IMPLEMENTING A TRAUMA-INFORMED APPROACH TO VAWG: A GUIDE FOR STATUTORY SERVICES

BY DR. JESSICA TAYLOR

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Content warning:

Whilst seeking multi-agency feedback about this document prior to publication, some professionals discussed their own personal responses to a document which focussed on trauma, mental health, and a shifting paradigm. For some, it was personally triggering due to their own connections with the topics, or their own personal experiences of pathologisation, psychiatry and trauma. For others, it felt professionally challenging, and made them feel uncomfortable about their practice or training.

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Foreward by Dr Jessica Taylor

At VictimFocus, my team and I have been impressed by the number of services, authorities and leaders who are seeking change and improvement in their responses to VAWG. It has of course, been a long time coming, and I know I speak for many when I say that we should not have failed so many women and girls in order bring us to this point, where people are now ready for reflection, change and systemic overhaul.

I have dedicated the last 12 years to attempting to create discussion, debate, and critical thinking about victim blaming, misogyny, women's rights, and pathologisation.

I have been privileged to work with police forces, local authorities, charities, companies, and individual professionals who have come to the same conclusions as I have: that our response to women and girls who are subjected to violence and abuse often includes systemic victim blaming, and then the systemic pathologisation of their trauma responses and coping mechanisms. We expect women and girls to be the 'perfect victim', and when they do not reach such impossible standards, they are unlikely to be taken seriously, and they are unlikely to get justice for the crimes committed against them.

Instead, they are likely to have their trauma overlooked or stigmatised. Women and girls in the UK are 7-20 times more likely to be diagnosed with personality disorders when they have been subjected to violence and abuse, for example. Where their traumas should be being supported as normal, expected, valid, natural, and justified – they are being told they have mental disorders, illnesses, issues, and require professional treatment. Their testimonies and accounts are called into question, and they do not have confidence in our services.

A trauma-informed approach to all UK VAWG services would transform this experience, and hopefully, eradicate it.

This document has been created to begin conversations. It is not an instruction manual, and it is not exhaustive. What I hope it will become, is a springboard for senior leaders of a range of services to work together to consider if, how and when they can become trauma-informed, anti-misogyny, anti-victim-blaming and anti-oppressive in all they do. It has been built to include questions, reflections, case studies, examples, checklists, and ideas for senior leaders to consider on their path to creating and sustaining trauma-informed services for women and girls subjected to violence and abuse.

Dr. Jessica Taylor
CEO VictimFocus
Chartered Psychologist

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Thank you for taking the time to read this guide for leaders of statutory services, who are working towards implementing trauma-informed approaches to ending violence against women and girls.

This guide has been created to offer information, principles, and examples of what good trauma-informed practice and policy could look like, if it was successfully applied to our services and projects working with women and girls subjected to violence and abuse.

In December 2021, DCC Maggie Blyth released 'Policing violence against women and girls: National framework for delivery', which, amongst other policing strategies, included her vision for trauma-informed responses and approaches to addressing the abuse and violence that women and girls are subjected to frequently in the UK.

This is a historical and pioneering decision, which has started national strategic conversations about how to move towards trauma-informed practice, theory, policy, procedure, and environments when supporting women and girls.

Whilst trauma-informed approaches have been talked and written about for many years, these approaches have become more mainstream in the last few years. Unfortunately, as they become more mainstream, they are in danger of being misused and misunderstood if not carefully explained, and then implemented. 'Trauma-informed' has recently become something of a buzzword in public services and academia, without much underpinning knowledge of its theoretical and practical origins and implications.

This guide will provide a detailed understanding of trauma-informed approaches to VAWG, to support with service design, delivery, scrutiny, commissioning, and communications.

Who can use this guide?

Anyone can use this guide, but it is aimed at service leaders, directors, commissioners, and decision makers in the following UK services:

- **Police forces**
- **Police and Crime Commissioners**
- **Crown Prosecution Service**
- **Children's social care and safeguarding services (CSA, CSE, CCE, MASH, MARAC, SG)**
- **Adult's social care and safeguarding services (DA, SV, MASH, MARAC, SG)**
- **Health services and partner agencies**
- **Charities and voluntary services working with women and girls (and families)**
- **Local authority and CCG commissioners**
- **Funding decision makers/commissioners**

Definition of a trauma-informed approach

An approach to understanding mental distress and mental health which considers that a change in behaviour, thought, or emotion arises from past or current trauma. Within this context, trauma can be variable and dynamic. Whilst trauma was historically considered to be a one-off, life-threatening event, it is now accepted to encompass any event or set of events that cause deep distress, disturbance, oppression, fear, harm, or injury.

How is this approach different to current approaches to mental health and human distress?

A trauma-informed approach is opposed to the labelling, medication, pathologisation and problematising of humans. Instead of seeking what is 'wrong' with the individual (whether that is called a 'mental health issue' or a 'disorder'), the trauma-informed approach supports the individual from the perspective that their responses to distress are normal, natural, justified, understandable, and valid. Therefore, a trauma-informed approach does not engage in systems or narratives which seek to position the individual as having an internal issue that needs to be diagnosed, treated, managed, or solved with therapy, medication, or social isolation.

What are the different theoretical approaches to mental health and human distress?

You may be wondering why this guide begins with information about theoretical frameworks of mental health and distress, and if you are, this may mean that you require more information about trauma-informed approaches. The term has been heavily used recently, and is in danger of becoming a meaningless, toothless buzzword. The reason we must ensure all leaders have a solid understanding of what it means to be 'trauma-informed' is precisely because it is a framework of mental health.

When we talk about being 'trauma-informed', we are talking about a theoretical and philosophical approach to understanding mental health, disorder, illness, distress, oppression, and abuse. It is one of several theoretical approaches. It is quickly becoming more popular but is not the most dominant approach to understanding human distress. The most common approach is the widely used 'medical model', which is dominant in all sectors in the UK (and wider western cultures/societies). Our NHS, policing, social work, safeguarding, probation, prison services, psychology and psychotherapy services, nurseries, schools, colleges, universities, charities, court services, law and legislation are all based on the medical model of mental health.

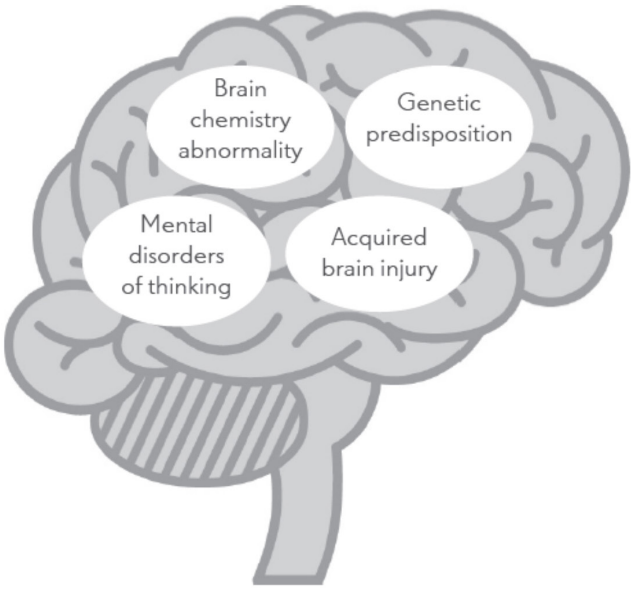
To move towards a trauma-informed approach is to move towards revolutionary paradigm change. Whilst this may feel particularly huge and/or insurmountable, there are already many trauma-informed NHS funded pilots, police forces, education providers, social work projects, charities, and private services that have successfully implemented change. Change is possible. There are four main approaches to understand:

1. Medical model

The 'medical model' is shorthand for a theory of mental health which suggests that mental illnesses, diseases, and disorders should be identified, treated, and managed in the same way as physical injuries, illnesses, diseases, and disorders. This model describes and responds to mental illness as 'a set of mental disorders caused by or linked to brain diseases which require pharmacological treatments to target presumed biological abnormalities' (Deacon, 2013). The medical model tends to assume that mental health issues are caused by biological and neurological issues in the brain.

Some people lean towards 'brain chemistry' explanations and some talk about 'neuroscience' explanations. Some talk about 'hereditary mental illness' and 'genetics'. This approach places the mental health issues and illnesses securely and exclusively in our brains. It posits that mental illness is 'just like physical illness' and should be treated as such. It is more heavily used in psychiatry but is now prominent in psychology and some areas of psychotherapy too.

