivors* in a compassionate, connected way, and to have strength in that knowledge as it can empower them to take some control in their responses.

Understanding the mechanics of trauma also relieved survivors' sometimes crippling sense of guilt and shame by making sense of their *responses during* traumatic experiences and situating them as normal, natural and nothing to feel deficient or guilty about.

As Naomi advised:

> *'Yeah, like fight, flight of freeze, understanding all of that, understanding why I couldn't fight. I wish I could've done, you know, hit, kicked, bitten, anything but I just froze. And I understand why I froze. I felt guilty for not fighting back and not having the courage to speak up sooner than I did. So just understanding that and why I couldn't at the time, you know, it's my body's way of coping.'*

Self-blame and shame is one of the core manifestations of abuse-related PTSD and the ability to offset this and appropriate blame where necessary, to forgive and understand the body's responses as natural and self-protection, play a significant role in mitigating the impact of PTSD (Hyman et al., 2013; Fiering and Taska, 2005; Choularia and Karatzias, 2015). By having her reactions made sense of as normal and part of the body and brain's coping strategy to protect itself, Naomi could forgive herself and recognise that she *had* in fact responded to protect herself, just not in a way she initially recognised.

In addition to self-blame, CSE often distorts the way survivors feel about themselves, feeling ashamed and debased because of their abuse and so often survivors did not feel worthy of care, of taking time for themselves and carried around intense negative

feelings about themselves. The compassion and interest shown by her worker helped offset this for Cassie, who felt worthy of being heard:

> *"She made me feel like I was somebody... At the start of the conversation, she makes you feel like you're something when you're actually feeling degraded, dirty, neglected, ashamed, embarrassed. She actually lifts that a bit and it takes (ignore my language) a lot of balls for someone to do that job…for someone to make you feel like you're something when you've lived with this for 20/30 years, and to make you feel that you can achieve things."*

Several professionals also referred to an initial reluctance among survivors to dedicate time to themselves, noting that often they did not feel worthwhile and instead tried to find validity and acceptance through devoting their efforts entirely to others. However, the professionals worked with survivors to help them realise and accept the value of self-esteem and self-care in both managing trauma and in optimising their capacity to be present for loved ones.

Cassie attested to the opportunity for self-care and reflection that this provided for survivors who are frequently overwhelmed and overcome by external responsibilities and stimuli in their daily lives:

> *"The fact that you're giving yourself 50 minutes each week that's just yours is massive. This is your space, and you are giving yourself that space and that in itself is a shift in response to trauma. That's quite unique because when you're at home and you feel overwhelmed with whatever responses you're having, whether it's anxiety or flashbacks, to share is a real burden, because you don't wanna give that to you husband or you don't want your kids to find out that you haven't made tea. It's all the practical stuff. Whereas it's a freedom to be here and there isn't that consequence."*

Another iteration of the understanding provided by trauma stabilisation is in the resolution and sense of self that survivors can gain from appreciating themselves as a victim of an offence, not as being somehow culpable.

Anne remarked:

> *"I think for some they've been able to get on, it's almost like an acceptance that that's a period in their life that happened. A lot realise they're not to blame and it lies with the perpetrators, and rather than blame themselves, they apportion blame where it belongs. And for me, just seeing people, where something clicks inside with some of these women."*

This is a potentially very powerful benefit as while convictions are not guaranteed and cases may take years to resolve, by being able to recognise themselves as a victim and the offender as the one to blame, women may be able to gain some security and relief in recognising that they were not immoral, deviant, criminal or remotely responsible.

The stabilisation techniques themselves were highly valued by many survivors who spoke of using various strategies including colour breathing to manage the symptoms of their trauma (such as flashbacks) but also in more everyday experiences such as to help with anxiety or anger in social situations. Several survivors also successfully used the stabilisation skills with their children. As Emma advised:

> *'I haven't been to court yet so I haven't really felt like I've needed to use any of the techniques…. I can see myself using it when it gets to court…I did teach my son the colour breathing techniques from stabilisation though; he's only young*

and you know when they just have a complete meltdown? It's really helped him with calming down and managing when he's stressed."

Emma highlights here the power of having stabilisation tools available ready to respond to particularly stressful and potentially triggering events such as court proceedings; while several women (Emma, Zoe, Keira, Joanna) were using the techniques day to day, Emma had not but was empowered and reassured knowing she had them in her toolkit when she would need them, and thought highly enough of the strategies to have used them with her child.

Emma also found the compassion and understanding of her worker and being able to talk about how trauma impacted her and how she could manage that to have a transformative effect:

"Before, when I would have bad days I wouldn't be able to do anything, like I would be in bed for days totally unresponsive but now I can look at what I can do, like if you're having a bad day focus on what you can get done and do that so now I can get up and get the kids fed and to school, the important things."

As well as improving Emma's quality of life to the extent that she was no longer bedridden and dissociated for days on end, trauma fluent support helped her to be present for her children which would improve their quality of life and their attachment to Emma, also allaying the need for social services intervention as she can now meet their needs. Jodie, too, credited the support provided by the voluntary sector with helping her to rationalise and respond calmly and strategically rather than through fear or other emotional survival responses and that this had helped her become more available and present for her children:

"Now I can deal with things better, how to approach things and make rational decisions, even just through to my children and being able to give them that feedback and be the best person I can."

Zoe also benefited in this way, using the colour breathing technique when she recognised that her trauma symptoms were heightening. As a result, she gained control and stability and also developed greater understanding of her triggers and thus greater ability to anticipate and be ready to respond to them.

"When I feel like I'm getting quite agitated and things… she did this one where you do 5 things you can see…because I get flashbacks as well, and I've learned what the trigger is, and I've done that to bring myself back down. An example is, I didn't know checked shirts would trigger me but after going over a certain incident with my worker we figured it out, it was the checked shirts. And now I can deal with it."

If we imagine ourselves as Zoe, prior to realising and understanding that checked shirts are a trigger, life must have felt constantly threatening and frightening as checked shirts are highly common. Now, rather than feeling generally overwhelmed by anxiety, peril and flashbacks, Zoe can recognise the specific objects or sensory input that is causing her symptoms and apply techniques to manage them. The implications of this shift for Zoe's ability and comfort in engaging in day-to-day life is resounding.

Trauma responsivity also goes *beyond* the recognition of the main symptoms such as flashbacks, dissociation, and emotional dysregulation; survivors were also supported and educated to undertake self-care in their daily lives to ensure they were more able to meet their basic needs and overall wellbeing was optimised.

For example, Naomi had received support around her nutrition, schedule, and the debilitating impact of her insomnia:

> *"There's stuff about my routine she's talked about; eating habits, or not eating in my case. Things like eating little and often. Preparing meals so it's quick and easy to throw in the microwave or oven. Also, that has an effect on my sleep, if I'm all full of food and content that way then I'll sleep better. And a lot of it has helped make sense of things, you know, this is why I don't sleep and why I've got no energy. I found it really useful."*

Often when survivors are overwhelmed or exhausted due to their trauma, their ability to take care of themselves and think about their basic needs is severely undermined. This may be particularly common during especially stressful periods such as criminal justice proceedings, where the support of the survivor's wellbeing is of paramount importance, both on an individual and judicial level.

An unexpected but significant finding concerning survivors' ability to recognise and respond to their trauma was their confidence in the value and power of their self-knowledge, which obviated the need for further professional validation.

For example, Naomi:

> *"I've still not got a diagnosis of PTSD, but I've not tried to get one and I don't need one because I know it's there, just from my worker explaining what PTSD is and the flashbacks and things…I don't need to go to my doctor. I know what it is and how to deal with it now when things flash in my head and things like that, it's not real. It's not here and now, it's the past, it's what happened then."*

The powerful impact of the self-sufficiency provided by the techniques and the knowledge of self these built is evident; not only in Naomi feeling she didn't need the input of healthcare services but also in her confidence and assurance in her knowledge and ability to self-reason and manage.

As we have seen, the impact of trauma recognition and response on survivors has been significant. Survivors are able to feel safer and more stable while participating in challenging and arduous criminal justice processes; their personal relationships and the lives of their families have improved, and they have been able to begin re-entering their communities while protecting themselves.

Naomi encapsulates the power of appropriate trauma support:

> *"I've just done my degree too, with COVID and all the Stovewood stuff going on, I'm really proud of myself, at my age as well."*

Naomi is also raising two children, has left an abusive relationship and with the support of trauma fluent services has been able to achieve a degree, despite a pandemic and an ongoing uncertain and stressful criminal investigation.

5.3. Services

Trauma informed practice (TIP) is an increasingly popular concept, and as Sharpen et al (2018) noted, the pressure among services to be 'trauma informed' can overtake their understanding of, and ability to be, truly trauma informed. Touching upon this discrepancy, Heidi described the transformation in her knowledge and practice that the support of the TRS had enacted; '*I've been working in the domestic abuse field for just over ten years now so I've always understood that clients have experienced*

trauma but if I'm honest I've never fully understood the impact that trauma has on people's wellbeing and everyday life until I did the TRS training.'

Heidi illustrates the difference between being aware that service users are likely to have experienced trauma and being able to recognise and respond to trauma in ways that are beneficial for the survivor and the professional.

