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Multidimensional Trauma and Systems Change in Rotherham: Summary

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Introduction

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This report describes the impact of trauma-informed systems change in Rotherham, which has been spearheaded and driven over seven years by the Trauma and Resilience Service (TRS) through a unique model. The TRS model began by focusing on Rotherham and is expanding across South Yorkshire and beyond, working to support survivors of CSE (child sexual exploitation) and CSA (child sexual abuse) through supporting professionals who work with them. This is being done through a new Pathfinders Service commissioned by NHS England Health and Justice and includes rolling out the TRS model across South Yorkshire. They offer Trauma Matters training, commissioning in mental health to reduce siloed working across organisations that support people who have been sexually abused and enhance the mental health offer for people experiencing complex trauma.

The TRS provides training, clinical consultation and facilitates multiagency collaborative working through the Hub; a platform for professionals to present survivors' cases and explore options as a professional network with the support of trauma-informed specialists. Previous service evaluations describe the development of the TRS and its impact upon professional capacity and the experiences of some survivors. These developments comprise a systems transformation described as the 'Trauma Informed Network' (TIN).

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

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

Methodology

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This research builds on relationships established with the TRS and their commissioned providers, GROW and Rothacs[1] (Rotherham Abuse and Counselling Services) in the voluntary sector, where services were already familiar with the researcher and her competence, intentions and trustworthiness.

The aim of the research was to build a holistic understanding of a handful of survivors' experiences and journeys, to develop a baseline understanding of the potential impact of trauma-informed systems change, conceptualised as the MTIR; that is, trauma upon individual, community and systemic levels.

To encapsulate both the experiences of survivors and the impact of and processes behind systems change, survivors *and* **trusted professionals identified by survivors** in the voluntary sector were interviewed.

The design of the research was primarily trauma-informed and this involved careful consideration of the principles of trauma-informed care at every stage of the research design; safety, trust, choice and control and empowerment underpinned every decision and aspect. This included ensuring survivors were carefully selected with the support of familiar trauma-fluent workers who could advise on those who would be most able to engage without risking retraumatisation (this meant having successfully undergone trauma stabilisation work and so having a toolkit of proven strategies they could use to self-regulate), and who felt participation could be empowering and beneficial (Fisher et al., 2018).

Survivors' choice and consent was of prime importance, and so approaching and engaging with participants followed a carefully designed process to ensure that survivors were informed of, consented to and guided through the research every step of the way:

1. First, survivors who had been identified were approached by their trusted worker who provided them with a flyer and information about the research, asking if they were interested.
2. If survivors gave consent, I would begin by interviewing the professional in the voluntary sector who was supporting them. These professionals had all benefited from and had been involved in the TRS' training, clinical consultation and multidisciplinary networking, which are key elements in the Trauma Informed Network. Interviews with professionals allowed me to explore experiences that survivors might find triggering to discuss and so provided a welcome opportunity to avoid survivors revisiting trauma by re-telling stories. These interviews also allowed me to ask professionals about any less overt triggers for survivors and to

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[1] Rotherham Abuse Counselling Service - How Can We Help?

use this extra layer of more intimate knowledge to tailor research questions to each individual survivor, again prioritising safety.

3. Survivor interviews were designed according to this insider knowledge and focusing on empowering survivors through exploring their strengths and successes, including their knowledge of self, confidence, achievements and plans for the future.
4. In addition to the voluntary sector trauma fluent professionals who were at the centre of survivors' journeys and positive experiences, survivors were asked about other professionals who had been important on their journey. Two survivors mentioned Independent Sexual Violence Advocates (ISVA), one a police officer (who had initially been willing to be interviewed but after the riots of 2024 went understandably 'off the radar'). Other survivors did not have professionals they could mention in a positive light; this could be due to the simple absence of them or the nature of the Trauma Informed Network, and the 'behind the scenes' nature of a lot of the training, consultation etc. that has benefitted survivors without their knowledge. It could also be because of the challenges survivors face in forming trusting, positive attachments after their experience of abuse and the time and trauma-fluent approach this requires. However, this is something that I hope to explore in future research.