Biological model of mental illness (medical model)



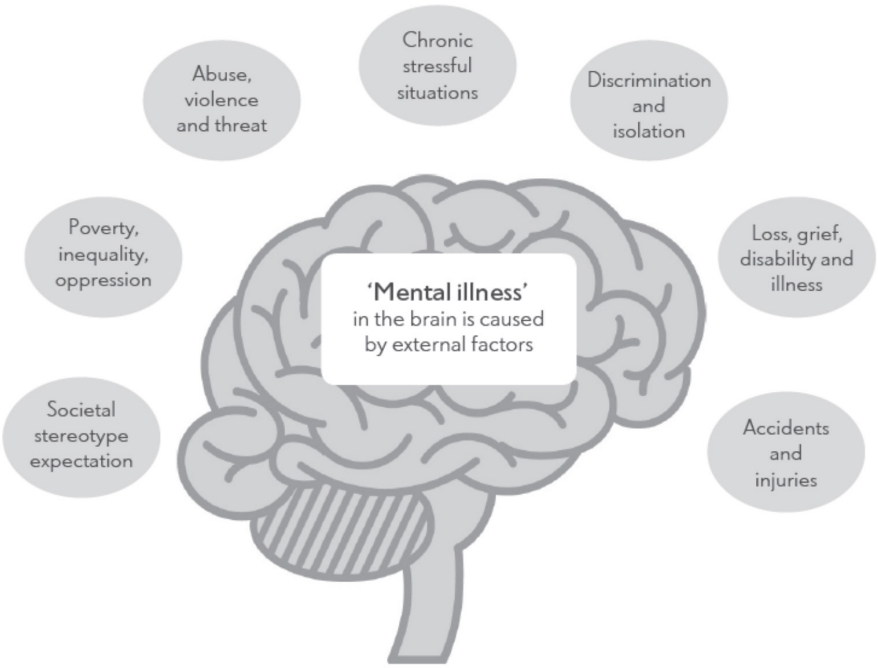
Taylor (2022)

2. Social model

The 'social model' is shorthand for a theory of mental health which suggests that humans are impacted by their context, environment, and experiences. Instead of suggesting that behaviours, feelings, and thoughts are mental illnesses or disorders, the social model encourages us to look at the factors surrounding the person to consider what might be causing their distress. The social model usually does not support psychiatric diagnosis but can sometimes be used to argue that social factors are 'causing' mental illnesses.

The social model of mental health locates the cause or root of a so-called mental health issue within the social environment or context of the person, instead of inside the person themselves. The social model opposes all biological models. Rather than suggesting that mental health or illness is in the brain or body of the person, those who subscribe to this model examine the factors around the person. Every and any contextual, social, cultural, or environmental factor could be the cause of distress or mental health issues, including accommodation, poverty, oppression, abuse, discrimination, peer and family issues. Whilst this model doesn't support biological models of mental health, it is often used this way. It is not commonly used in psychiatry. It is more common in psychology, social work, and psychotherapy.

Social model of mental illness



Taylor (2022)

3. Biopsychosocial model

The biopsychosocial model is an interdisciplinary approach to understanding mental health by looking at the way biological factors in the medical model, socio-environmental factors in the social model and other psychological factors intersect.

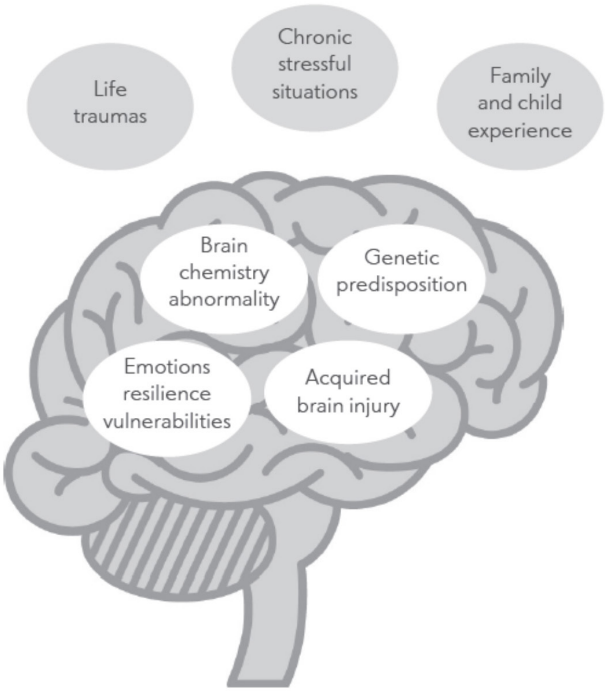
The biopsychosocial model of mental health was developed in part to address some of the gaps of a purely biological, biomedical model of mental health.

In 1977, George Engel argued that the biomedical model ignored many other factors that could be contributing to mental illness. There are three domains to explain mental illness:

- Biological factors (genetics, brain chemistry, disease, brain injury)
- Psychological factors (emotions, resilience, interpretation, vulnerabilities)
- Social factors (life trauma and stressors, family and child experiences)

The original arguments were that mental illnesses were made up of complex interplay between these three domains, with many connections between and within them, however, as time has gone on, this model has become gradually more medical and biological, with the other intersecting factors being minimised.

The biopsychosocial model of mental illness



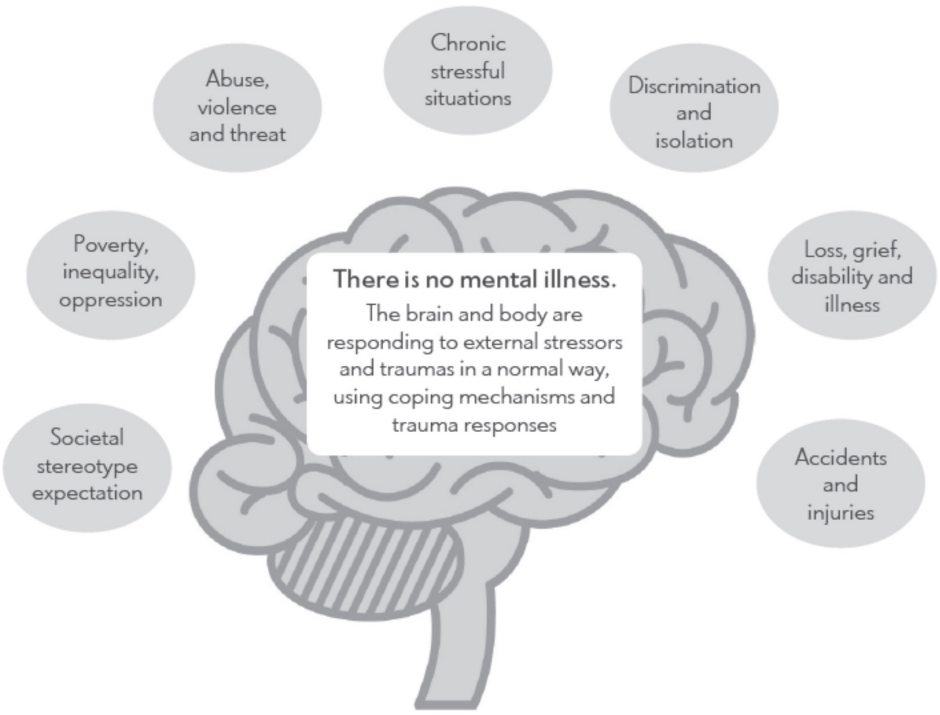
Taylor (2022)

4. Trauma-informed model

An approach to understanding mental distress and mental health which considers that a change in behaviour, thought or emotion arises from past or current trauma. Within this context, trauma can be variable and dynamic. Whilst trauma used to be considered to be a one-off, life-threatening event, it is now accepted to encompass any event or set of events that cause deep distress, disturbance, fear, harm or injury.

The trauma-informed approach to mental health, illness and distress argues that there are undeniable and consistent strong correlations between all so-called 'mental health issues' and human trauma, distress and oppression. Therefore, it is argued that 'disorders', 'illnesses' and 'diseases' are likely to be natural physical and psychological manifestations of human trauma and distress, in response to events and experiences in our lives – not brain abnormalities or mental illnesses.

Trauma informed approach to mental health



Taylor (2022)

Deficit-based approaches

An approach to social issues, mental health, abuse, and oppression which uses the negative events, experiences and so-called 'deficits' in a person's life to predict their risk level, future or present behaviours, thoughts or circumstances. A trauma-informed approach would strongly oppose deficit-based approaches, and would not use the negative events in someone's life to judge, assess or predict their future.

Strength-based approaches

The opposite to deficit-based approaches, the strength-based way of working in social issues, mental health, abuse and oppression focuses on the strengths, skills, talents and wisdom of the person instead of defining them by their 'deficits'. There is a current push towards strength-based approaches in many fi elds including social care, policing and mental health practice.

Patriarchy

Systems (both private and public) that are controlled and led by men, including social control, politics, authority, norms, narratives and privilege. Up to the present day, the world has always been a patriarchy, and so too, are most institutions including religion, education, law, politics, entertainment, media, finance and so on.

Misogyny

The systemic hatred, contempt, and oppression of females. Misogyny has been demonstrated to be a global issue and has been for millennia.

Pathologisation

To characterise a behaviour, thought or feeling as medically or psychologically abnormal. This includes the practice of seeing those behaviours or thoughts as medical symptoms as an indicator of a disease or disorder of the mind.

VAWG or EMVAWG

VAWG often stands for 'violence against women and girls', where the more specific term used by some activists, professionals and academics is EMVAWG which stands for 'ending male violence against women and girls'.

The purpose of the second acronym is to deliberately name the leading cause of all forms of violence against women and girls: male offenders, and a male-centric patriarchal society.

Why does VAWG require a trauma-informed approach to service design and delivery?

We must improve our responses to, and support of, women and girls who are traumatised by violent crimes they have been subjected to by others.