The power of the trauma stabilisation programme comes both from its utility as a technique but also its relational underpinning with, together with supervision, offers a framework for managing emotionally impactful relationships. This is informed by the Tavistock Systems Psychodynamic approach and without the support of the TRS' experienced professionals it is likely that the trauma stabilisation programme would have likely had far less of an impact. The TRS provides support to professionals during supervision and in doing so helps them negotiate their relationships with survivors. This means that the Trauma Stabilisation work is beneficial to both survivors and professionals and is uniquely underpinned by the invaluable expertise of the TRS practitioners.

Anne attested to another vital benefit of trauma informed practice for survivors; the knowledge that they are finally being listened to and believed, which can only be attained in services through the building of a trusting therapeutic relationship.

> *"Women come here really apprehensive, and we get that a lot, 'I'll really miss our sessions'. And there's a lot within that; firstly, somebody's listening, because a lot of the time these women will come and they'll say nobody's listening, nobody's listening to what I've got to say. And we do, because it's important for that person to listen to that voice and for that person's voice to be heard and we all come from that standpoint."*

Hearing and believing are the essence of trauma informed practice as this recognises the reality of survivor's traumatic experiences and validates their right, as a victim, to be heard and to be responded to. This was quite revelatory for survivors as this was often their first experience of being truly heard.

The voluntary sector partners delivered support to survivors in group and one to one sessions, each with their own particular benefits.

As we see in the Safety section, it is valuable for several survivors to be able to choose one to one interventions as anxiety can make the prospect of groups daunting. It was also the preferred choice for services when court cases and trials are coming up or underway, as Claire advised, to avoid evidence contamination. One-to-ones also allowed professionals to provide more intensive, personalised support. For example, Claire commented:

> *"I do it more around their specific needs and we do a lot of embedding work that people really seem to most benefit from, where we've covered everything and then we do the embedding, so going over the skills, what works for them, it's more personalised I suppose, where we look at different skills and techniques, practicing it, finding what works and what's not working."*

However, for those for whom group work was preferred and suitable, one of its unique benefits was that peer support provided a sense of normalisation and camaraderie, Heidi described this as:

> *"The realisation they get that it's not just them, that these are common symptoms…you can see on people's faces the recognition of 'well I do that' and you can see them looking at one another and the little things they say, you can*

sometimes see the relief in their faces. It sort of normalises those feelings and those experiences for them. Some of them have felt as if they're going mad."

One of the crucial roles of the trauma support provided is in supporting survivors through the criminal justice process of the Stovewood investigations, optimising their wellbeing and their ability to build their case. Dana surmised:

"At the end of the day we are preparing survivors potentially for a trial and we know that if they are going to go forward with a prosecution the chances are they will be called to deliver evidence. If we can give them the skills and tools to recognise that while they're giving their evidence there might be triggers, all the things we've discussed, we can give them the skills to be able to give the best evidence to their ability and have the best outcome for them as well as the general public."

Public awareness campaigns can also reduce stigmatisation and increase compassionate responses in the community to often marginalised and misunderstood populations. As Cassie remarks:

"I could've been a person, and I know people that were in children's homes and felt neglected and turned to drugs and…do things. People judge them by that, but they don't understand what happened to them before. So, they go 'oh my god they're a druggy' or an alcoholic or whatever but they don't actually know the story."

As Cassie points out, behind the oft-judged exteriors of women who are homeless, addicts, have complex mental health problems etc., are often stories of childhood trauma that provoke compassionate and empathetic understanding. By raising awareness of this correlation, especially in Rotherham where a significant proportion of the population are affected, survivors may experience greater acceptance and understanding in the community and feel more encouraged to come forward and move forward, being seen as survivors, heard in their own right, and believed and validated for their endurance and bravery.

As well as empowering survivors to understand their trauma, to keep them safe during criminal investigations and to recognise themselves as blameless victims who can manage their symptoms, the support of trauma fluent professionals has been *practically* and holistically transformative in women's lives. Attesting to this for example, is Anne:

"Some women have gone onto better themselves in going to college courses, some have gone into work. They're getting on regardless and that's what we want for these women." The impact of the support of the trauma network is multifaceted and undeniable then, and encompasses survivors' mental and physical wellbeing, sense of self, ability to engage in the community and be present in their relationships and to begin to make active steps in their lives towards fulfilling their goals. These accomplishments are valuable to the survivor as examples of their autonomy and taking back control of their lives, and the benefits to their families and to society are an unarguable added benefit to this."

5.4. The case for continuing trauma support

Both professionals and survivors' anecdotes and opinions really emphasised the importance of the continuation of the Trauma and Resilience Service on a long-term basis. This appears crucial for several purposes- to continue developing the reach of the Trauma Network (as discussed in the Services and Recommendations sections, there is a strong need for trauma fluency to be embedded throughout multiple sectors);

to perpetuate cultures and practices of trauma fluency within partner organisations rather than relying on particular staff members; to ensure that future victims of CSE or survivors who may identify as such and be ready to seek help years later have the same access to support those currently in the system do, and to support survivors throughout the process of criminal investigations which can often be retraumatising due to the requirements of interviews and evidence giving and the uncertainty over outcomes. Jodie provided a heart-breaking illustration of this continued need:

> *"My son started getting groomed, which I wasn't aware of…I felt really guilty that because of me not exposing (her own abuse), and the ripple effect and because I'm really numb…when I look back at the support (from voluntary sector worker), the tactics and things, she made me be able to turn all my guilt around and realise it wasn't my fault. I don't think I'd have ever gotten past that stage of feeling guilty if I hadn't had that support."*

It is tragic yet to be anticipated that survivor's children may also become victims of grooming and the permanent continuation of support for survivors and their family is fundamental.

Naomi was mid-investigation and so while she was stabilised by the techniques, she was aware that the progress of the investigation could disrupt this and mean she needed further support.

> *"I don't know how things are going to turn out in the future and how I'm going to deal with that because I may find that I'm using all these techniques and things and it's not working or it's not as effective anymore…it depends what's happening in the future I suppose, with Stovewood stuff, because there are all these question marks hanging there at the minute. So, I think in the future if I need it, I can ring up and ask for the sessions again or something different, it depends on what's happening for me at the time, what works best."*

The Stovewood investigations are on a hitherto unknown scale for CSE, and the breadth and complexity of the cases as well as the backlog in courts due to COVID-19 mean that there is an extra layer of uncertainty and a likelihood that cases will take many years to process. Naomi's confidence in the future availability of support and also of its responsiveness to her needs is extremely encouraging and demonstrates a reliance and expectation that it is critical not to disappoint by withdrawing that support.

Eve identified the uniqueness of the Rotherham model, which sustains a trauma focus at the heart of service delivery and professional development, and contrasted it to the more mainstream approach of delivering occasional trauma training.

Previously, *"a lot of the professionals they just tick the box because it's a bit like everything else. Currently, you mention CSE, and some professionals have completely forgotten about it and it's not high on their agenda anymore and they forget. So, when they're dealing with someone who has trauma sometimes some of their actions, the professional retraumatises that person again and they don't even see that's an issue."*

Eve attests to the importance of thorough trauma training being delivered universally, and of trauma fluency holding a permanent place on the agenda and in the professional development of all professionals.

Encapsulating the need for the maintenance and continued development of the trauma network and the support of the TRS, Eve asserted:

> *"It's no good the TRS only being available for a bit of time. It might take years for survivors to get to a place where they need help, but if it's not there when they do*

decide, how can they do that? How can you put a time limit on someone wanting to be able to get help that I have only heard from the women and our own daughter is positive? It can't be a time-limited thing. I think there will be more people who need this as years go on…I think it would be a travesty for it not to be there in some shape or form. It may be that for a survivor it's come up on the news and that's set off a whole load of their triggers and they've not gone to a GP appointment or drug appointment or their child's not gone to school that day…my biggest concern is that at some point there won't be any funding for anyone to access and that means there will be a lot of survivors out there who are not ready now to access but may be in the future and it's not there…so where do they go, where do they go?!"

5.5. Safety- Physical and Psychological

One of the main symptoms of PTSD is the hypervigilance to threat and related difficulties in feeling safe and secure. Professionals recognised that before expecting women to be able to open up and engage with them, it was crucial to first establish their sense of safety. A key part of this involves patient relationship building underpinned by an understanding of the impact of trauma upon a survivor's ability to form relationships. As Anne explains:

"You've got to build that relationship with these women, that takes time. You can't just expect these women to open up; though they're not encouraged to talk about their personal traumas, you can't just expect these women to trust you because they've spent a whole lifetime not trusting because of what's happened. So being able to have that, it's been invaluable and having them (the TRS) there and them saying 'you're doing the right thing', these women are very vulnerable, cautious and untrusting and quite rightly so given their experiences."