In total, I interviewed six survivors and eight professionals. All 14 interviews were thematically analysed according to the Multidimensional Trauma Framework and the principles trauma-informed care.

2.1. Case Study, Survivor M

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

Survivor M's story is set out as a case study because her experiences involve long-term connections with a network of services and illustrates the importance of trauma-informed collaborative working. It also raises important points about the nuances and challenges of supporting survivors who have experienced lifelong trauma. Survivor M was described by the several professionals I spoke to, as very well supported and able to access that support, as well as being skilled, resourceful and often very strong. However, she has also experienced multiple traumas throughout her life from her earliest years and has experiences of trauma that can be described as multidimensional, including interpersonal experiences, isolation and rejection in the community and experiences of services that have felt punitive to her.

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

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

> *Everyone I spoke to said that she was really capable, but was also really, really isolated. So in terms of family support, Survivor M has next to no family support. She has a Nannan, which is pretty much the only support she has. She's in contact with a mum and dad, but her mum has been neglectful and emotionally abusive since Survivor M was about six.So she's been in and out of lots of services, sort of through childhood, but never officially taken into care. But she was homeless, I believe around 14 and went into different sort of support living accommodations.*
>
> *Because of Survivor M’s childhood, she was sort of lost. She didn't really have much papers, weren't sure which was supposed to be doing, was never really given any guidance on sort of like your day-to-day living. (Professional K)*

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

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

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

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

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

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

> *Luckily I got compassionate ambulance people and it was like the mental health ambulance vehicle which is vital; probably in Rotherham, which I think we need more of… they're trained paramedics within the paramedic service, and there's been mental health training... they came and they took me to hospital. They were really compassionate, making the hospital where of how serious it actually was. And I think the nurses in the hospital was understanding. I think if I got different nurses, I might not have been admitted… I've had experiences in past where like I've had nurses call me attention seeking… I've had ambulance staff call me attention seeking before. And the nurses that have like put me in a hospital, made me sit there for hours. Not even notified the mental health team. (Survivor M)*

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

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

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

> *Because being in the hospital is horrendous, being in a mental health ward full of really ill people is also not a nice place at times, so there's something driving that need for care so strong and then I linked it to a reassurance that they'll always be there. They'll always be there. But then I thought about the word reassurance and I thought, short lived because I think what happens is that for that moment, for that time, for that section, her pain will ease. They will have to be here now. They will have to be here.*
>
> *But it's short lived and then the void comes back , and even when she has these professional encounters, the big void that she's got doesn't get very full. It fills up a little bit, doesn't it? So then it gets emptied again, and then it's, you know, you're feeling empty. (Professional Q)*

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

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

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

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

> *Let's see if you care for me and I can list some of the ways that I can (subconsciously) test to see if you're a trusting, safe person and the only way that she knows whether somebody possibly can be trusted is if they do the thing that she says she needs. And sometimes that's from that's coming from a different perspective to that professional of what she needs, like that crisis call, where the crisis call professional thinks the thing that she needs to do is to remind herself that she can take care of herself. She can undo the ligature. She can take autonomy and power. You know, they might have been coming from a place of thinking that's going to get her back into her sense of, you can do these things for yourself. You can make a choice to look after yourself . But Survivor M is then saying I can't make any choices. I need the ambulance. I need the crisis team to come in and do this for me. I'm relinquishing my own control and my own power, and I'm giving it to you. And then she's met with a message of the crisis team or whomever, saying we're not going to take that power and control off of you. We're going to try and empower you, but that must feel incredibly, abandoning and rejecting at that time. (Professional O)*