Currently and historically, women and girls have been pathologised and blamed for being subjected to all forms of male violence against women and girls. Many of our public campaigns have focussed on encouraging women and girls to reflect upon and change their own lives, behaviours, or thinking, to protect themselves from violent crime.

Women and girls have been found not to trust statutory services, and are unlikely to disclose to professionals that they have been subjected to violence and abuse (Brown, 2021). Reporting rates to police have been decreasing year on year, and national confidence in police responses to VAWG have been falling (CSEW, 2021). Academic research between 2000 and 2022 has found that women and girls are treated poorly when they do report/disclose (Taylor, 2020).

Those women and girls who do report, often find themselves in a confusing system which has been shown to further traumatise them. Studies have long shown than women blame themselves more after engaging with statutory services, and regret reporting their experiences (Taylor, 2020).

Some studies have even shown that engaging in statutory services after crimes such as sexual violence is perceived to be more traumatic than the sexual violence itself (Beckett & Warrington, 2015). Teenage girls who dropped out of the prosecution process after being subjected to CSE, had better wellbeing and outcomes, and were less traumatised than the girls who continued through the prosecution process (Beckett & Warrington, 2015).

Alongside these systemic issues, and despite the near-universal experience of being subjected to misogyny, sexism, and violence; women and girls are much more likely to be diagnosed with psychiatric disorders and mental health issues than men and boys. Being female positively correlates with every single psychiatric disorder listed in the DSM5, and women and girls are 7 times more likely to be diagnosed with borderline personality disorder than men and boys with the same 'symptoms' (The Lancet, 2016; WHO, 2021).

When women and girls are sectioned under the Mental Health Act (1983), and staying in secure NHS mental health services, they are 6 times more likely to be chemically sedated using forced injections of powerful sedatives than men and boys (Taylor, 2022). Despite this, a large proportion of the women and girls receiving mental health support such as this are known to have been subjected to male violence including rape, domestic abuse, trafficking, and child abuse (Bailey & Taylor, 2022).

Finally, professionals working in all service settings where they are responding to VAWG must be supported and understood to be traumatised, themselves. This is covered in more detail on page 38.

Ten principles of trauma-informed VAWG services

Creating a trauma-informed VAWG service or strategy requires a set of principles that underpin everything from design to policy. For some, this would mean significant change, and for others, it would require little change from current operation/strategy.

Below is a list of ideal principles of trauma-informed VAWG services.

In a trauma-informed VAWG service:

- ☐ 1. Women and girls are supported and understood as traumatised, distressed human beings who have been subjected to violence, abuse, oppression, and harm. Their trauma responses and coping mechanisms are understood to be normal, natural, logical, valid, and expected.
- ☐ 2. Women and girls are not positioned or diagnosed as mentally ill or disordered when they have been subjected to violence, abuse, oppression, and harm. When trauma is present, no diagnostic process should begin.
- ☐ 3. Women and girls are supported and understood to be living in a society which is inherently misogynistic and patriarchal, where it is near-universal experience to be sexually harassed, assaulted, abused, raped, bullied, belittled, or insulted based on their sex at some point in their lifespan.
- ☐ 4. Women and girls are not encouraged or forced to accept psychiatric disorders and psychiatric medication when they seek help as a victim of violence, abuse, and crime.
- ☐ 5. Women and girls are supported in a strengths-based approach to their lives, choices, experiences and needs. We do not define or discuss a woman or girl based on her past, or on what other people have done to her. We do not predict her outcomes based on the actions and crimes of others that she was subjected to as a victim of crime
- ☐ 6. Women and girls are not perceived as unreliable witnesses because they have been diagnosed with psychiatric disorders, mental health issues or personality disorders. Women and girls have full access to justice processes no matter what their medical files may say.
- ☐ 7. Women and girls are not positioned as 'vulnerable', 'responsible', 'risk-taking' or otherwise victim-blamed for being subjected to violent crime by others. We do not seek to modify the behaviour of the woman or girl to stop others from committing violence against her
- ☐ 8. Women and girls are not expected to disclose repeatedly, in detail, to all services. They are supported and understood based on the information required only.
- ☐ 9. Women and girls are not referred into services that require them to be diagnosed with a psychiatric disorder to access therapy or support services.
- ☐ 10. Staff and management are supported with their own trauma responses, compassion fatigue, burnout, and distress from working in VAWG

All trauma-informed approaches to VAWG must be anti-victim-blaming. All anti-victim-blaming approaches to VAWG must also be trauma-informed.

The two concepts must be seen and employed as intrinsically linked. Pathologisation is a form of victim blaming, and much victim blaming of women and girls uses their trauma responses and coping mechanisms to stigmatise and blame them.

To achieve an excellent approach to VAWG, services must rigorously avoid victim blaming women and girls, whilst validating their trauma and experiences and committing to protecting them from further retraumatisation in our services and systems.

Victim blaming is defined as the act of attributing to the woman or girl, the cause, blame, fault or responsibility of violence or abuse committed by a third party. Due to the acts being criminal, the responsibility of those acts should always lie with the perpetrator. In most cases of VAWG, the third party is a male, and is often known to the victim.

Victim blaming can be displayed in many different forms. Some can be overt (she deserved to be raped). Some can be more subtle (she needs to take responsibility for the actions that led to this happening to her again). Some types of victim-blaming expect women and girls to change themselves or their lives to protect themselves from offenders (women need to stop listening to headphones whilst on the tube, as it puts them at risk of rape). Victim blaming can also include beliefs that women and girls are responsible for the choices of men and boys who commit violence and abuse (if she didn't want negative male attention, why was she out dressed like that?)

Victim blaming can also take the shape of common rape myth acceptance, and the belief in sexist stereotypes. This includes the concept of a 'real rape' in which a woman is attacked by a stranger at night, dragged into a van or bush, is violently assaulted, has visible injuries, attempted to fight back, goes straight to a police station, has DNA evidence, supports prosecution, was not drinking, is able to provide witnesses or there is CCTV which corroborates the incident, does not have a criminal record, did not send messages or flirt with the perpetrator beforehand and is therefore perceived to be totally 'blameless' (Taylor, 2020).

This kind of offence is not only extremely rare, but is based on victim blaming narratives and rape myths which further the immense pressure on women and girls to be the 'perfect victim'.

Along this line of reasoning, when a woman or girl does disclose abuse or violence, it is common for her mental health to be called into question, or for her to be referred to mental health or psychiatric services, which then position her as mentally ill, or as having a personality disorder. Instead of the trauma from VAWG being validated and acknowledged as natural and expected, it is seen as a weakness or an illness/disorder that can then be used to discredit her account, her eyewitness testimony, her recollection of events or her own behaviour. This is undoubtedly where victim blaming and pathologisation overlap.

Victim blaming language – alternatives to common phrases

Overt victim blaming may be rare (she was asking for it, she deserved it), but more subtle forms of victim blaming are often found in professional conversations and records about women and girls subjected to VAWG.

Below is a table of common phrases and anti-victim blaming alternatives to consider

Common phrase	Anti-victim-blaming alternative
Her risk-taking behaviour led to being sexually assaulted.	The perpetrator led to the sexual assault and is the sole cause of the sexual offence. The behaviour of the victim does not cause or influence the actions of an offender.
She exchanges/sells sex for things she wants and needs.	The perpetrator exploits her for sex, and uses things she wants or needs in order to groom her and exploit her to commit the sexual acts.
Her vulnerabilities put her at risk of abuse.	Vulnerabilities do not cause or lead to abuse. The perpetrator is the sole cause of the abuse, and dependent on the type of offender, the 'vulnerabilities' may or may not be relevant to their choice of victim. It should not be assumed that perpetrators are targeting women and girls due to vulnerabilities, when many offenders do not use this to select victims.
She continually goes back to the perpetrator.	The perpetrator keeps persuading/grooming/controlling/ coercing her to return.
She refuses to leave the abuser.	She is not able to leave the abuser.
She needs to be educated in order to understand the red flags in her relationships.	Education of unhealthy and abusive relationships is not enough to protect a woman or girl from abuse. The perpetrator needs to be stopped and prevented from abusing her. Intervention should not rely upon a victim protecting themselves from a perpetrator with more power than them.
She should have known it was going to happen.	Women and girls should never have to predict or prevent offences committed against them.
She should have told someone sooner/reported this sooner.	Women and girls should never be blamed or judged for not being able to disclose or report sooner.
Her low self-esteem and self-confidence make her vulnerable to domestic abuse.	Low self-esteem and self-confidence do not cause or make women more vulnerable to domestic abuse. Perpetrators are responsible for their offences.
She is not protecting her children from the perpetrator.	The woman and the children are all victims of the perpetrator, and she may not be able to protect herself or the children from the violence and abuse.
She is difficult to engage/ work with.	Our service may not be what she needs or wants at this time. We need to consider that we might not be the right service, and may not be approaching her in the right way.

Trauma informed language – alternatives to common phrases

Much of our language about women and girls subjected to violence and abuse is still highly medicalised, pathologising and stigmatising.

Below is a table of common phrases and trauma-informed alternatives.