Without understanding the effect of trauma upon survivors, professionals could become impatient and misinterpret women's caution or reluctance as disinterest or unwillingness. With the support of the TRS to back up the knowledge they've acquired, the voluntary sector partners are validated and confirmed in their tentative approach to relationship building. This was attested to by Claire who described the impact of her work with the TRS as *"being able to build relationships with and recognise responses of people. The main thing has been the importance of safety and to establish that before being able to move forwards."*

TRS partnered professionals also understand the importance of explicitly avoiding discussing traumatic events and being clear from the start with survivors about this in order to protect against re-traumatisation and/or contamination of evidence, and to ensure the focus of work remains on establishing safety through learning about symptoms and coping strategies. Jodie expressed relief at this explicit avoidance of triggers by professionals:

"The way she delivered it, I didn't have to go back into my childhood or my past because it were the way she explained it to me, you can tell people what you want to tell them. You don't have to expose yourself."

By being confident she would not have to relive or recount past traumas, Jodie felt comfortable and confident in trusting her support worker and engaging with the stabilisation sessions. This is a precaution often overlooked in services, for example, drug treatment, which may require service users to disclose their intimate histories as part of assessment processes or interventions, without the service having the capacity to contain and manage this safely and make it of benefit to the survivor (Nelson-Zlupko et al., 1996).

Whereas prior to stabilisation, survivors mentioned responding to challenging situations aggressively, even violently, or by withdrawing, or submitting without asserting their rights, many had examples of techniques helping them to contemplate, strategize and manage their responses.

Naomi attested to the versatility of the colour breathing techniques, which she used to soothe and control a range of feelings:

> *"I'd learned those new practices for when I'm feeling a bit on edge or stressed. I start imagining the colour coming out of my mouth and the words with the colour. I usually imagine a cloud of smoke, because I smoke as well. It's like you're blowing it all out. And I change my colours, something I've noticed is I change my colours with whatever mood it is. So, if I'm feeling a little angry it's usually red, or if I'm feeling jealous of something it'll be green, so it helps to change it up a bit as well. And sometimes I just do pink, because I just like pink, and it makes me feel calmer as well."*

Throughout the criminal justice process and also during their re-engagement in the community, where many challenges will arise, survivors are likely to be overcome by a maelstrom of various emotions. Similarly, in their personal lives, their reactivity and dysregulation may also cause disruption and conflict. By having a portable toolkit that can be personalised responsively according to the situation and emotion, survivors can manage these overwhelming and intrusive waves and keep themselves safe and secure while protecting their relationships, those around them and being able to engage with services and the criminal justice process to the best of their ability.

Naomi was in the middle of an investigation and didn't yet know whether her case would be progressed, so was understandably haunted by thoughts of her traumatic experiences and anxieties around the criminal justice process. However, she was using the techniques she learned to stabilise herself:

> *"Thoughts go round in your mind about Stovewood stuff and all that, and it's hard to switch off from doing that. So doing these techniques, like colour breathing or laying and tensing your toes and you notice what's going on in your body and then releasing it all, I've found that really helpful."*

Not only are these techniques useful in optimising the criminal justice process as survivors are better equipped to stay engaged while feeling more stable and so better able to access memories, but they also help survivors manage their symptoms and allay the likelihood of re-traumatisation during the investigation and beyond.

By understanding that trauma recovery is non-linear and experiences such as criminal investigations are likely to breach survivor's window of tolerance and temporarily 'set them back', professionals were able to be accommodating and compassionate to this and be mindful of overloading survivors in work going forward. Heidi gave one such example, "*I've one client, she's completed trauma stabilisation, but something's happened that's triggered her, and she's asked to revisit trauma stabilisation which we're happy to do. But her first two sessions she cancelled both of them. Although she's asked for it it's as though she's not quite ready for this."* Heidi attests to the value of allowing survivors to disengage and to ask for support without being punished for nonattendance so they are not triggered by pressures or expectations from services. Instead of responding to nonattendance punitively, Heidi recognised this was connected to the survivor being triggered and that her desire for support was genuine, she just needed the opportunity to further stabilise.

For survivors who were less stable and had more complex needs, such as Eve's daughter who had mental health problems and substance addiction, the stabilisation techniques were effective as a protective factor even in moments of crisis and risk.

Eve attested, *'When she is in a more manic stage and heavy drug using, what she's been through in the more stable part is ironically what she draws on and drags her through…If you see her and she's at her absolute most manic, even if you speak to her at the time she'll still be using certain techniques she's learned and she'll be doing that without even thinking about it sometimes.'*

By arming Eve's daughter with stabilisation techniques, she was able to protect herself even when in an especially vulnerable place, keeping herself safer by mitigating risk until she regained stability and could re-engage with support. The fact that the techniques had become almost second nature to Eve's daughter meant that even when she was overcome in other ways, she was partly still always managing and grounding herself, keeping herself safer in the community.

The ability of survivors to avoid or mitigate crises by drawing upon trauma stabilisation and the support of trauma informed workers was especially powerful for Cassie, who credited the support she had received with saving her life:

> *"At times when I was self-harming, I was slashing my legs, I was feeling suicidal, she actually made me laugh on the phone call that we had! Because we interacted on the phone with each other and she actually made me laugh which was a big relief because there were times, well years, where I felt I couldn't laugh or smile…I've got three children and if it weren't for her, I wouldn't be here now, for definite. I wouldn't be here."*

Cassie also illustrates the potential of remote interventions, forming connections and giving survivors hope and value even when face to face contact may not be available or suitable, such as in a pandemic.

Survivors frequently attempt to protect themselves by moving away from Rotherham, both to avoid triggers and because of intimidation and threats from perpetrators. Survivors also frequently have family and friends in Rotherham, so moves were rarely a magic bullet and consequently there was often movement between areas. Jodie is one such survivor whose voluntary sector worker was understanding and responsive to this need to move and ensured she could still receive support; *"We did start doing it face to face but then a lot of my traumas were coming back from the building in Rotherham, the area. I've moved out of Rotherham and put myself somewhere safe now."*

However, cross border working was often not without difficulties, in particular due to sectors in different regions refusing to work together.

Eve describes the impact of this fractured system:

> *'At one point she was in Sheffield and wanted to come back to Rotherham. Oh, my word, cross the border working, it was harder than it would be to get across one of the borders in Europe! So, the services in Sheffield were saying well we can't do anything about it because she wanted to go to Rotherham and the services in Rotherham were saying well, we can't do anything about it because she's in Sheffield… So, it was trauma on top of trauma on top of trauma, because of paperwork, because of red tape because they don't do border crossing and that just compounded it all, it just made her spiral a bit more out of control and put herself in even further danger."*

The division of responsibility by locality ignores the transitory nature of trauma survivor's living arrangements as they may be alternately fleeing triggers and seeking support from loved ones. By refusing to work together, services risk retraumatizing survivors by adding to their distress and experiences of rejection and denial of support. It is worth noting that the TRS and voluntary sector partners *do* work with survivors who have moved, and examples of this arose in 'Travelling Through Trauma' as well as this year, with survivors being supported across the County.

5.6. Choice, Control and Trust

Choice, control and the formation of trusting relationships are especially empowering for survivors as they provide positive experiences of connecting with and opening up to others. These experiences are reinforced by survivors being reassured and learning that they can have a voice, that their voice and opinions are valid and that they can exercise this to effect in their own lives without fearing reprisal.

Whereas many services are outcome-led rather than survivor-led, and so interventions are rigid, structured and guided by the service's need to attain demonstrable targets, survivors frequently praised the flexibility of their sessions with the TRS partners. This had not always been the case in these organisations, and the training staff received from the TRS was influential in developing this understanding of the importance of and correlation between trauma fluency and the need for flexibility and for survivors to dictate the pace of their engagement. For example, Anne, who worked in one of partner organisations remarked:

> *"I think the biggest learning I've had with all of this is it takes time to go at that service user's pace, not our pace. An example I've got of that is one woman I'm working with, because of her ill health and the impact of the trauma she's suffered, it's affected her physical health as well as her mental health. So, some of the appointments we've set up she's been unable to make because she's been physically ill due to stuff that's happened with her specific traumas, so we've had to put that off."*

This demonstrates the impact of trauma upon the brain and body and the importance of responding to this compassionately and flexibly, as trauma is not linear, not confined to the brain and can disrupt survivor's ability to engage at various stages on their journey.

This flexibility to engagement and the structure of interventions also meant services were able to be guided at the survivor's own pace and to make sure that they were comfortable, grounded and reassured that sessions were about them, rather than the goals of the service. Zoe commented:

> *"She really lets me take things at my own pace. When I first see her in the morning, we will always talk about what kind of a week I've had. We have spent a lot of time talking about how my week's been and then in the time we'll get on with what we're supposed to be doing. But even just coming in and having a bit of a chat about what's been going on has been really helpful."*

The importance of establishing safety prior to commencing work is a critical element of Trauma Informed Practice (reflecting Herman's Recovery Model (2015)), and a preliminary casual chat can be grounding and help professionals check in with survivors and help them be present in the work and best able to engage. Also, mentioned by other survivors and professionals, the checking in chat in itself has been therapeutic and transformational for survivors who often haven't felt themselves worthy of taking time out for themselves, are preoccupied with pleasing others and who have struggled with forming social connections in which they can just 'be' and don't have to

perform a role or provide something. Walker (2003) terms this tendency among trauma survivors the 'fawn' response, where people-pleasing takes on an extreme role and the wishes, needs and identity of the survivor are subsumed. By taking time each week to have their own validity and importance affirmed, and to have fewer opportunities for people-pleasing, survivors can begin to reconstruct their role in their world view and their sense of worth.