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

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

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

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

> *So a lot of the work I'm doing at the moment is around how we make the interventions matter because we are only involved for such a short period of time, so how can we make those interactions better? So we'd asked her ISVA through the MDT, the professionals meeting, to maybe think about that with Survivor M and give some suggestions which are helpful to the staff, so getting that prior knowledge is really helpful because quite often people are told to ring us with no expectation and obviously we've got to understand who that person is, understand what they're going through.*
>
> *Ask lots of questions which might not be helpful to that individual, but if we don't know them, that's what we've got to do. We've got to determine mental state and risk, whilst establishing rapport, enable someone to feel comfortable, so any preparatory work where we can understand that individual and make that interaction better is gonna be really useful. (Professional M)*

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

Unlike survivors who are harder to engage with and reach, who may be excluded from support, or survivors who have only been able to build trust with one service and professional, Survivor M is very engaged in the system. However, this presents its own problems in terms of how she is able to manage endings and the extent to which she can pursue independence, which must be a daunting prospect as it would mean losing the 'robust' network around her and many of the regular social communications and sources of validation, support and care that have punctuated her life over many years. Furthermore, Survivor M has not experienced the early developmental care and positive relationships with a caregiver that form our earliest attachment styles and our understanding of our place in the world and our value to others. Because of this, relationships with professionals, not peers, have become her world and the challenges of forming relationships that are reciprocal are something that her professional network felt may be a significant barrier to her independence.

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

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

> *Obviously from a historical perspective, something very similar happened last time (Professional M)*

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

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

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

> *Let's see if you care for me and I can list some of the ways that I can test to see if you're a trusting, safe person and the only way that she knows whether somebody possibly can be trusted is if they do the thing that she says she needs. And sometimes that's from that's coming from a different perspective to that professional of what she needs. The crisis team thinks the thing that she needs to do is to remind herself that she can take care of herself. She can undo the ligature. She can take autonomy and power.*
>
> *They might have been coming from a place of thinking that's going to get her back into her sense of, you can do these things for yourself. You can make a choice to look after yourself and she's saying I can't make any choices. I need the ambulance. I need the crisis team to come in and do this for me. I'm relinquishing my own control and my own power, and I'm giving it to you. And then she's met with a message of the crisis team or whomever, saying we're not going to take that power and control off of you. We're going to try and empower you, but that must feel incredibly, abandoning and rejecting at that time. (Professional O)*

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

> *She's worked with lots of different services, so she's worked with therapists, she has done trauma stabilisation, she's worked with other sort of local community groups, with a residential and day care centre for vulnerable adults that do some quite intensive support. And she's had a lot of support off them through the years.*

> *But she kind of falls in and out of services mainly because she feels as though they're not providing her with what she needs, and then she kind of pulls back the service, takes that as though she's disengaged. They will close her, and then she feels that she's ready to re-engage and it becomes a never ending cycle for her. Professional K).*

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

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

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

> *My best friend for 25 years, lives out here… so I've got somebody, just, hopefully the Council can see trauma as much as other people. the hospital and my ISVA has done me a letter in support. 'Cause a lot of councils want local connection, which I think's a bit wrong again, I think needs to change. Because some people don't speak to their families.*

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

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

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

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

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

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

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

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

> *It’s so painful for somebody like Survivor M, who has not only gone through and survived all of the things that she's survived. She's left with this often conflicting message as an adult about who's responsible now, for things getting better and I feel like she moves between those positions of, well, other people have to do this*

> *to do more, other people have to do better and in a different way. And I'll reach out to housing, can improve or crisis team can treat me better or this person can just do something that will see the what's happened to me as a child. And no, I can't fix this.*
>
> *And then the other part of her that when she does feel gently, carefully supported to see herself now in that kind of adult role that goes OK whatever's happened to me is absolutely not my fault. But now the things that I choose for myself are about how can I build up that self to self, that sense of worth, that sense of value.*
>
> *And that when something feels really distressing for her, her core Survival Instinct is to hand over that to somebody else because you will feel emotionally very young inside. (Professional O)*

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

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

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

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

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

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

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

Findings

3

3.1. Context and limitations

This was a small-scale research project that makes an important and unique contribution to knowledge on the impact of trauma-informed systems change upon levels of trauma and resilience at individual, community and systemic levels in and around Rotherham.