Common phrase	Trauma-informed alternative
Ever since she was abused, she has serious attachment issues.	Her perpetrators groomed her in order to harm her, she is now cautious of forming new relationships, and is re-evaluating existing relationships.
She has anxiety disorder.	Her perpetrators made her feel very scared, she is now often frightened that they will harm her again. Due to this, she lives in a state of fear, and is often anxious and scared. This can show up in related and unrelated situations, but is a very common trauma response.
The girls in this case all have severe mental health issues from the abuse.	The girls in this case are suffering with their wellbeing due to the trauma inflicted on them. Many of them experience flashbacks, nightmares, or become triggered by smells or places. Some of them are trying to take back control in various ways. While this isn't always healthy, it is a very common coping mechanism, and we must support them to process their trauma safely.
She has a diagnosis of borderline personality disorder (BPD), girls like that are not reliable witnesses.	Psychiatric diagnoses such as BPD do not negate a victim's right to justice after abuse.
The videos were really hard-hitting. It made the girls realise how much danger they were putting themselves in.	The videos were traumatic, and made the girls feel responsible. We shouldn't use resources that re-traumatise victims or attribute any blame towards them for what they were subjected to.
I think this woman may have a personality disorder.	It's likely that this woman is very traumatised after the abuse she was subjected to. We should expect to see a variety of trauma responses and coping mechanisms and try to support her as best we can. The concept of a 'personality disorder' is one that is highly contested across the disciplines of psychology and psychiatry. Professionals should not offer their opinion of mental health or psychiatric disorder when working with women and girls, as this may be used against them.

Common phrase	Trauma-informed alternative
She needs therapy.	Following the trauma she has been through and has been subjected to, I think she would benefit from trauma-informed therapy. This phrase is commonly used as a passive aggressive insult. Professionals should not use 'needing therapy' as an insult, or to put someone down.
She refuses to disclose or engage with our service.	Our service triggers her as she must regularly disclose her abuse and be reminded of it. She doesn't like how this feels and may have been let down by other professionals in the past. Her abuser worked hard to gain her trust, and eventually used this to harm her. She worries the same will happen in our service due to some of the similarities in the way humans form bonds with one another. We must consider ways of working with her that do not rely on her repeated or detailed disclosures.
Her ACE score is 7, making her likely to go on to have issues with drugs, alcohol and criminality.	The abuse or hardships somebody is subjected to or experiences in childhood does not define or predict their adulthood. We should work in a strength-based way rather than a deficit-based way. ACE scores are not a true measure of trauma or adversity, and should not be used to describe anyone.
Mental illness is common in women following abuse	Psychological trauma and distress is common in women who have been abused. This can look different for different victims, and it's important to validate their feelings whilst supporting them to process is safely. Trauma responses and coping mechanisms are common, normal and expected – they do not constitute a disorder or illness of the mind or brain.

Developing services for women and girls that are trauma-informed requires that considerable time is spent recognising and understanding how oppression, marginalisation and discrimination play a role in trauma, abuse, violence and our subsequent portrayal of behaviours, cultures, traditions, expectations, and stereotypes of victims.

Whilst little known, the term 'victim blaming' is not confined or specific to VAWG, and was first used when describing the way that Black communities in the US were blamed for being subjected to segregation and racism by the White ruling elite, and the White communities around them. Marginalised and oppressed groups of people have long been pathologised, and then blamed for their own oppression. Psychology and psychiatry have long histories of diagnosing, medicating, sectioning and abusing people based on their race and ethnicity, sexuality, social class, age, disabilities, cultures, traditions, appearances and even languages.

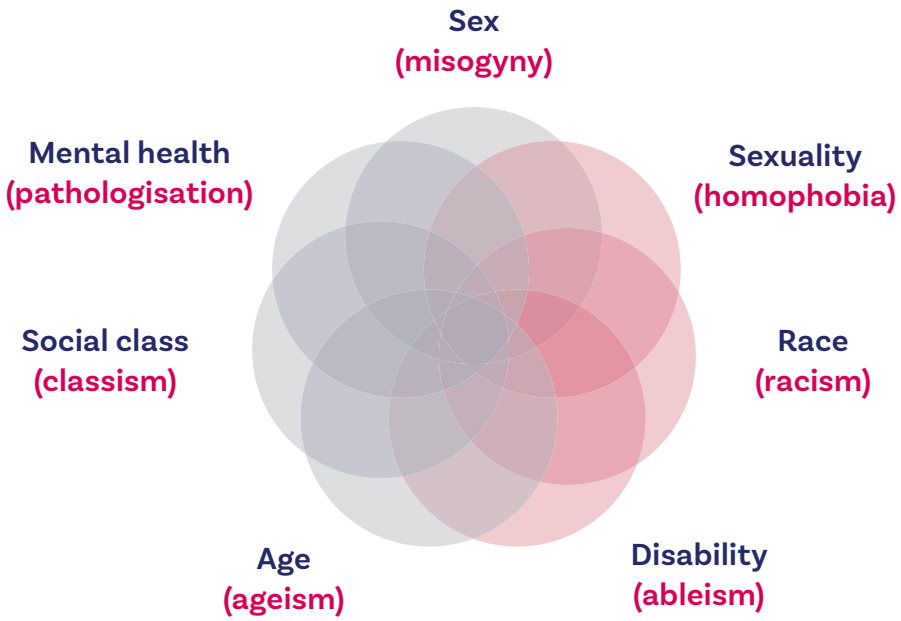
In the present day, Black women are still more likely to be portrayed as angry, aggressive, violent, out of control, disordered, emotionless, and uneducated. Lesbian women are still more likely to be diagnosed with personality disorders, and make up a disproportionate amount of people in psychiatric wards. Women with disabilities and health issues are still likely to be told that their experiences are exaggerated, made up, attention seeking or part of a mental disorder. Behaviours that are celebrated and glorified as recreational in higher social classes such as drinking or taking Class A drugs, are portrayed as dangerous, violent, and unstable in working class people (Carr & Spandler, 2019).

Applying a trauma-informed lens to Kimberle Crenshaw's work on intersectionality may be useful for VAWG services, in which we can explore how oppressions intersect and overlap – and how they are subsequently used to pathologise and blame women and girls for being subjected to abuse and violence (diagram overleaf).

Issues needed to be considered by service leaders:

1. Are assumptions or stereotypes made of certain groups of women, and their experiences of VAWG when delivering or designing services?
2. Do you notice that certain groups of women are blamed more than others?
3. Do you notice that certain groups of women are diagnosed and medicated more than others?
4. Have you noticed that you receive more (or less) referrals for certain groups of women than others?
5. Do you understand the way homophobia/racism/misogyny/ageism/ableism/classism would change the way a woman's trauma responses and coping mechanisms are perceived and responded to by professionals in your service?
6. Do you understand the way culture, tradition, expectation and personal belief systems of each group of women might change their own understanding of their trauma, mental health, abuse, violence and experiences?

An example diagram of intersectionality, and how multiple forms of oppression and discrimination overlap and intersect for women



Taylor, 2022

Case example

Melissa is a 41-year-old Black lesbian woman. A few months ago, she was raped by a White taxi driver who had picked her up from a birthday party in the city centre. She had been chatting to him when he started asking her if she was single. She started to feel uncomfortable and texted her girlfriend to say the taxi driver was being weird.

He pressed her for information about her relationship, and whether she had a husband. She said that she did not have a husband, and that she didn't want to talk about it. He explained he was only joking around and carried on chatting. She told the taxi driver that she was Lesbian, and the taxi driver reverted to asking her offensive questions about whether 'her kind' were allowed to be gay, whether her religion thought it was a sin, and whether she had ever tried to have sex with men, to be sure she was definitely gay. He suggested that she should have sex with him, to 'turn her straight'.

He locked the doors and pulled over, becoming angry and aggressive. The taxi driver sexually assaulted Melissa whilst she tried to fight him off. Eventually, she managed to get out of the car and ran into a takeaway to call her girlfriend and her sister for help.

Melissa didn't want to report the assault to the police because she was worried about racism and homophobia, but she struggled for weeks with the impact to her wellbeing and physical health. She went to her GP because she had been having problems with eating and sleeping since the assault, but the GP pressured her to report the assault in order to 'protect other women from the taxi driver', which made Melissa feel very guilty.

Trauma informed arguments against distance diagnosis and assumed diagnosis

It is common in our services, and in wider society, to hear people engage in 'distance diagnosing'. Trauma-informed services and professionals will avoid all forms of pathologisation and diagnosis of women and girls subjected to VAWG, but this section addresses a common behaviour in professionals in which they wrongfully diagnose women from their observation or opinion of them.

'Distance diagnosis' is when a person suggests or states that a person has a mental health issue, disorder, diagnosis or disability when they have not met them or know very little about them.

Due to how common pathologisation and criteria-listed, self-reported 'diagnosis' of mental disorders are, many people believe they can 'tell' if someone has a psychiatric diagnosis from listening to them speak, seeing them for a short amount of time, watching them on TV, looking at their social media, or reading their written word.

Distance diagnosis is not possible, and is highly stereotypical. Often, it is based on myths, stigma, and insults about mental health and psychological wellbeing. Distance diagnosis can also be used to demean or abuse others, by suggesting they have mental illnesses or disorders to discredit, belittle, or silence them.