Keira had experienced this in many aspects of her life but had been encouraged and empowered to assert her boundaries and advocate for herself by counselling that built on her confidence: *"For me one of the things that's changed is I was never able to say no to anyone. I was always a people pleaser, even in work life, home life…I've learned to say no, and I've learned to raise issues in my work life and personal life…now I feel like I'm able to have that voice and my voice is important too."*

Feeling unable to control their experiences, being rushed or coerced by professionals could render interventions useless as the survivor's traumatic experiences are replicated, they are triggered and thus unable to feel safe and be present. This was recognised by professionals who ensured that survivors were able to exercise choice and control in their engagement and content of care. Naomi remarked:

> *"Everything was at my pace so I could go back and revisit any session that I wanted to recap. I was offered an extra session at the end to go over everything from start to finish which was very good because by the time you finish your weeks you kind of forget what was in the first week. So going over it all again in the very final session really helps."*

Naomi here illustrates the flexibility of the trauma stabilisation delivery and that sessions were led by survivors rather than an imposed schedule. The opportunity for a further session allows survivors to embed their learning and gives them greater choice than most structured programs.

For survivors who preferred to communicate and work in nonverbal ways, services were also responding and providing them with choice. Alicia's support worker had noticed her struggling with the usual format and worked with her to find a way for her to engage in a way that spoke to her: *"I think it was the third session, we were doing stabilisation in groups and I think, because I was off on one of the days she picked upon it so we left the stabilisation for a bit and figured out what was going off in my head. So, she just got the paper out and we started doing art and we led it from there."*

Eve spoke to the unsuitability of services that exclude survivors for nonattendance and observed how this approach misunderstands the mechanics of trauma; the window of tolerance may be breached in the process of engagement and so survivors' withdrawal actually constitutes a natural protective response to that; '*Sometimes people go 'oh well they've not turned up three times. Well, they might not have but that's because they're in turmoil and they likely will go back when they are able to do so.'*

The importance of flexibility and appreciating the processes behind the scenes of intermittent engagement is critical if services are to avoid triggering survivors by replicating experiences of rejection and control and if they are to effectively engage with this client group. Heidi demonstrated how consultation with the TRS had supported her to develop an approach that meant she was able to keep an open door to very difficult to engage clients without this negatively impacting her outcomes:

> *"Well there is one Stovewood client and she's really, really difficult to engage…I saw her once then I couldn't get hold of her, she didn't answer her phone, she didn't respond to text messages…I spoke to the TRS clinician and that's when she first spoke to me about pausing clients, not actually closing them but pausing*

them. So I left her a voicemail and I also sent her a text explaining how I've spoken to the TRS and it had been suggested that maybe now isn't the right time for her to be able to engage so I'd wait for a response (and I gave her a couple of weeks to get back to me) and just say 'can we pause you for now if you're not able to carry on and if it's not the right time. Give me a call back by (date) and if you don't get back to me, I'll take it that you want to me paused for now. Then what I'll do is I'll pause you and give you a couple of months and get back to you, see if you're ready to engage then.' and she actually rang me back within that deadline, thanked me for the offer of being paused but said she'd had a think about it and she did want support and she carried on." By 'pausing' rather than 'closing' and by making this explicit but without any consequences to survivors, emphasising a consistent open-door, services can help survivors engage at their own pace, according to their own comfort levels and without taking control away from them.

The control is also gained through in the versatility of the techniques survivors are taught in stabilisation. Rather than being dependent on the support or input of a second person, or requiring visible, noticeable activity, techniques can be used in public. Naomi stated that:

"I've found that I'm not as stressed and on edge for as long, because as soon as I start feeling stressed, or anxious or on edge, I start doing the colours breathing and I can start doing it wherever. I could be standing in a crowd of people talking and I can do it and they won't even know I'm doing it!"

Survivors frequently feel self-conscious and anxious even being in public, and certainly don't want to draw attention to themselves or identify themselves as struggling or vulnerable. By being able to use soothing and grounding strategies discreetly, this empowers them to keep control while expanding their horizons and experiences in the community.

The modality of trauma-informed support also offers survivors the rarely available but powerful opportunity for them to be active participants in their sessions and to take that agency with them into their everyday lives. As Naomi remarked:

'It's OK talking to somebody and telling them what you feel and what you've been through and stuff like that. But they give you something to go away and put into practice when they're not there, in that second where you need something, you can do all the strategies and help yourself.'

Whereas previously Naomi had felt very passive and inactive in counselling she'd received, being able to have insight from a responsive worker who provided her with tools to implement strategies for herself as empowering and pragmatically significant too.

An element of this is the self-sufficiency conferred by being given versatile tools that can be taken away and used in a range of situations, as Keira attests, '*She gave me the tools to continue after….I had the tools, and I had the confidence to do it.'* This meant that Keira was able to recognise her own signs of trauma and respond to it but also to use the tools in asserting her boundaries and her right to say no.

A common symptom of trauma and especially in response to CSE is a feeling of powerlessness, fear and paralysis and a sense of lack of worth around having a voice and rights.

A significant finding regarding this is how an understanding of their trauma and the use of stabilising techniques are giving survivors the confidence and self-esteem to assert themselves in social and professional situations. We saw this with Keira who was now

confident in asserting herself and saying 'no' in her family life and workplace. Similarly, Anne had seen this first hand in many of the women she worked with:

> *"We see how in the women then their confidence changes in how they respond to other professionals in their life, recognising that they have got a voice and they have got a right to be heard…very often these women come along and they don't feel they've got any right in the world and that's absolutely huge."*

By giving support to instil women with the skills and sense of self to assert their autonomy and the validity of their needs, boundaries and rights, they are equipped both to take a more active, participative role in their own care and counter the feelings of worthlessness, invisibility and powerlessness that often accompany CSE and PTSD.

Heidi referred to supporting survivors to challenge decisions made by professionals in a controlled and healthy manner that would protect them from the emotional impact of the anger or futility that often accompanied their resistance to and experience of punitive responses of services; *'I always say you have a right to challenge. If you feel somebody from a different agency is asking you something, if they are asking you something and you don't understand or agree, you can either challenge them or ask them to clarify…it's about doing it in a healthy way.'* Heidi asserts the importance of finding the balance for survivors in feeling empowered to assert their boundaries and to question authority but to do so in a calm, collected and non-triggering way. With survivors who have complex needs, they might often be faced by challenging requirements or decisions from agencies, and it is important that they do not feel victimised or powerless in these exchanges and can engage in debate and ask questions without being perceived as aggressive or unstable.

5.7. Collaboration- Survivor input and collaborative working among services

An unintended and tangential but nonetheless very real and important development of collaboration was described by Eve, who had observed the contagion of enthusiasm among women who had accessed trauma stabilisation and their consequent advocacy of it to other women.

> *'The women I've worked with who've accessed services and the courses all were encouraging other women who were saying 'I don't want to do any of that' and they were saying 'you absolutely need to do it, it's the best thing! It's the* ***best thing!*** *It is the best course you can go on; it gives you a proper understanding of why your brain works like that and how you deal with trauma as a person, and it's done this for me, and it's done that for me…'*

Not only is this a powerful testament to the benefits of trauma fluent support for survivors but the informal advocacy between women that has naturally developed indicates the momentous impact of these benefits.

Survivors were also being given opportunities to use their voice and to have some control in reports being passed between agencies; whereas usually this was very much a matter of professionals' jurisdiction, voluntary sector staff were collaborating with survivors to allow them to contribute to or make decisions over their representation to other professionals. Anne advised, '*I've written reports for people that have done stabilisation. I've written reports for court, reports for social care, so what I did was put in the sessions she's attended, and I put in her demonstration of learning, her understanding. I let that woman read that report. If she doesn't agree with it, then we change it, or I don't send it. In both cases it's been positive, they fully engaged in the work, and demonstrated learning to their ability.'*

As detailed in Travelling Through Trauma (2020) The TRS Hub provides a forum for multi agencies to collectively discuss cases and develop collaborative, bespoke care plans with a trauma informed focus. Dana referred to the development of this and the crucial role it is playing in the strengthening and flourishing of the Rotherham Trauma Network; '*Setting up the Hub, how that has grown and developed over the past couple of years, that's amazing. We've got statutory and voluntary sector coming together really well and having that open communication and having the Hub (TRS clinicians) there, to discuss cases and bring clients in is amazing.'*

There was also encouraging evidence of relationships built by the voluntary sector partners with other services functioning to help bring a trauma informed perspective to survivor's experiences of support and care. Dana describes of one survivor; *'She'd got other services involved but then we were able to liaise with these services and give them an idea of trauma informed practice etc., and then they were able to come in and offer that intense support and it was becoming a very successful outcome for that family.'* As Dana attests, these relationships allow a change of experience for survivors from services' involvement they may traditionally have found threatening and destabilising to a supportive, compassionate and transformative one.