It is a small-scale project and was restricted in scope and length so took place over one year, speaking to 6/7 survivors who were contacted through established relationships with trusted, trauma-fluent professionals in the voluntary sector, who have been trained and supported by the TRS. Due to this, there are several caveats to bear in mind when reading this report:

1. My relationship with services in Rotherham and the Trauma Network has been established over seven years. Systems, professionals and organisations in the borough experienced organisational trauma that reflects the trauma experienced by survivors themselves, and so there were many protective barriers to overcome to be able to conduct this research. This raises an important point about expectations in research to be able to swiftly engage with services and populations who have experienced trauma and stigmatisation; just as it takes time for survivors to feel safe, through being able to place trust and have that leap validated, and through receiving compassion, and seeing that positive words are followed by positive actions, the same is true when building the relationships that are critical to precede a research relationship.
2. The survivors I was able to speak with are those who are in a stable, supported place and who, through higher levels of human, social and physical capital, may have experienced fewer traumatic experiences and had greater assets, meaning higher levels of resilience and thus capacity to resist the impact of trauma. Because of this, these survivors may be considered ‘high functioning’ compared to those survivors who are perhaps most in need of trauma-informed support from a network of services due to their marginalisation and the extent and complexity of their unmet need and trauma. However, these survivors are harder to ethically and safely engage in research because they are often earlier on in their ‘journey’, more vulnerable and less engaged with available support because of their often entrenched and severe distrust of others, socially and in terms of professionals.

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

3. Because of the limitations of time and capacity, the most effective and efficient approach to engaging survivors and speak with professionals supporting them was through the trauma-fluent voluntary sector, and so the findings of this report are somewhat centred around the impact of the voluntary sector on individual, systemic and community trauma. However, this is not to say that other sectors are not playing important roles and also undergoing system change to better engage, understand and empower survivors. The Trauma Network also includes statutory services including the police, social services, healthcare and mental health services. While survivors in this report describe challenging and upsetting experiences with these services, this is not an indictment of the sectors as a whole, but an illustration of what survivors experienced and felt in their interactions with them at moments in time.
4. This research reveals an important jigsaw piece of the puzzle that is the role that trauma-informed systems change may play in supporting a community to recover from and build resilience against complex and chronic trauma at multiple levels. The next steps are the submission of an ambitious proposal for a longitudinal project over several years to a.) capture the journeys and experiences of harder to reach, more vulnerable survivors, b.) incorporate all levels of systems change, including statutory service, c.) introduce a focus on vicarious trauma among professionals and d.) introduce an economic component which reveals the fiscal benefits as well as the social benefits of trauma informed systems change. In this research, I discovered after my interview with their voluntary sector professional that I had previously interviewed one survivor in 2021. In the three years since that interview, the woman described by their professional bore little resemblance to the person I had spoken to, having blossomed in wellness and confidence and now pursuing her passions professionally and in the community. Unfortunately, for reasons I cannot know, I was unable to arrange an interview with this survivor this time. Because of my time constraints, I did not want to ‘chase up’ contact repeatedly in such a short period of time to avoid the survivor feeling pressurised. The survivor whose case study stands alone also went through periods of fluctuating stability and wellness, and while her desire to add her voice to the research was consistent, her ability to do so waxed and waned as she worked through various struggles. It is the unpredictable and inconsistent nature of trauma and of the human condition itself that a longitudinal project will be better poised to capture, charting the shifts in survivors’ lives and the years needed to engage and build trust with the hardest to reach survivors.