Examples could include a professional talking to another professional about a woman they have never met, and saying, 'It sounds like she has traits of borderline personality disorder. Women like that tend to be very manipulative and emotional.'

Another example might be a professional writing their opinion in the notes of the woman they have only met a handful of times, stating, 'She often has short relationships that she cannot hold down. She does not like to get too close to anyone, and clearly has attachment issues.'

It is important that this practice is discouraged and eventually eradicated from our services and professional practice, as it fuels further stigma, discrimination and pathologisation of women and girls subjected to VAWG (and everyone else in wider society). Professionals should feel supported to call this behaviour out as unethical and unprofessional, especially when distance diagnoses are being used as accusations, insults, or ways to discredit women and girls.

Why people might oppose a trauma-informed approach in favour of diagnosis, medication, and treatment

Whilst this document encourages and promotes a trauma-informed approach to VAWG, it is important to recognise that some professionals and organisations may oppose this approach in favour of diagnosis, medication, and treatment of women and girls.

In this section, you will find some common reasons why people may lean towards or continue to support medical models of mental health in VAWG, despite its weaknesses/issues.

- Women and girls want/seek out psychiatric diagnoses and treatments after abuse and violence, because they believe it will make them feel better to be 'validated' by a diagnosis of a mental health issue or personality disorder. Further, some women and girls feel that they will only be taken seriously if they have a diagnosis on their file, or they are taking medication for the impact of the VAWG.

- Professionals are taught that 'trauma' causes mental disorders and personality disorders, and so feel they are already 'trauma-informed'. This is a common position, in which professionals have been trained to believe that trauma-informed change will occur if they simply acknowledge the trauma of the women and girls, rather than destigmatise and normalise it until we understand that the diagnoses are not needed.

- Professionals report that women and girls are much better when they are adequately medicated for their 'mental disorders'. This reason is complicated by issues such as placebo effect, and the way much medication makes women more docile, slower, quieter, calmer, more tired, more withdrawn, and therefore, often, more compliant. This means that professionals can often feel that traumatised women and girls are easier to manage whilst medicated, despite this not necessarily being in their best interests.

- Services are built around the medical model of mental health, and many services use psychiatric disorders to gatekeep or streamline referrals of women and girls. Due to so many of our services using psychiatric diagnosis as a way of legitimising need, some professionals have been encouraged to seek and confirm disorders for women and girls who need trauma therapy or long-term support. Without the diagnosis, the service may reject their referral or request for support.

- Psychiatric disorders are used to 'prove' harm and trauma in legal environments, and without them, professionals feel they cannot prove the harm to the woman or girl. Due to the medical model being so dominant, it is used frequently in legal cases (civil, family, criminal court) to demonstrate suffering or harm, even though the diagnosis itself could then be used to discriminate against, or discredit the woman or girl.

- Psychiatric disorders are used by the welfare and benefit system to 'prove' disability or need for financial support. Due to the medical model being so dominant, simply being traumatised by VAWG is unlikely to meet the threshold of medical evidence.

Key issues to consider for police leaders:

1. Do you feel confident that women and girls trust your force to respond to, and protect them from, all forms of VAWG? Have you asked women and girls in your force area how they feel?
2. Do you feel confident that police officers are adequately trained to support women and girls when they are subjected to violence and abuse?
3. Do you have a specific and ongoing training and resources programme to upskill and refresh all ranks of officer on all forms of VAWG, psychological trauma and support skills?
4. Is there evidence that VAWG is seen as a nuisance or time-wasting crime type that is becoming volume crime?
5. Do you feel confident that police officers understand what it means to be trauma-informed | when working with women and girls? Do they understand trauma responses, coping mechanisms, and trauma impacts from VAWG?
6. Is there evidence that misogyny and sexism is seen as a 'political' issue and is not relevant to the force?
7. Do your senior leadership teams understand how to lead and manage their officers to respond to VAWG in a trauma-informed way?
8. Do officers of all ranks understand and acknowledge their own vicarious trauma, burnout, bias, and compassion fatigue? Is there evidence that this is a concern for your force?
9. Do female officers feel safe in your force? Are they treated with respect and compassion when they report sexism, misogyny, sexual assault, or domestic abuse at work? Would they feel confident to report at all?
10. Have you explored the experiences of women and girls you are working with, to understand their perspective of the service they have received when reporting VAWG?
11. Are you confident that your force does not retraumatise or traumatise women and girls who come forward? Have you tracked their journey from their first call to 101/999 through to outcome, to explore where women and girls are most likely to be traumatised/retraumatised by systems or staff?
12. Do you understand that police comms to the public about VAWG can often have victim-blaming undertones that impact the trust and confidence of women and girls reporting violence and abuse? Have you reviewed all comms strategies about VAWG?
13. Do officers understand that their case notes and observations about the mental health, trauma response, body language, eye contact, tone, or behaviour of a woman or girl could be used against her during the prosecution/defence process?

Best practice example of responding to VAWG with a trauma-informed approach

There have been several sexual assaults of young women reported in a local park.

There are no current suspects, and an investigation has begun to identify a suspect and/or witnesses. Police decide to release information to the public about the sexual assaults. The police force gives information about the assaults and the information needed to investigate, but they do not warn women and girls to change their behaviour or imply that walking through the park is risk-taking behaviour.

All comms clearly state that the suspect is responsible for the assaults, and women have a right to a safe life. Comms state that police are investigating and taking it seriously.

When women do come forward to report a sexual assault, they are asked what they need to safely report, and to feel supported whilst doing so. They are supported with compassion and respect and are not pressured or blamed by officers undertaking the investigation. Their psychological state is not scrutinised, and it is understood by officers that victims of sexual assault can present and disclose in many ways. Their trauma response to the sexual assault (whether they froze, ran away, fought back, or tried to appease the suspect) is not scrutinised or blamed, and officers have a good understanding of the commonality and purpose of trauma responses during and after assault. The women are not asked inappropriate questions which imply blame or culpability. They are not pressured to press charges to 'protect other women from this happening again'. They are not given 'crime prevention advice' that makes them feel to blame for being sexually assaulted in the park, and they are reassured that there is nothing they could have done that would have 'caused' the suspect to assault them. They are reassured that they are supported.

Regardless of investigation progress, and whether there is a criminal justice outcome or not, the women are kept up to date regularly, and are often asked how they are feeling/doing since the assault. They are asked whether they require any emotional or psychological support, and how best they would prefer to access this. They are not pressured to access psychiatric or psychological services, and it is not inferred that they are mentally ill, disordered, or not coping. If a referral to a service is needed or requested, specialist women's services, sexual violence or VAWG services should be considered first. Officers understand that the experience of being sexually assaulted is life-changing, and the trauma will manifest in many ways in each woman they support. Officers do not work from the assumption/stereotype that woman will behave, speak, or respond in a particular way.

The police force regularly engage in reflective practice, feedback and seeking experiences of women and girls who have had a range of outcomes to their cases, to understand how to improve. Officers working on VAWG cases have regular supervision, training, and counselling, to support them with their own vicarious trauma and compassion fatigue.

Key issues to consider for health leaders:

1. Do you feel confident that women and girls would feel safe and supported to disclose VAWG to their healthcare provider should they want/need to?
2. Do you feel confident that healthcare professionals are adequately trained to support women and girls when they are subjected to violence and abuse?
3. Do you feel confident that healthcare professionals understand what it means to be trauma-informed when working with women and girls? Do they understand trauma responses, coping mechanisms, and trauma impacts from VAWG?
4. Do your senior leadership teams understand how to lead and manage their teams to respond to VAWG in a trauma-informed way?
5. Do you have a specific and ongoing training and resources programme to upskill and refresh all healthcare professionals on all forms of VAWG, psychological trauma and support skills?
6. Do healthcare professionals understand and acknowledge their own vicarious trauma, burnout, bias, and compassion fatigue? Is there evidence that this is a concern for your teams?
7. Do female healthcare professionals feel safe in your service? Are they treated with respect and compassion when they report sexism, misogyny, sexual assault, or abuse at work? Would they feel confident to report at all?
8. Have you explored the experiences of women and girls you are working with, to understand their perspective of the service they have received when they have disclosed VAWG crimes to a healthcare professional in your service?
9. Are you confident that healthcare professionals ask the right questions, and use trauma- informed language when responding to a disclosure of VAWG? Have you explored this with healthcare professionals?
10. Do healthcare professionals understand that their case notes and observations about the mental health, trauma response, body language, eye contact, tone, and/or behaviour of a woman or girl could be requested from your service, and then used against her during a prosecution/ defence process?
11. Do healthcare professionals understand that medical settings and procedures are likely to be traumatic and triggering for women and girls subjected to VAWG?
12. Do healthcare professionals understand that gathering or giving medical information to a male partner or family member may put a woman or girl at risk, if it is suspected that she is subjected to domestic or sexual abuse?
13. Do your services provide information, strategies, and extra support for women and girls who may become triggered or traumatised by medical procedures such as cervical smear tests, blood tests, X-rays, general check-ups, internal examinations, scans, biopsies, and operations?
14. Are you confident that your healthcare services follow safeguarding protocols when they suspect a woman or girl is subjected to VAWG?