5.8. External service experience and access

Prior to the TRS' development of the Trauma Network, Jodie noted there had been a dearth of suitable support for survivors in Rotherham, *'I just noticed things really dropped off in Rotherham (about ten years ago) and there wasn't the support there that people obviously needed at the time.'*

In contrast to the flexibility with regards to appointments, engagement and content of support offered by the TRS' voluntary sector partners, many services were identified as being unable to give trauma survivors the requisite freedom and patience to be able to engage. Anne advised that:

> *"A lot of services they want you to sort of roll in and roll out, it doesn't work like that because these are people's lives that we are stepping into, and we are only scratching the surface a lot of the time and that's why it's imperative to take time and be patient. But a lot of the time that's not what these women have experienced from other services; it is very much we need it now; we need you to do this now and it doesn't work like that unfortunately."*

As Anne recognises, where services expect survivors to attend, engage and demonstrate set progress outcomes within a mandated time frame, this runs counter to the needs of trauma survivors for whom having control, taking time and being able to take breaks when over faced is crucial. However, where services aren't or are unable to be understanding of survivor's various engagement styles, including intermittent or avoidant, they are perpetuating survivor's experiences of rejection and exclusion and potentially adding to their trauma.

Another need identified by survivors that was often unmet in statutory services was the opportunity for survivors to have control in and direct their care, instead they often felt pressured to move at a certain pace and in a certain direction in order to meet the targets of the service. For example, Keira:

> *"When I've had counselling before – it's always felt like their agenda and what they want to push. Whereas, working with (voluntary sector partners) was person centred because as things cropped up throughout my weeks of working with her, we'd discuss them as they arose."*

This rigid way of working, lack of trust and familiarity and dictation of tasks had several negative consequences:

> *"I stopped going, I disengaged with it because I didn't feel believed. I didn't feel like it was genuine, and I didn't feel like I was building a trusting relationship to discuss stuff with them… It was 'we're doing this' and 'you've got to do CBT' and 'we don't do that here'...and when my anxiety is high, I become a bit demand avoidant so if they say to me 'you need to…' I won't do it because you've told me I've got to rather than advising I might want to look at that because it's going to help me in these ways."*

As we have seen, the voluntary sector partners are commissioned differently by the TRS, focusing on interventions being tailored by and led at the pace of the survivor, of building safety and trust in relationships and ensuring that the voice of the survivor and their expressed needs remain central. This facilitates the professionals in these organisations to work in a trauma-informed way where other services may not be able. As Sharpen (2018) asserts, survivors of trauma are often hyper vigilant to body language, trustworthiness and other signs of safety or threat from professionals. Ensuring survivors feel in control, do not feel manipulated or pressured at the behest of someone else's desires and know that they can rely on and be listened to by professionals is critical in mitigating this, as illustrated in the difference in survivor's responses to the TRS' partner organisations and to services where they have not felt valued, in control, safe, listened to and believed.

Regarding experiences with other sectors/services, both survivors and professionals spoke of difficulties with the family court social care interface.

Several illustrations were provided where the system could be felt to be using trauma stabilisation in a coercive way by including it in their requirements of survivors who are at risk of losing custody of their children. Claire described this as:

> *"What I found today is one lady in particular, she'd come into the group, and I think she'd come in with a massive barrier, her guard up, and actually feeling quite unsafe and triggered because she's been forced to come. So, before we can actually get anywhere, I've got to look at that and break that down. It is an issue, it is a trigger for a lot of people, I suppose it's that feeling out of control. Social care is saying it's one of the tick boxes they want them to do, in their eyes, to get their children, which is a real misunderstanding of trauma."*

As Claire identifies, using coercion to compel survivors to engage with trauma interventions is contrary to the principles of trauma informed practice which aim to build up survivor's safety, feelings of control, autonomy and agency. This speaks to the tension between the remit of social services, which must primarily focus on potential risk to children and have exhausted all opportunities for intervention, and the ethos of trauma informed practice which applies a more compassionate lens to, for example, survivors struggling with motherhood and service engagement due to their trauma. However, the TRS is working with social services to develop a trauma informed approach that acknowledges the crucial importance of social care's safeguarding work and also brings in an alternative perspective that can allow reflection in the family courts system and provide more opportunities for families to be supported in a gentler way.

Even shifts in tone can provide a trauma informed approach which has significant effect. An illustration of how a careless response can trigger survivor's traumas and feelings of threat and helplessness was provided by Zoe whose worker agreed with her need to be hypervigilant of her violent ex. *'He got arsey on the phone and she rang me up and I said, 'well I'd better watch my back then if he's on the warpath' and she*

said, 'yeah you best had.' While it is likely the worker didn't mean to infer to Zoe that she was unsafe and on her own and the comment may have been flippant and lacking consideration, it exemplifies how trauma awareness needs to inform the minutiae of professionals' responses and how their choice of words and methods of delivery can be received as threatening or reflecting traumatising experiences and messages. It is relevant to note that workers often struggle to manage enormous caseloads and a huge amount of pressure and responsibility, but by having the support of the TRS to offer an alternative perspective and way to reflect on the power of good that careful language can do services and service users, professional responses can be improved. Indeed, the TRS are currently engaging for, example, with social care in significant work to develop trauma fluency throughout the service.

Eve and her daughter had had a multitude of difficulties with services, and Eve felt much of this revolved around her daughter's complexity of need not being understood through a complex trauma lens, resulting in her receiving less thorough support and feeling subject to moral judgements. Eve's experiences contributed to her feeling that statutory services were particularly in need of an understanding of trauma:

> *"My daughter was kidnapped and horrifically sexually assaulted. The man got a x sentence and as a result of that she was offered some compensation' she went on to describe how outraged she was that her daughter was then denied the compensation 'in case she spent the money on drugs…Professionals might not like the choices she makes, and she might spend it on drugs, but she has full capacity and it's none of their business"*

Eve went on to suggest that an understanding of trauma might have made a difference in how this was handled. The money perhaps represented acknowledgement of the abuse that had been endured and to deny the money was equated with denial of the abuse and of her voice. In withholding the compensation, for safeguarding reasons, in the face of the survivor and the family's perspective, meant that there was a risk of also denying the chance, even if minimal, for hope and reparation. Instead, the family felt misunderstood by the system. These are complicated and contested areas within a context of a history deep mistrust and misunderstanding emanating from the Rotherham story such as represented in the Casey Report 2015. In situations where there is an intense emotional atmosphere, for families and professionals, working through the situation as an ethical dilemma to a shared position is really very hard to achieve.

Jodie had, as many survivors have, negative experiences of the police but since being supported by the voluntary sector, she recognised her validity as a victim and gained the confidence to call on the police for protection:

> *"We've had so much hate crime…Before I had problems with the police, I just used to deal with things myself and really just have to go mental…it's like a coping mechanism…I was speaking to (support worker) and I learnt to, not go out and kick off but think about what I'm doing, think about me kids and then what I would do is start ringing the police and reporting them because then I learned about hate crime and I learned that these people are hating me for no reason at all, so what I did is I learnt to ring the police."*

This illustrates how self-confidence and support to help survivors step back and resist being controlled by emotional responses can also improve their perception and experience of other services. Jodie's experience suggests that for her, this was a satisfactory alternative and stood in contrast to her experiences of the support landscape a decade ago, indicating significant change.

"The support, it's changed over the last ten years, it's different now. I've got more faith in the system. Not 100% but I'd say at least 95%. What I learnt from (support worker) with the police it isn't about hiding, I don't want my kids to think that. She made me less in fear of the police."

It is important that these positive, transformative relationships and experiences are replicated throughout organisations. Eve's professional experience led her to observe the need for professionals higher up in organisations to also be engaged in trauma training, as without understanding of trauma and appropriate responses permeating services, workers may be constrained in their ability to apply their knowledge:

"I think managers, any kind of local councillor, should really do this trauma training because it's not just around CSE it would cover a whole load of things. So, we gets the workers to do it, so you can have a worker that's very switched on and they can say 'I understand why the person's doing this', but their manager hasn't got a clue, so nothing gets done."

As Eve notes, trauma fluency has relevance to a multitude of professional areas beyond CSE, such as within drug treatment, education and housing and so it is important that organisations are speaking the same language throughout, and across the broad landscape of services that will encounter trauma survivors.

5.9. COVID-19

At the beginning of this research, COVID-19 was somewhat of an unknown quantity in that vaccines had not been discovered there were uncertainties around transmission and much of the country was under stringent lockdown measures. The impact and potential future impact of these seemed huge, and so was felt to be a significant area for investigation. By the time the interviews took place, vaccinations had begun to be rolled out and professionals were on the cusp of tentatively returning to office.

However, the impact of COVID-19 upon survivors' receipt of support and their wellbeing is notable and provides an important insight into how services can respond to obstacles to face-to-face service delivery.

Dana describes the effects of covid and how her service worked around the limitations at the time; *"Obviously it hit, and it hit hard and there was a complete change in how we had to work. We were very few and far between and we offered telephone support, delivered trauma stabilisation. But we were used to face to face appointments and groups, so we had to develop a new way of being able to work… we now have successfully completed trauma stabilisation over telephone and I have completed virtual stabilisation over Teams."*

In addition to challenges for service delivery, COVID-19 also took its toll on the wellbeing of survivors; "COVID has been another impact on people's mental health. It's added to people's isolation, it's also added to people's physical health, long COVID things like that. So, we've been extremely mindful of that…during lockdown when the schools were closed sessions weren't always able to take place. It was right, we'll try and have a session, but it might just be a welfare call if your children are around. Which is exactly what I've just done with a client recently…we agreed to pause it over the six week holidays so welfare calls were made, she was aware she could contact me if she needed to Not every service can do that but we're fortunate to be able to do that and do you know the client was really grateful we were able to be flexible in our delivery?"