3.2. The profile of survivors in this report and future goals

- Many survivors do not ‘tick the boxes’ for what it is often presumed a survivor will ‘look like’. This research mostly spoke to survivors who are outwardly ‘well’ and are not just coping but ‘functioning’.

  This attests to the insidious and pervasive nature of the experience and impact of trauma; some survivors are better able to ‘mask’ and live outwardly acceptable lives. However, this does not mean the effects of trauma upon them are not significant. These survivors experienced debilitating anxieties and often had difficulties with letting down the protective walls that allow them to appear ‘well’, meaning their relationships with their children, friends, family and partners could be superficial, they were unable to place true trust in these people and so while often in company, were frequently alone. Furthermore, the effort of masking can be debilitating physically and mentally, too, and at some point, this is no longer sustainable, which may betray the suffering and agony that the survivor has been wrestling with for decades beneath the surface.

- Many survivors are in great crisis and are experiencing chronic complex needs (including mental health crises, substance use problems, housing instability and homelessness, anti-social behaviour, criminality and loss of custody of children) and regular involvement of services that can increase trauma (such as social services and police). However, such survivors were not captured in this report for two reasons:
    - As attested to in this research, building relationships with survivors takes time , whether professional, research or personal and survivors who have experienced high levels of trauma and adversity across their life course need greater time to build trusting relationships. This was not possible with this project but is the intended focus of a longitudinal bid that will target more complex, higher risk survivors over five years to explore how the nature of trust and the impact of abuse, how survivors' ability to trust and engage develops and (likely, given the non-linear nature of trauma and trauma recovery) fluctuates.
    - Because of the greater level of need and complexity of this population of survivors, they are less likely to meet the inclusion criteria of this research which was that survivors must be safe and stable and have been supported by the Trauma Network to enable them to be in the best place possible to take part in research.

  This demographic reality of the report speaks to the importance of time and patience, as well as the differing circumstances and timelines that will affect different survivors.

- Time emerged as a hugely significant factor, in several ways and this must underpin trauma-informed support and systems development if it is to be seriously committed to and expected to see results.
    - Even the survivors who did not meet normative assumptions about survivors, e.g. were successfully masking, needed lots of time and a sensitive approach from professionals that had particular characteristics that allowed their input to be positive and helpful. The trauma-fluent voluntary sector professionals supported by the TRS were ideally poised to provide the support needed for these less 'conventional' survivors and indeed all other survivors because their approach and skills facilitated the following in their work with survivors:
        - Allowing survivors to engage and disengage when they were overwhelmed/breached their window of tolerance, and this be understood as a natural part of working with trauma, not a sign of disinterest, incapacity or an unsuccessful intervention.
        - Did not expect 'hard outcomes' within rigid timelines.
        - Understood that trauma damages survivors' ability to trust and thus to connect and engage with peers, family and friends but also professionals. This trust must be established first before any work can begin.
    - However, while externally some survivors may not outwardly/immediately appear in crisis, their internal experiences and the external impact of this was still significant, albeit occurring on a spectrum, for example in terms of transgenerational trauma and survivors' relationships with their family. For other survivors who are only partly captured in this report, their traumas and symptoms are more chronic and complex. This small sample group exemplified a spectrum of survivors, those who are successful at masking

(but nonetheless their traumas may be having less obvious effects, such as intergenerationally, where their loved ones and children are aware of an unspoken silence or an unknowable distance), and those who are unable to mask and whose symptoms are very visible.

- For survivors who may have experienced repeated traumas throughout their life course or have had less by way of protective factors and resilience so had co-current complex needs such as problematic substance use and homelessness, their relational experiences are especially tarnished and so work should be expected and understood to take a long time.
- Bringing services into a trauma-informed network also takes time, and the professionals we spoke to have been involved with the TRS model for years, so have undergone a journey themselves involving an expansion of their way of thinking and working that has naturally also involved overcoming their own challenges.