15. Do healthcare professionals understand that women and girls are much more likely than men and boys to have their physical health complaints reframed as mental health issues, and therefore not supported with illnesses/injuries?

16. Do your services understand and acknowledge that medical misogyny plays a role in ignoring and/or pathologising women and girls who disclose physical or psychological impacts of VAWG?

17. Where relevant, are your services pro-choice, and do they support women and girls to have information about, and access to, terminations/abortions of pregnancies when and how they need to?

18. Do you feel confident that healthcare professional will not pressure or force a woman or girl to report their experiences to police, if they are not ready or do not want to?

19. Does your service employ trauma-informed language, policies and procedures when supporting women and girls subjected to VAWG?

Best practice example of responding to VAWG with a trauma-informed approach

A young woman was recently sexually assaulted in a park, and the investigation is ongoing. She visits her GP because she is not sleeping very well, her hair is falling out, and she is having panic attacks.

The GP listens to her concerns and is careful not to respond with disgust or shock. They ask her if she would prefer a female GP. The GP does not make victim blaming or inappropriate comments and does not imply that the woman is overreacting or being unreasonable. When the woman asks for help, the GP explains that her responses to being sexually assaulted sound completely normal and natural, and there is nothing 'wrong' with the way she is responding. The GP explains trauma-responses and coping mechanisms to the woman and helps to explain why the body responds physically to psychological distress, including the cause and purpose of panic attacks.

The GP does not seek to diagnose or suggest the woman is suffering from a mental health issue and does not refer instantly to psychiatric or psychological services. Instead, the GP asks the woman what support she might need, and how best that could be accessed. The GP asks whether the woman would prefer anonymous or face-to-face support, and then offers a range of helplines, local women's services, and online resources for the woman to get specialist advice and support.

Before touching or examining the woman, she is asked for her consent, and asked if there is anything the GP must not do, or places she cannot be touched. The GP asks whether there is anything they can do to help them feel safer, whether they would like a trusted person with them, or whether they would like a chaperone with them.

Key issues to consider for education leaders:

1. Do you feel confident that women and girls would feel safe and supported to disclose VAWG to their teacher/tutor/pastoral care should they want/need to?
2. Do you feel confident that teachers/tutors/pastoral care are adequately trained to support women and girls when they are subjected to violence and abuse?
3. Do you feel confident that teacher/tutor/pastoral care understand what it means to be trauma-informed when working with women and girls? Do they understand trauma responses, coping mechanisms, and trauma impacts from VAWG?
4. Do your senior leadership teams understand how to lead and manage their teams to respond to disclosures of VAWG in a trauma-informed way?
5. Is there evidence that your education setting pathologises and wrongly diagnoses women and girls with personality disorders, behavioural problems, attachment disorders, learning difficulties, ADHD, or Autism when they have disclosed trauma from VAWG?
6. Do you have a specific and ongoing training and resources programme to upskill and refresh all education professionals on all forms of VAWG, psychological trauma and support skills?
7. Do female education professionals feel safe in your setting? Are they treated with respect and compassion when they report sexism, misogyny, sexual assault, or abuse at work? Would they feel confident to report at all?
8. Have you explored the experiences of women and girls you are working with, to understand what happens when they disclose VAWG in your settings?
9. Are you confident that teachers/tutors/pastoral care ask the right questions, and use trauma-informed language when responding to a disclosure of VAWG? Have you explored this with education professionals?
10. Do your services provide information, strategies, and support for women and girls who may become triggered or traumatised by educational materials, modules, content or environments?
11. Are you confident that your teachers/tutors/pastoral care follow safeguarding protocols when they suspect a woman or girl is subjected to VAWG?
12. Do you feel confident that teachers/tutors/pastoral care will respond to and then protect women and girls who are subjected to VAWG within the education setting?
13. Does your setting employ trauma-informed language, policies and procedures when supporting women and girls subjected to VAWG?
14. Do your teachers/tutors/pastoral care take care not to refer women and girls into psychiatric services when they disclose VAWG?
15. Do your teachers/tutors/pastoral care take care not to victim-blame or pathologise women and girls who begin to struggle in education settings after being subjected to VAWG?

16. Has your education setting removed/banned all traumatic resources, productions, and content which show scenes of sexual and domestic violence as either education, or intervention?

17. Do you feel confident that your SRE modules, materials and resources are trauma-informed, anti-victim blaming and anti-misogyny?

18. Has your education setting implemented a policy which sets out adjustments and provisions for women and girls who have been subjected to VAWG, and may need extra support, extensions, rooms, or advice?

19. Has your education setting considered what is best for the woman or girl in their studies/ access to education whilst they are processing or being subjected to trauma?

20. Does your education setting provide information and advice to women and girls (or for young girls, their parent/guardian) about VAWG and trauma?

Best practice example of responding to VAWG with a trauma-informed approach

A 17-year-old girl was recently sexually assaulted in her local park. She reported to the police when she heard that other young women had been assaulted. Since the assault, she has been missing classes and deadlines.

Instead of beginning performance/behavioural management, teaching and pastoral staff have a meeting to discuss their concerns, and how best to approach the girl without retraumatising her. They create a possible list of adjustments/approaches they could implement to ensure the girl feels fully supported at school.

They offer her a meeting, which she is free to decline if she wishes, and offer her some written information about what will be discussed in the meeting. She is reassured that she is not in any trouble, and they are hoping to support her whilst she processes the trauma from the sexual assault. They explain that they are not going to ask her for any details about the assault, and they do not need a disclosure to help her. She is informed that she can have a trusted friend or family member with her.

The staff work together to offer a range of flexible options such as having some time off from her studies, changing her planned examinations, accessing further support, being given extensions on deadlines, being able to work from home for a period, being given a safe space in school, and being allocated a pastoral care team member to meet with her weekly to support her. The girl is offered a range of external specialist women's/sexual violence support services that she can pick from in her own time, if required. She is not referred to psychiatric services unless she chooses this herself.

Only staff members who need to know are involved in these conversations and the disclosure/ information about the assault is not shared with anyone who does not need to know.

Key issues to consider for mental health leaders:

1. Do you feel confident that women and girls would feel safe and supported to disclose VAWG to their MH professional should they want/need to?
2. Do you feel you understand your own service theoretical and strategic position on the labelling, pathologisation, medicalisation and treatment of women and girls subjected to VAWG trauma?
3. Would you describe your service as trauma-informed, anti-victim blaming, and anti-pathologisation? Why/why not?
4. Do you feel confident that MH professionals are adequately trained to support women and girls when they are subjected to violence and abuse?
5. Do you feel confident that MH professionals understand what it means to be trauma-informed when working with women and girls? Do they understand trauma responses, coping mechanisms, and trauma impacts from VAWG?
6. Is there any evidence of a culture in your MH service in which women and girls are often diagnosed with particular disorders when they have been subjected to VAWG? If you do not know, could you do an audit to find out?
7. Do your senior leadership teams understand how to lead and manage their MH teams to respond to VAWG in a trauma-informed way?
8. Do you have a specific and ongoing training and resources programme to upskill and refresh all MH professionals on all forms of VAWG, psychological trauma and support skills?
9. Do MH professionals understand and acknowledge their own vicarious trauma, burnout, bias, and compassion fatigue? Is there evidence that this is a concern for your MH teams?
10. Do female MH professionals feel safe in your service? Are they treated with respect and compassion when they report sexism, misogyny, sexual assault, or abuse at work? Would they feel confident to report at all?
11. Have you explored the experiences of women and girls you are working with, to understand their perspective of the service they have received when they disclosed VAWG to a MH professional in your service?
12. Are you confident that MH professionals ask the right questions, and use trauma-informed language when responding to a disclosure of VAWG? Have you explored this with MH professionals?
13. Do MH professionals understand that their diagnoses, case notes and observations about the mental health, trauma response, body language, eye contact, tone, and/or behaviour of a woman or girl could be requested from your service, and then used against her during a prosecution/defence process?
14. Do MH professionals understand that medical settings and treatments (including therapies) are likely to be traumatic and triggering for women and girls subjected to VAWG?