Survivors were overall quite stoic concerning the disruption caused by lockdowns, with most acknowledging it as an unfortunate but unavoidable consequence.

Some struggled initially, but also found benefits to virtual delivery of sessions.

Naomi had never met her worker and remarked, *'So that feels a little strange, it's like I don't know who I'm talking to. But even if I was in the local area, I probably wouldn't see her anyway because of all the COVID restrictions so it's not something that can be helped. It's just a difference but it's been good over the phone as well. There were times when I was in tears and breaking down and she was very, 'do you want to take a minute' and she paused while I blew my nose and things like that. Whereas I think if she'd been sat in front of me, I'd have been more embarrassed I think, her seeing me.'*

Naomi had moved to a different area for her own safety, and as discussed in the Services section, the ability to work across borders is a valuable and rare one for services working with a cohort who may have moved out of area for their own security and wellbeing.

As did other survivors, while Naomi found virtual working a little unusual at first, she did feel there were positives, particularly with regards to helping her feel less conspicuous and self-conscious when upset. This could be particularly valuable for some survivors who are uncomfortable with being seen or feeling exposed by having their vulnerability viewed by others, so long-distance interventions may provide an extra measure of security beyond the originally intended infection control.

5.10. Recommendations

The TRS

Provision for Children and Young People

The impact of the TRS partnership with the voluntary sector for Stovewood survivors has been spoken of glowingly by survivors and professionals. Professionals did identify a need for a similar trauma stabilisation program to be developed to specifically cater towards younger people and given comments survivors made regarding worries and the actuality of their children being groomed, this seems an area of development to be prioritised. Anne advised, '*I would like to see a specific program for younger people because I have teenagers on my caseload and some of this stuff is way over their heads. I'd like something specific to be developed for younger people. I know there's stuff out there, but I don't think there's a specific program tailored for younger people.'*

Several survivors spoke of teaching their children the stabilisation techniques and of how powerful that had been when they were overcome with emotion too, so it seems a powerful tool that can be adapted for younger audiences. Backing this up with an understanding of trauma and how it manifests could also be valuable for younger people who have directly or indirectly experienced trauma.

The work in schools being done by the TRS discussed in the 'Service Development' section illustrates the progress made in raising trauma awareness in schools. Several survivors pointed to the importance of school children being made aware of available support and normalising talking about abuse and exploitation. For example, Cassie advised, '*If I could get up in a school... And you can talk to them about knife crime, alcohol abuse, manipulation, paedophiles and how they can manipulate people, about being able to speak to people about sexual things that had happened, even if their family has been threatened and you can give a number…It needs to change at a younger level, so that children know.'* While Cassie and others were willing to take on the role of providing this education themselves, this would potentially be retraumatising for them in these vulnerable early years where stability and safety are still being worked on and court cases are ongoing.

The TRS work very closely with the child sexual exploitation pathway in CAMHS and indeed share the same leadership structure. There is a shared consultation service which offers a family view upon the impact of CSE servicing both children of survivors as well any contemporary victims. There are close relationships with the local authority Evolve team as well as Barnardo's, early Help, GROW, Rotherham Rise and Rothacs. In this way Rotherham CCG commission, an overarching service for both adults and children. Some of this innovative work was described in a department of health project 2018 (reference Transforming services for children who have experienced sexual abuse).

The TRS schools project works closely with 'Me in Mind' schools mental health service and offers support to schools for complex and developmental trauma that contributes to the widening of the offer from CAMHS. Specifically, where survivors and perpetrators live in the same area and their children attend the same schools. A trauma stabilisation programme is currently in development in response to this demand.

Awareness Raising

Professionals and survivors raised concerns around public awareness of the support available and so an awareness campaign that is clear about what is on offer, from where and to who could be a valuable method to optimise the ability of survivors throughout the borough to access support. As Emma mentioned, '*I do think an issue could be people not knowing about what the services are doing now, I only knew because of my job and finding out through there. It's not really publicised'.* Regarding publicity, Eve suggested adverts in public places or on council documents which could reach survivors but also raise awareness of and empathy towards trauma survivors among the general public.

National Roll-Out

There was an overwhelming and conclusive endorsement by survivors of the impact of trauma informed care in services and this was accompanied by assertions that this must be embedded in services and continue to be developed and expanded to ensure current and future survivors continue to be supported. For example, Keira remarked. '*In working with people it's about embedding that in services rather than it being unique to that person…to embed that in that service so that in 10/15 years' time when they might not be part of that service, to make sure people get that same experience.'*

The TRS is well placed to offer consultation and guidance to underpin the roll out of trauma informed services and sexual assault services nationally. They are clearly a trailblazer who have had significant impact in a short period of time under demanding circumstances. It would make good economic sense for the learning and evidence base from Rotherham to be shared nationally and for this model to be tested out in other localities, in order to develop a (currently lacking) wide evidence base.

Below, I detail the core benefits of the TRS model and its potential for nationwide rollout.

- The Multidisciplinary Team Meeting, providing a mental health and well-being focus at the criminal justice interface, is well received. The MDT is unique in it bringing a multidisciplinary, collaborative and trauma informed dimension to criminal justice processes. This model could be transferred to great use in other parts of the country where vulnerable populations are involved in criminal justice proceedings.
- The TRS/VCS hub is another transferrable concept that enables a paced approach to building tailored packages of care in a community and place setting.

- The TRS clinical and organisational consultation service is wide reaching and provides the 'glue' that augments system integration around survivors, especially high risk and complex survivors.
- The TRS contribute to a learning culture in Rotherham through conferences and focussed training packages that are then embedded in practice. The training is free and available across the Rotherham footprint.
- The TRS integrates the 'Voice' of the survivor within partnership working. This embodies the TIP principle of 'doing with' and not 'doing to' and focusing on 'what has happened to you' rather than 'what is wrong with you.' It also provides a framework for further developing models to implement co-production in service design and evaluation with survivors.

NHS and Government

Investment and Capacity

The prevalence of trauma and mental health problems in general was a strong theme, with survivors highlighting the critical need for a quick and appropriate response. This is curtailed by the impact of high demand, especially as a result of COVID.

As Naomi remarked, *'Everybody's suffering even more now with the COVID than ever so there needs to be more services for counselling, therapy and things like that. The waiting lists and things are way too long. Not in my case but in other things the waiting list is absolutely diabolical. When people need to speak to somebody and they're in that moment they need it there and then and not 2 or 3 months down the line, you've got a whole new set of problems on top of the original ones by then.'*

As Naomi recognises, often the window of opportunity for intervention in trauma is brief but it is vital that it is recognised because lack of response and the ongoing aggravation and accretion of symptoms only adds more strain upon the individual and the system to address when they do and can respond. Therefore, by investing in services to respond appropriately when the opportunity arises, greater cost (fiscal, social and individual) can be avoided in the longer term as people's needs are met before crisis point is reached.

Emma attested to the importance of this, *'Before this I hadn't had any contact with other services, but I know waiting lists can be a big problem for people. If I had been put on a waiting list for talking to (my worker) it would probably have put me off following it through.'*

We have seen in the findings how accessing trauma support has helped survivors in a multitude of ways, including saving lives, so the cost of missing these opportunities and lack of capacity inadvertently deterring survivors cannot be overstated.

Rather than continuing to invest in conventional services alone, it is also imperative that priority is given to the development of trauma fluency and also trauma focused networks of services regionally. Survivors unanimously identified the urgent need for services and support like they have accessed to be available nationwide and the TRS' Trauma Network and the Survivor Pathway ensures waiting lists are minimal by providing support through services in the community.

The Legal System

Because of the risk of being accused of evidence contamination or of counselling notes being used by the defence against survivors, pre-trial guidelines might prohibit survivors from receiving counselling for their trauma until after the investigation is

complete. This means survivors who may dearly need to be able to talk through the impact of the trial are unable to. Zoe is one survivor who felt the support she received was much later than she'd have preferred; *'I needed it much earlier, but I was under pre-trial guidelines, that's so frustrating because the investigation went on for over two years, so I was pretty rock bottom. I don't agree with that pretrial thing. I understand why but it makes it tougher on the victims when they can't get help.'*

It seems that this is an area that requires further consideration, whether of the possibility for exemptions to be made where further harm will be done to survivors through exclusion from talking therapies or by greater consideration of what could be offered instead. This would require a shared approach by legal professionals, the government and providers of trauma services. While there isn't the space to explore this in depth here, the issue of balancing victim's welfare and the potential consequences of therapy for court proceedings is a topic in its own right. However, the trauma stabilisation programme is designed to be offered at any point throughout the criminal justice process as it is designed so as to not contaminate evidence. This provision is an impressive contribution to this tricky area.