3.3. The impact of the Trauma Informed Network: The creation of a Multidimensional Trauma-Informed Rotherham

The bullet points below summarise the ways in which the Trauma-Informed Network is affecting understanding of trauma, symptoms of trauma and its legacy in systemic impact (how services and professionals can contribute to or alleviate trauma), individual symptoms and experiences and the community (including intergenerational transmission of trauma and survivors' capacity to engage in the community).The sum of this is the Multidimensional Trauma-Informed Rotherham, a burgeoning reality that has the potential to transform the reputation, reality and future of the borough.

These are organised according to the different iterations of trauma; individual, community and systemic, but these forms of trauma do also overlap and intersect.

The findings were also analysed thematically, according to the core principles of trauma-informed practice – Safety, Trust, Choice and Control and Empowerment. This approach has provided a golden thread throughout my research exploring trauma, which continues to embody and reflect not just the work being done by professionals but survivors' own needs, challenges and successes.

Each principle of trauma informed practice is discussed, shedding light on particular aspects of trauma, but it is important to remember that just as forms of trauma overlap and intersect, so do the benefits of the different principles of trauma informed practice. This is exemplified below by a quote from a professional, who encapsulates the complex and far-reaching impact trauma has on the worlds of survivors but also on the far-reaching impact that work done to alleviate these symptoms can have:

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

The above quote brings to life how trauma can tarnish survivors' ability to trust, with people they are already close to, strangers in the community (including potential new friends, employers, or anyone they might encounter informally and socially) and professionals who they might voluntarily or involuntarily need to engage with. Rebuilding of trust is complex, and entails safety primarily, so survivors are able to let down their guard without feeling under threat. To have choice and control in how and when they do this is also crucial to the maintenance of safety and the building of trust, and the empowerment that comes as a result arises from relationships successfully built, hurdles overcome and debilitating fears and beliefs being deconstructed *through the maintenance of safety, trust and empowerment*. So, behind each interaction or story described in this report, a complex multitude of transformations, shifts and connections have occurred. These have had similarly complex and broad-reaching effects on survivors, the wider community (including children, for the intergenerational transmission of trauma impacts the futures of places and people more broadly, as well as family units and the individuals) and the systems and people within them that are working to safeguard and promote the wellbeing of communities and individuals.

3.4. The Trauma Informed Network's impact on individuals, communities and systems – The creation of a Multidimensional Trauma-Informed Rotherham (MTIR)

Systemic

- The trusted professionals were all able to work with survivors flexibly, creatively and responding to survivors' own timelines. This includes recognising that trauma recovery and journeys through trauma are not linear , that survivors may complete or disengage from interventions and come back at a later date or access support repeatedly .Understanding that periods of disengagement or repetition us not 'a failure' but an essential and natural part of living with and travelling through trauma, the Trauma Informed Network is able to provide services that are responsive to the realities of the fluctuations of living with trauma, and to meet survivors' own timelines and priorities.
- Creativity and flexibility in the voluntary sector has been crucial in services being able to support survivors in a truly trauma-informed way, exploring and developing bespoke interventions that are based upon survivors as individuals. Survivors and professionals spoke of a wide range of stabilising techniques that survivors used to offset trauma symptoms such as experiencing triggers, nearing breach of their window of tolerance (and thus nearing trigger point) or countering emotional dysregulation. Techniques mentioned included multiple breathing techniques, cognitive strategies such as counting and 'noticing', using objects to ground and meditation. In addition to this, professionals were able to develop strategies outside of the more traditional toolkit, demonstrating the creative, iterative nature of the development of the Trauma Informed Network. Through trauma education and stabilisation techniques, professionals give survivors a language with which to understand, access and process intolerable experiences through words and concepts, empowering them through knowledge.