15. Do MH professionals understand that gathering or giving medical information to a male partner or family member may put a woman or girl at risk, if it is suspected that she is subjected to domestic or sexual abuse?
16. Are you confident that your mental health services follow safeguarding protocols when they suspect a woman or girl is subjected to VAWG?
17. Do MH professionals understand that women and girls are much more likely than men and boys to have their physical health complaints reframed as mental health issues, and therefore not supported with illnesses/injuries that require investigation?
18. Do your services understand and acknowledge that misogyny plays an influential role in ignoring and/or pathologising women and girls who disclose all forms of VAWG? What is being done in your service to address systemic misogyny?
19. Do you feel confident that MH professionals will not pressure or force a woman or girl to report their experiences to police, if they are not ready or do not want to?
20. Does your service employ trauma-informed language, policies and procedures when supporting women and girls subjected to VAWG?
21. Does your service observe NICE guidelines and best practice which state that psychiatric disorders should not be diagnosed or medicated in people who are responding to/suffering with trauma?
22. Does your service observe NICE guidelines and best practice which state that children under the age of 18 should not be diagnosed or treated with 'personality disorders' (and especially when trauma is present)?
23. Does your service support women and girls to challenge inaccurate and harmful psychiatric diagnoses they have been given when they were traumatised by VAWG?
24. Do MH professionals remove or correct misleading or inaccurate information about the woman or girl they are working with?
25. Are women and girls given full information about treatment options (medication, therapy, alternative forms of support)? Does this include neutral and accurate information about side effects, withdrawal effects, addiction and dependency on psychiatric medications used in your service?
26. Are women and girls supported to taper safely off psychiatric medications when they ask to no longer take them? Are they supported in their choice to do so?
27. Do you feel confident that MH professionals would not employ a therapeutic method or style that could increase self-blame, shame, guilt and trauma responses in women and girls subjected to VAWG?
28. Does your service have a trauma-informed alternative pathway which does not encourage medicalisation of human trauma and distress?

Best practice example of responding to VAWG with a trauma-informed approach

A young woman has recently been referred into a mental health service because her family have serious concerns about her mental health. She was sexually assaulted two months earlier in a park. Police are still investigating the crime and have not yet made an arrest. Her family have reported that she has become isolated, aggressive, avoidant, and paranoid.

Mental health professionals in the service approach the young woman with respect and compassion, and without presumptions about her experience or feelings. They do not base their interview or assessment on the comments from the family, or notes from other agencies, but decide to conduct a humanistic, trauma-informed discussion with her to explore her own perspective and feelings. All services are then guided by her own goals, needs and ideas about her own experiences.

The mental health professional listens carefully to the young woman but reassures her that she does not need to disclose the assault in any detail. The young woman explains that she doesn't feel she is coping with being assaulted, and she feels she is 'losing control'. The mental health professional does not seek to diagnose or medicate the young woman, as she is clearly traumatised from the sexual assault. Instead, she works with the young woman to explore what kind of support she might need, and what might be best for her. The professional always asks what the young woman wants/needs but accepts that this may change week to week.

The mental health professional works with the young woman to explore and process the trauma responses and/or new coping mechanisms that have developed since the assault, and used trauma-informed resources, strategies, or approaches to support her whilst she begins to understand why her body and brain is responding in such a way to being sexually assaulted. They explore self-blame, guilt, shock, trauma, shame, feelings of injustice, change in world view, any new or reoccurring triggers from this trauma/other trauma and the impact the sexual assault is having on her relationship with her partner.

They discuss her worries and fears about the police investigation and look to develop some strategies to cope with the multiple possible outcomes (and how they may make her feel).

If/when the young woman is ready to talk about what happened, the mental health professional works with the young woman to access the right kind of therapy or support for her and does not employ a therapeutic method that might traumatise her or make her feel responsible for being assaulted.

Key issues to consider for children's social care leaders:

1. Do you feel confident that girls would feel safe and supported to disclose VAWG to their support worker should they want/need to?
2. Do you feel you understand your own service theoretical and strategic position on the labelling, pathologisation, medicalisation and treatment of girls subjected to VAWG trauma?
3. Would you describe your service as trauma-informed, anti-victim blaming, and anti-pathologisation? Why/why not?
4. Do you feel confident that social care professionals are adequately trained to support girls when they are subjected to violence and abuse?
5. Do you feel confident that social care professionals understand what it means to be trauma-informed when working with girls? Do they understand trauma responses, coping mechanisms, and trauma impacts from VAWG throughout ages and stages of development?
6. Is there any evidence of a culture in your children's service in which girls are often referred or diagnosed with particular disorders when they have been subjected to VAWG? If you do not know, could you do an audit to find out?
7. Do your senior leadership teams understand how to lead and manage their teams to respond to VAWG in a trauma-informed way?
8. Do you have a specific and ongoing training and resources programme to upskill and refresh all social care professionals on all forms of VAWG, psychological trauma and support skills?
9. Do social care professionals understand and acknowledge their own vicarious trauma, burnout, bias, and compassion fatigue? Is there evidence that this is a concern for your teams?
10. Do female professionals feel safe in your service? Are they treated with respect and compassion when they report sexism, misogyny, sexual assault, or abuse at work? Would they feel confident to report at all?
11. Have you explored the experiences of the girls you are working with, to understand their perspective of the service they have received when they disclosed VAWG?
12. Are you confident that social care professionals ask the right questions, and use child-friendly, accurate, accessible, trauma-informed language when responding to a disclosure of VAWG? Have you explored this with your teams?
13. Do social care professionals understand that their case notes and observations about the mental health, trauma response, body language, eye contact, tone, and/or behaviour of a girl could be requested from your service, and then used against her during a prosecution/defence process?

14. Do social care professionals understand that their services are likely to be frightening, traumatic and triggering for girls subjected to VAWG?
15. Do your services understand and acknowledge that misogyny plays an influential role in ignoring and/or pathologising girls who disclose all forms of VAWG? What is being done in your service to address systemic misogyny?
16. Do you feel confident that social care professionals will not pressure or force a girl to report her experiences to police, if she is not ready or does not want to?
17. Does your service employ trauma-informed language, policies and procedures when supporting girls subjected to VAWG?
18. Does your service observe NICE guidelines and best practice which state that children under the age of 18 should not be diagnosed or treated with 'personality disorders' (and especially when trauma is present)?
19. Do social care professionals remove or correct misleading or inaccurate information about the girl they are working with?
20. Has your service removed/banned all traumatic resources, productions, and content which show scenes of sexual and domestic violence as either education, or psychoeducative intervention?
21. Do you feel confident that your materials and resources are trauma-informed, anti-victim blaming and anti-misogyny?
22. Have you reviewed all 'early intervention' and 'prevention' direct work, to ensure that it does not blame girls, or place responsibility on them to change their behaviour, appearance, feelings, responses or thoughts in order to 'protect themselves from VAWG'?
23. Could you conduct an audit/dip sample of case records or meeting notes about girls who have been subjected to VAWG, to explore whether the language and approaches to those girls were trauma-informed and effective?
24. Have you reviewed serious case reviews or investigations that included a girl subjected to VAWG – and have you taken action to address the learning from them?
25. How confident are you that the care placements you are using for girls who are placed into care are trauma-informed? If they are described or sold as 'trauma-informed therapeutic placements', have you checked what that means and whether it is being fulfilled?
26. Are foster carers and partner fostering services trauma-informed? If you do not know, could you raise this with them to find out?
27. When referring to partner agencies and signposting to local services, are social care professionals aware of which ones are trauma-informed and which ones are not? Would they know the difference, and would they know how to ask?
28. Do social care professionals use ACEs? If so, do they understand that ACEs are not trauma-informed and should not be used to score, classify, assess or monitor children in any way?

Best practice example of responding to VAWG with a trauma-informed approach

A 15-year-old girl has been referred into children's services because she has disclosed sexual assault to her teacher. She is already known to services because she also disclosed sexual abuse by her father as a young child. No action was taken in the case against her father because there was no evidence, but he was later convicted of domestic abuse against a new partner, and she does not see her father.

Social care professionals in the service approach the girl with respect and compassion, and without presumptions about her experience or feelings. They do not base their interview or assessment on the comments from the teacher, or the case records about her from when she was much younger, but decide to conduct a humanistic, trauma-informed discussion with her to explore her own perspective and feelings. All services are then guided by her own goals, needs, and ideas about her own experiences.

The professional works with the girl to develop a sketch of her life as she sees it, choosing to use a trauma-informed, social model to explore her life, relationships, strengths and needs.

The professional listens carefully to the girl but reassures her that she does not need to disclose the assault in any detail. The girl doesn't want to talk about what happened and regrets telling her teacher. She is scared of social services. The social care professional notices that she is very frightened and is traumatised from the sexual assault. She does not seek to diagnose or make comments about her mental life, but instead works with the girl to explore what kind of support she might need, and what might be best for her. The professional always asks what the girl what she wants/needs but accepts that this may change week to week.

The social care professional works with the girl to explore and process the trauma responses and/or new coping mechanisms that have developed since the assault, and uses trauma-informed resources, strategies, or approaches to support her. They check in regularly, and the professional is patient and understanding when she goes through different stages of processing. They make sure they are contactable, and that they have another named contact for when they are leave, or busy with other cases.

If/when the young woman is ready to talk about what happened, the professional works with the girl to access the right kind of therapy or alternative support for her, and does not employ a method, or refer to a service, that might traumatise her or make her feel responsible for being assaulted. Whilst she is still at school, the professional works with the school to engage them in a trauma-informed response to her education and access to the school environment whilst she is struggling. The social care professional advocates for the girl and ensures that everyone around her utilises a strengths-based approach to her support – and does not perceive her to be a one-dimensional 'repeat victim' of sexual violence.