The NCA

The development of the MDT has been well received on all sides in terms of promoting partnership working despite different work cultures. It has provided assurance to the NCA of multi-agency support and it has increased the sensitivity of response to the complex nature of the trauma experienced by survivors and their vulnerabilities. As an example of the change, prior to their work with the TRS, Cassie had experienced an unexpected visit when her children were present:

> *"My kids had to hear things I didn't tell my children and it upset them knowing what I was going through. So that trauma I was going through was put on hold, because for them to hear it, it upset them… they've not been offered any support."*

The NCA is now considering whether children are home prior to approach, as illustrated in the MDT Case Study chapter, and Cassie's experience attests to the importance of that.

Support for children though consultation from the CAMHS CSE pathway, as part of the TRS package, is available but prevention of re-traumatisation through system change is more efficient.

The Voluntary Sector

The voluntary sector is already operating a 'train the trainer' model with the TRS and the organisational learning has already had a cascading effect. The potential of these trainers for working with other services could also be explored, increasing the scope of multi-agency working and providing other professionals with an insight into the on the ground operation of trauma-informed practice by others who also did not come from a TIP background. Cassie attested to the value of cross-professionals' dissemination of experience:

> *"Someone like (my worker) teaching people, giving them training to handle these delicate situations. Because there's been times that I could've had help but I've chosen not to because of the way that it was handled."*

By training being delivered by professionals from clinical and non-clinical backgrounds, other sectors can gain experience from those with theoretical and practical experience at various stages of learning and expertise.

There was a lack of clarity around how many trauma stabilisation and counselling sessions survivors were entitled to. Several survivors referred to feeling able to go back and ask for help again if they needed it in future, but Cassie was under the impression a limited number of counselling sessions were available, advising *'I don't think the 22 sessions that are given are sometimes enough.'*

Dana also felt that offering six trauma stabilisation sessions was not enough though she and other professionals had been breaking these up if necessary; *'I would like to see it maybe longer than the six weeks…we are bespoke and it's not just like we deliver that six weeks but maybe let's introduce more techniques and more learning. What's great with the TRS is that when we have our group supervision, they will bring something new for us to discuss and to reflect upon and give us some new tools.'* Dana and survivors identified that the need for trauma stabilisation and counselling sessions could be variable, and it would be helpful to be able to be explicit and flexible to survivors regarding the capacity of this. Also, as the TRS continue to provide professional development to the voluntary sector, which was praised by several professionals, it would be encouraging to see them being given the time and space to incorporate that more formally into their work with survivors, when felt desirable and useful.

5.11. Other Services

Survivors often move, involving crossing borders, to keep themselves safe and avoid triggers. This needs to be recognised and barriers to cross-border working addressed as it is critical that localities can work together to support survivors without punishing them for protecting themselves.

A suggestion was that trauma informed care needs to be embedded in social work qualification requirements and continued through professional development; it must also permeate throughout from management down so the whole service can work united by an understanding of how to recognise and respond to trauma. The partnership working being undertaken between the TRS and Social Care is an extremely positive and potentially powerful step in integrating the priorities and perspectives of a child safeguarding and risk averse sector and one that is more led by the needs and capacity of the survivor.

Another useful suggestion regarding how social care could incorporate a trauma informed approach while still maintaining their focus on their remit of child protection came from Dana; *'Obviously their priority is safeguarding the children and that is key but being able to include that (trauma) in the assessment of parents could be really helpful.'* Providing a space for acknowledgement and consideration of parental trauma in social care assessments could ensure professionals hold this in mind when working with them. For example, this could involve avoiding potentially triggering coercion or threats, being more compassionate and understanding of the often-nonlinear nature of trauma survivor's attendance to counselling and other therapeutic work and exploring how trauma could be impacting parenting and how this could be mitigated.

Several survivors and professionals spoke of the need for more services to be incorporated into the Trauma Network and to embed working to support survivors from a multidisciplinary, trauma informed practice throughout the service delivery landscape in the Borough. Anne attested to the importance of this:

> *"I think there's a lot of work to do with partnerships and …we can make that pathway a better pathway in partnership working rather than one or two organisations trying to struggle along when we could all be working together for the common good to support these women."*

This speaks to the importance of *continuing* to expand the Rotherham Trauma pathway, bringing in new services and incorporating trauma informed practice and partnership working throughout organisations at every level.

As first responders at crime scenes, police are likely to be entering situations where there is at least one trauma survivor and, as Dana identified, being able to work in a trauma informed way would enable them to work more effectively and compassionately to explore what has happened; *"You've got people in a heightened state, they're hyper aroused, they're hyper vigilant, they're feeling under threat etc. I think it would be really useful, for the police to have that knowledge about the trauma response. I think the police obviously they have a job to do, and they are a statutory service so have a format which they have to follow, but they can be quite matter of fact and I often have seen and heard that the victim has been arrested as well."*

As with social care, an inclusion of a trauma assessment in first responder's response assessment framework could provide space for this and it has potential to assist officers in their work by ensuring victims are not arrested or further traumatised.

5.12. General

A couple of survivors mentioned anxiety around the communication methods used by services. Some had found the use of withheld numbers and voicemail destabilising and frightening as they were also victims of persecution and threats over the phone.

Naomi advised, *'The only thing I would suggest is, I don't really answer withheld numbers, but my worker is a withheld number. So, if I knew she was ringing I'd know it was her. I used to have all withheld numbers barred but I've had to take it off. Even the investigating officer sometimes rang, and it's been withheld as well.'*

To avoid exposing survivors to feeling vulnerable by being unsure about the identity of the withheld caller, a possibility might be to alert survivors beforehand by text, advising who will be calling and roughly when, so they can anticipate the call and be more secure in knowing who is at the other end of the phone.

5.13. Next Steps- Interest in co-production

Finally, we wanted to further consider how to continue developing models to capture the survivor voice. involving survivors in co-production in future, whether evaluations, service review or design, or all of these modalities. Naturally and reflecting the principles of trauma informed practice, the first essential step was to assess survivor's interest and the potential benefit for them in doing this. I was aware that survivors may feel pressured or for the desire to 'people please' to lead to them agreeing to things they are not sure of. Therefore, we will be meticulous about the process of informed consent going forwards.

However, all of the survivors were effusive and positive about being involved in co-production further down the line, and several had shown their interest in contributing to trauma support before I breached the subject. This is extremely encouraging, and the next steps will be to carefully consider, with the TRS and voluntary sector partners, how best to support and engage survivors in this work together. There is a great duty of care and there are many variables to be aware of when exploring how to do this in a trauma informed way. The potential for this piece of work to make a significant and new contribution to the field of co-produced, survivor-led knowledge and practice around trauma is significant.

The benefits of co-production are detailed below.

- Improves service experience for service users.
- Increased community capacity by enhancing professional and service user awareness, ability and confidence to advocate for and access suitable support.
- Enhances identification and attainment of service user centred outcomes.
- Promotes integration between services and between service users and professionals.

(SCIE, 2015)

Voorberg et al's (2015) systematic review of the literature identified the following objectives/outcomes from co-production in public health:

- Gaining more effectiveness.
- Gaining more efficiency.
- Gaining customer (user) satisfaction.
- Increasing citizen involvement.

Given the proliferation of historical and ongoing experiences of trauma and abuse among people with complex needs, it is especially pertinent to acknowledge the transformative role that co-production in commissioning and design can have in this respect. Fisher et al. (2018) remark that excluding service users from research and service development processes can represent a perpetuation of the abuse as their agency is denied, their voices silenced, and their opinions disregarded/expressed through third parties. The authors draw upon Herman (2015), noting the empowering role that co-production can have for abuse survivors, countering processes and experiences of 'othering' and serving as a 'key element enabling survivors to regain the power they lost through the violation of their initial abuse and its entrenchment through subsequent cultural and social forces' (Fisher et al., 2018: 2098). Therefore, there may be greater risks to service users if co-production is not facilitated, as the opportunity to recognise their 'legitimate expertise and knowledge' is a crucial part of designing person-centred services and identifying person-centred outcomes, and eliciting the lived experience voice can even serve as a 'turning point in recovery' for abuse survivors (Fisher et al., 2018: 2099-2103). Consequently, eligible survivors will be identified and supported throughout the process and beyond by trauma fluent workers, ensuring survivors can engage in the process in an empowering and safe way.

6 Conclusion

The work and reach of the TRS has continued to grow and deepen and the service is appreciated and now embedded within the Rotherham system. Its offer meets a variety of government drivers such as the 'Transformation of mental health services and the development of integrated systems: health social care and voluntary sector (ICS).

The TRS offers a transferrable model for enacting systemic change which would be of huge benefit nationwide. While these evaluations focus on the TRS, the research is also a vehicle to realising a snapshot of multi-agency functioning across the system. The importance of systemic change and collaborative, multi-agency support for survivors of CSE was most starkly highlighted in the 2014 Jay Report and is the core principle identified by for successful trauma informed systems change by Gerber (2019).