  When clients spend more of their time in that low mood, the freeze, it's harder because you have to connect in order to use the tools. So with that, it would be more about self-soothing. It would be more about self-care, it would be more about working with her self-esteem and her self-acceptance because they're grounding tools as well, thought not the traditional ones. But you know we need to feel safe within ourselves. (Voluntary Sector Professional, Survivor G)

- Many survivors described experiences in statutory services in particular where they had felt judged, unheard, dismissed and treated as a series of problematic symptoms rather than seen as a whole person. When services first encountered survivors, they were often struggling with extremely low self-esteem, debilitating shame and guilt, extreme difficulties trusting others and a lack of hope for their futures. Their experiences and the clinical impact of their trauma meant that many survivors were wary of trusting professionals but also that they were hypervigilant for suggestions that they were not being heard or valued. As a result, survivors may interpret insult, neglect or disinterest in interactions with professionals where it is not meant. Undeniably, survivors have also had experiences with professionals in the past that have been conducted inappropriately and insufficiently, lacking compassion and the capacity to elicit disclosure responsibly.

Intentional or not, where survivors experience interactions with services in this way, we run the very real risk of reinforcing survivors' trauma symptoms and hindering their progress, rather than helping. Services/sectors most frequently mentioned when survivors recalled traumatising and unhelpful encounters included GPs, police and the criminal justice system, social workers and mental health crisis teams. The report highlighted two kinds of systemic change needed – firstly, the more overt need for a trauma-informed shift at every level throughout all services to avoid stigmatising, harmful responses to trauma survivors, indicating an urgent need for systemic change. There is also the matter of the complexities of how systems and survivors interact and how within the system, services can struggle with the alternating needs for survivors to develop and realise their independence and capacity while also safeguarding their often vulnerable and hypervigilant inner child. This is especially highlighted in the case study of Survivor M, and the case consultation approach I incorporated in this section of her research really helped uncover and explore these complexities. Not only was this a valuable research approach but it also demonstrated the great value of the TRS' offer to the Trauma Informed Network of clinical consultation and supervision.

This findings regarding systemic trauma speak to the importance of continuing systemic transformation beyond Rotherham and beyond the voluntary sector, including both the overt trauma education and the more nuanced perspective and collaboration that can be attained through the inclusion of clinical insight throughout survivors' journeys. This is an endeavour that will require significant investment of time, resources and people, but which, as this report touches upon, will eventually reap enormous benefits for individuals, communities and the systems that serve and support them.

- TIN professionals stood in real contrast to the more negative experiences described by survivors. The trusted professionals were spoken of very highly and warmly by survivors, for allowing them the time and space to seek support *on their terms* – including timelines, frequency and intensity of engagement, and *what support looked like*. Several survivors really valued being able to have a safe space and relationship where they could offload about anything they needed to, unfettered by claustrophobic session formats. Reflecting this, professionals also recognised the importance of building a trusting relationship with survivors that did not force or pressurise them to focus only on trauma work. Indeed, they recognised that allowing relationships to develop and letting survivors have rare time to speak safely and honestly about their day to day lives and feelings **was trauma-informed work in itself** and an important part of instilling trust and safety.

Individual

- The Trauma Informed Network directly and indirectly impacts survivors' wellbeing in a holistic manner – namely physically, psychologically and emotionally.
- Several survivors had physical health problems including chronic pain, chronic fatigue and stomach problems that were instigated or exacerbated by their traumatic experiences and which were worsened when they were triggered by reminders of the experiences (this could be sensory, e.g. a sight, sound or smell that reminded them of the incident/s or an event, such as a similar incident happening to a loved one). Survivors' physical symptoms did improve as they progressed in their work with professionals, gaining insight and clarity on the impact of trauma, the normality and validity of their physical symptoms and in

some cases, feeling supported and empowered to self-advocate with other professionals to access healthcare.

- Trauma support had an undisputable impact on survivors' mental health; many described harmful and debilitating symptoms including agoraphobia, going into 'shutdown', self-isolation, rage, self-harm and suicidality as common features of their everyday life, prior to receiving support. While different survivors naturally had made different degrees of progress (because the complexity of their unmet need and the extent of their existing resilience and resources vary), all were in a much safer and more positive place and were able to use trauma stabilisation techniques to ground themselves and avoid the worst of their symptoms.