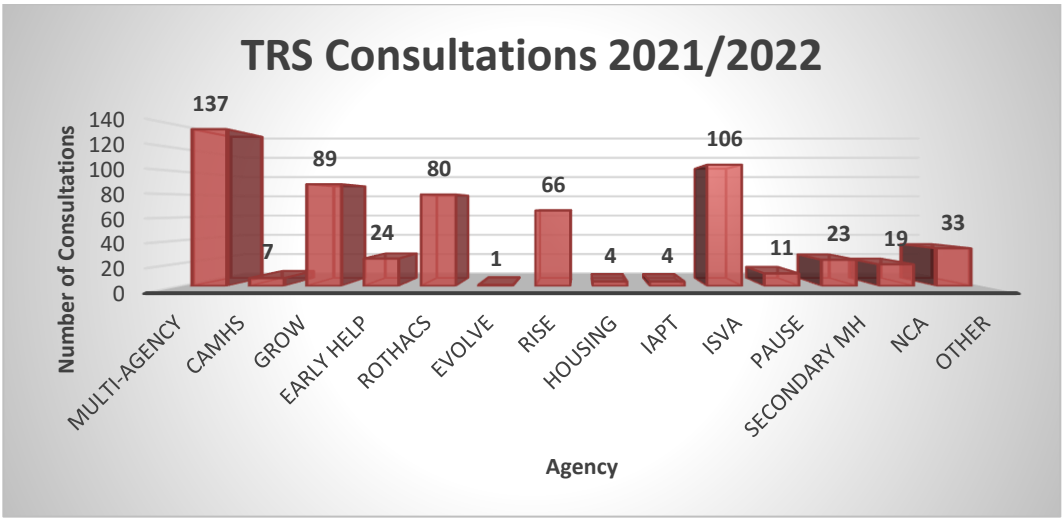
In 2022, these evaluations demonstrate how the TRS is achieving this by embedding systemic recognition of and response to trauma across the service delivery landscape and in survivors themselves. This level of transformation is highly desirable nationwide and across all services who are likely to work with people who have histories of trauma and offers enormous benefits, economically, socially and in terms of justice.

The following graphs and tables demonstrate the reach of the TRS' work in its fourth year.

6.1. TRS Consultations / Case Discussions 2021/2022

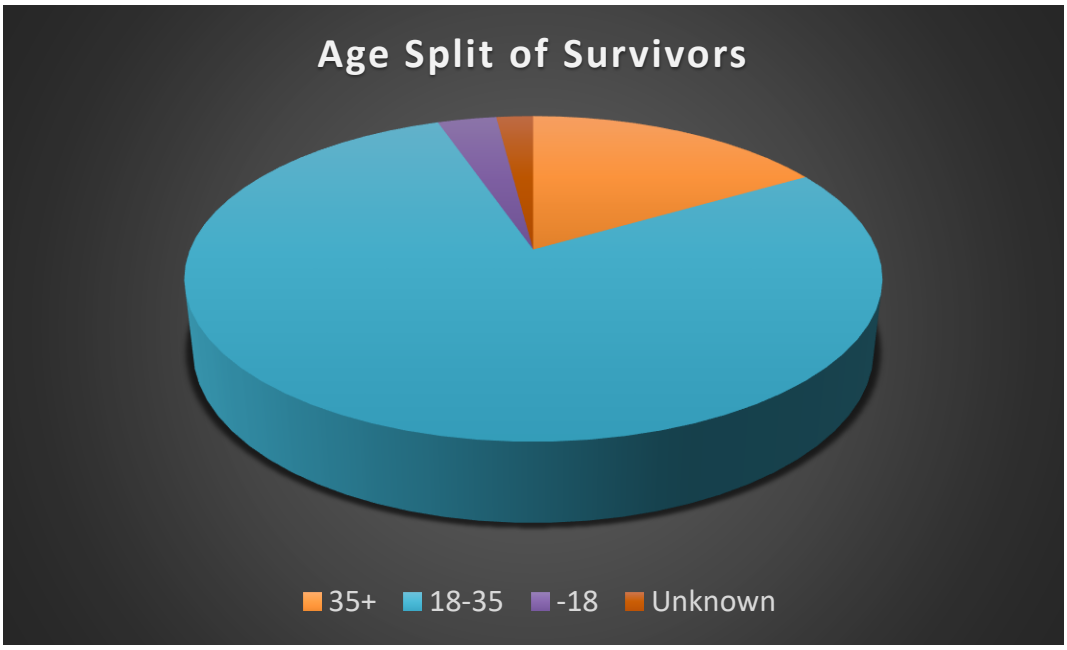
The data reveals that this year 174 survivors have been supported through the TRS and more via the wider Trauma Network. In the expertise developed through this, there is transferrable learning that can be applied for other survivors of different types of abuse in multidisciplinary support networks.

Graph 6.1.1



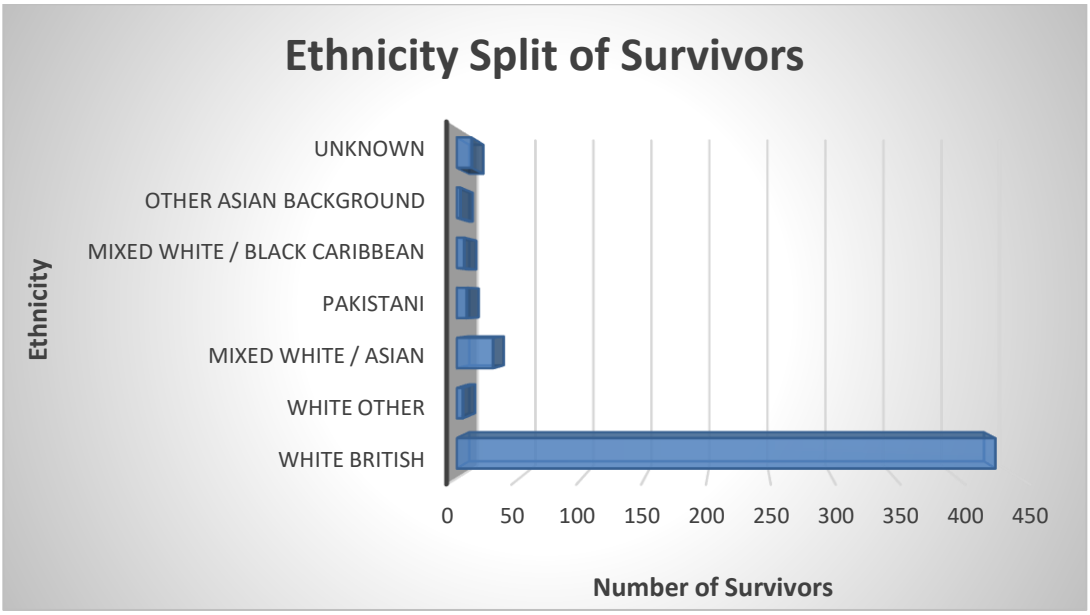
Total Number of Case Consultations:	604 Trauma Informed Consultation Sessions
Total Number of Survivors:	174 Survivors

Graph 6.1.2



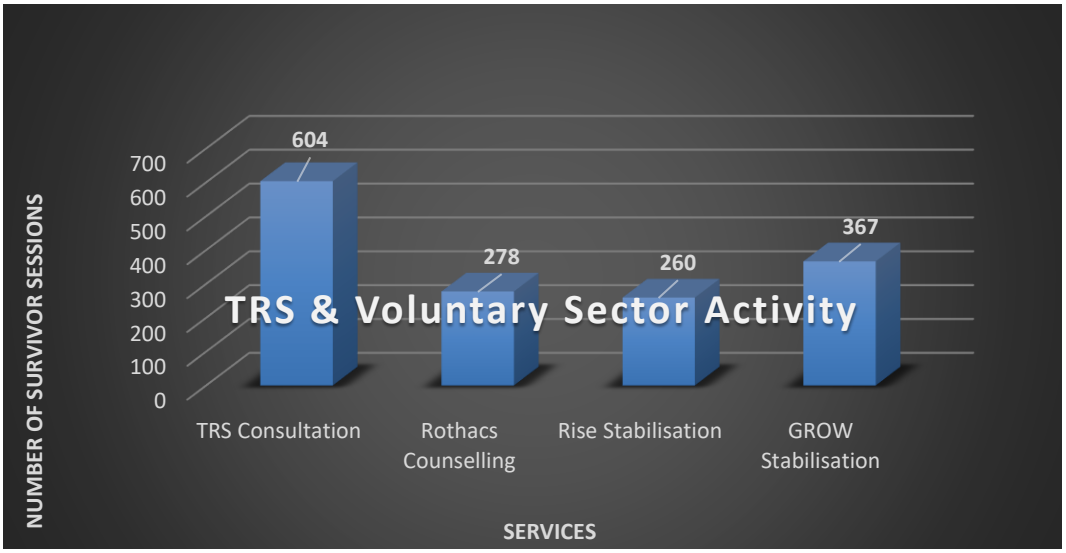
We can see that the majority of survivors are between 18 and 35, and so many of these will now have children of their own. This indicates the importance of the TRS' work with schools and the CAMHS pathway to ensure that these children are supported, especially during their own adolescence which may be particularly tumultuous for their mothers, who were abused during this period in their own lives.

Graph 6.1.3



6.2. TRS & Voluntary Sector Activity 2021/2022

Graph 6.2.1



Total Survivor Activity:	1509 Interventions

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