Community

- Some professionals were providing education around the impact of trauma to survivors' families; this was helping break intergenerational cycles of transmission of trauma by helping survivors be open, loving, vulnerable and genuine in their relationships, including placing trust in and expressing love to their loved ones.
- Trauma-informed support for families is also capable of transforming home environments and, by proxy, communities; previously home had often been a place of emotional dysregulation, where everyone felt unsafe, uncontained and in conflict. As a result of trauma-informed support provided to the entire family, this changed to a place of compassion, recognition and stability and safety.
- Through the support of the Trauma Informed Network of professionals, survivors' ability to engage with their communities often transformed. Many survivors had been unable to leave the house or had to exhaustively pre-plan 'every day' events such as going to the shops or meeting friends or lacked the confidence to engage in employment and education. However, through building trust, safety and techniques to manage their trauma symptoms and understand themselves compassionately, and to be proud of their accomplishments, survivors were now engaging in the community, facing fears and pursuing goals, for example several had started new careers where they would be providing a vital service to their community. Others were better able to be present in their jobs but also in their social experiences, and so were able to support others and improve collective wellbeing. Survivors are important, valued and powerful members of communities and the Trauma Informed Network is not just supporting them as individuals but through this, empowering communities by working with survivors to realise their potential. By reducing the taboo around surviving CSE and increasing survivors' positive experiences in their communities and realising the compassion that others feel towards survivors, social justice can be achieved through the dismantling of survivors' protective preconceptions about the safety and trustworthiness of their communities.

3.5. Future recommendations

- Child sexual exploitation and group grooming is a very topical issue, having been subject to media and public attention and runs the risk of being hijacked by far-right figureheads keen to pose as saviours, potentially exploiting and traumatising survivors again. Local inquiries have just been announced, but it is questionable whether these have the statutory powers and whether sectors have the capacity to bring about any change resulting from the findings. It is therefore crucial that existing recommendations including those of the Independent Inquiry into Child Sexual Abuse (Jay et al, 2022) are followed, and that other recommendations that are developed in consultation with survivors are also heeded. It is important that the focus of any efforts are on achievable and real change to support existing survivors.

- For survivors who are in greatest need and at their most vulnerable, they may be unable to engage with any pathway yet; these survivors may often present to the mental health crisis team, homelessness services, in drug treatment and are in regular contact with the police. They may be described or felt as ‘too chaotic’ to engage with or indeed cannot be found or seen by services which rely on beneficiaries being sent to or coming to their doors. For these survivors, there is pressing need for an increase in funding to support services to invest in outreach, finding those in the greatest need and meeting them where they are, both in terms of place but also ability to even consider the first steps of a trauma recovery pathway.
- Several sectors in particular would benefit strongly from Trauma Matters training and accessing the TRS offer throughout their work and throughout organisations from top to bottom. These include primary health care, social services, the criminal justice system and all emergency services including first responders.
- There is an inherent disconnect between the law and working culture in the criminal justice system and trauma-informed ways of working that presents a very real barrier to survivors of sexual violence, especially historical child sexual exploitation, receiving justice. A review of the criminal justice system and law with regards to CSE/A and historical abuse could consider how to reconcile this disconnect.
- The country has borne over a decade of austerity and this has had a significant effect on public services and the demand they are facing. There is no avoiding the fact that investment of resources, time and the ability for successful organisations (such as those involved in the Trauma Network) to operate flexibly and creatively is critical if the level of need in society is to be met. The benefits of this investment long-term appear to be significant, if these preliminary findings from the Fellowship are borne out – for individuals, their families, communities and the efficiency and effectiveness of organisations and systems.

4

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Multidimensional Trauma and Systems Change in Rotherham: Summary

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