Key issues to consider for adult social care leaders:

1. Do you feel confident that women would feel safe and supported to disclose VAWG to their support worker should they want/need to?
2. Do you feel you understand your own service theoretical and strategic position on the I abelling, pathologisation, medicalisation and treatment of girls subjected to VAWG trauma?
3. Would you describe your service as trauma-informed, anti-victim blaming, and anti-pathologisation? Why/why not?
4. Do you feel confident that social care professionals are adequately trained to support women when they are subjected to violence and abuse?
5. Do you feel confident that social care professionals understand what it means to be trauma-informed when working with women? Do they understand trauma responses, coping mechanisms, and trauma impacts from VAWG?
6. Is there any evidence of a culture in your service in which women are often referred or | diagnosed with particular disorders when they have been subjected to VAWG? If you do not know, could you do an audit to find out?
7. Is there any evidence of a culture in your service in which women are left in abusive and dangerous situations whilst an expectation is placed upon them to escape or 'recognise they are being abused'?
8. Is there any evidence of a culture in your service in which women are expected to leave their homes, jobs, areas, and families in order to escape a perpetrator, instead of disrupting the perpetrator and preventing their crimes?
9. Is there any evidence of a culture in your service in which women are perceived to be the cause and solution of their own abuse (including comments that they 'put themselves at risk', 'should have seen the signs', 'take risks', 'should have known')?
10. Is there any evidence of a culture in your service in which women's children are removed or placed into CIN/CP plans because mum is being abused or subjected to VAWG (where mum is seen as 'failing to protect' because she cannot escape an abuser)?
11. Do your senior leadership teams understand how to lead and manage their teams to respond to VAWG in a trauma-informed way?
12. Do you have a specific and ongoing training and resources programme to upskill and refresh all social care professionals on all forms of VAWG, psychological trauma and support skills?
13. Do social care professionals understand and acknowledge their own vicarious trauma, burnout, bias, and compassion fatigue? Is there evidence that this is a concern for your teams?
14. Do female professionals feel safe in your service? Are they treated with respect and compassion when they report sexism, misogyny, sexual assault, or abuse at work? Would they feel confident to report at all?

15. Have you explored the experiences of the women you are working with, to understand their perspective of the service they have received when they disclosed VAWG?
16. Are you confident that social care professionals ask the right questions, and use accessible, trauma-informed language when responding to a disclosure of VAWG? Have you explored this with your teams?
17. Do social care professionals understand that their case notes and observations about the mental health, trauma response, body language, eye contact, tone, and/or behaviour of a woman could be requested from your service, and then used against her during a prosecution/defence process?
18. Do social care professionals understand that their services are likely to be frightening, traumatic and triggering for women subjected to VAWG?
19. Do your services understand and acknowledge that misogyny plays an influential role in ignoring and/or pathologising women who disclose all forms of VAWG? What is being done in your service to address systemic misogyny?
20. Do you feel confident that social care professionals will not pressure or force a woman to report her experiences to police, if she is not ready or does not want to?
21. Does your service employ trauma-informed language, policies and procedures when supporting women subjected to VAWG?
22. Does your service observe NICE guidelines and best practice which state that psychiatric disorders should not be diagnosed or medicated in people who are responding to/suffering with trauma?
23. Does your service support women to challenge inaccurate and harmful psychiatric diagnoses they have been given when they were traumatised by VAWG?
24. Do social care professionals remove or correct misleading or inaccurate information about the woman they are working with?
25. Are women given full information about intervention or support options? Does this include neutral and accurate information about pros and cons, possible implications and what is known to work/not work?
26. Do you feel confident that social care professionals would not employ a method or style of working that could increase self-blame, shame, guilt, and trauma responses in women subjected to VAWG?
27. Does your service have a trauma-informed, specialist alternative pathway which does not encourage medicalisation of human trauma and distress?
28. When referring to partner agencies and signposting to local services, are social care professionals aware of which ones are trauma-informed and which ones are not? Would they know the difference, and would they know how to ask?
29. Do social care professionals use ACEs? If so, do they understand that ACEs are not trauma-informed and should not be used to score, classify, assess or monitor adults in any way?

Best practice example of responding to VAWG with a trauma-informed approach

A young woman is referred into the service due to her children's school noticing that the children seem to be coming to school looking unkempt recently. She is a young single mother of two small children. She discloses that she has been sexually assaulted in a local park. She said she reported it to the police weeks ago, but nothing else had happened.

She explains that she was not able to keep her job as she needed time off to cope, but she was on a zero-hours contract and lost her job. She stopped sleeping as she has been having nightmares about walking through the park to work, and worrying about the cost of her energy bills. She has been oversleeping in the mornings, and she has been trying to do less laundry to keep costs down. She is worried about being made homeless because she cannot afford the rent without the hours from her job, but she is not ready to go back to work.

Social care professionals arrange to meet with her and treat her with respect and compassion, without presumptions about her experience or feelings. They do not base their interview or assessment on the referral from the school, but decide to conduct a humanistic, trauma-informed discussion with her to explore her own perspective and feelings. All services are then guided by her own goals, needs, and ideas about her own experiences.

The professional works with the woman to develop a sketch of her life as she sees it currently, choosing to use a trauma-informed, social model to explore her life, relationships, strengths and needs. During this process, they map out everything that is worrying her, how it is making her feel, and how those circumstances could be addressed. They create a plan together to access benefits, housing advice, financial support, and therapy. The professional listens to, and validates her struggles and responses.

The professional does not seek to diagnose or make comments about her mental life, but instead works with the woman to explore what kind of support she might need, and what might be best for her. The professional always asks what the woman what she wants/needs but accepts that this may change week to week.

If/when the young woman is ready to talk about what happened, the professional works with her to access the right kind of therapy or alternative support for her, and does not employ a method, or refer to a service, that might traumatise her or make her feel responsible for being assaulted. The professional takes care at all times not to blame the economic and financial issues the family is having on the mother and works to make sure that the woman understands that it is not her fault that she lost her job when she started to struggle with trauma. The professional provides a range of materials, information, and sources from specialist women's services, sexual violence services and anonymous helplines so the woman can access additional support when needed, too.

Key issues to consider for all leaders:

1. If your teams work with any form of abuse, oppression, trauma, violence, distress, injury, death, crime, or harm – they will be experiencing different levels of their own trauma responses, compassion fatigue and burnout.
2. Does your SLT understand how common and normal vicarious trauma, compassion fatigue and burnout is? Do they know how to spot it in themselves and in their teams?
3. Does your service provide any support or information about vicarious trauma for your teams?
4. Is there evidence of a culture in your service in which being traumatised or burned out is seen as normal, 'part of the job', or to be expected?
5. What policies and approaches have you put in place to protect your staff teams from vicarious trauma and burn out?
6. Have you noticed compassion fatigue in your staff teams? Have they become desensitised to VAWG or trauma? How will you address this?
7. Do you feel you understand the impact a traumatised and burned-out workforce will have on your service delivery, staff turnover and quality of service?
8. Is there evidence of a culture in your service in which it is seen as weak or incompetent to admit you are not coping with the trauma/distress of the role? What can you do to change this narrative?
9. Have you considered doing an anonymous, internal audit of feelings of vicarious trauma, burnout, compassion fatigue and distress in your teams? Could you conduct one to learn more about the wellbeing of your teams?
10. Are you aware of how common VAWG is, and how likely it is that your own female staff and SLT are being/have been subjected to VAWG themselves? Have you considered how this would change and influence their own responses, practice, decision making and trauma responses?
11. Does your service provide regular training about vicarious trauma, compassion fatigue, burnout, and bias?
12. Do professionals in your service feel safe to admit/talk about their own traumas, or is this seen as 'unprofessional'? If the latter, what can you do to break down this harmful narrative?
13. What services are in place for staff who experience vicarious trauma and burnout? Are the services trusted by staff? Are they used effectively?

Best practice example of responding to vicarious trauma with a trauma-informed approach

A professional in your service is working a high caseload of children and teenagers who have been subjected to sexual violence. She has made several comments which suggest that she has become desensitised to child sexual abuse and seems to be losing motivation. She is one of the most experienced staff members you have, and you are concerned that she is not coping, or something is happening at home.

You approach her as soon as you reasonably can and ask to meet with her. You reassure her that she has not done anything wrong, but you would like to talk to her about how her role is going recently.

During the meeting, you explain what you have noticed/heard/seen, and she initially becomes defensive and angered. Eventually, she states that she is overworked, her caseload is too high, and she doesn't seem to be making progress with her cases. She mentions that her niece has disclosed that she has been sexually assaulted by a boy at school and has taken an overdose.

You work with her to discuss vicarious trauma, burnout, desensitisation, and compassion fatigue. This includes explaining that it is common, and to be expected when being confronted with trauma every day. Despite it being common, it cannot become 'part of the job', and you will seek therapeutic support for your staff member. At all times, you maintain confidentiality, and ask her permission/ideas to seek support for her. You devise a plan with her to provide support and provide a range of options (both external and internal, including anonymous helplines), so she can pick what she feels most comfortable with.

You consider how to practically help your staff member, including reducing her workload, offering flexible working, time off to rest, a change in role/focus for a while, or a secondment to another team or department.

Research shows that professionals become burned out and traumatised when they feel helpless and powerless in the workplace – so you explore those feelings with her, to see if there is anything you can do to help her make progress with the cases that are worrying her. You also work with her to understand if there is anything systemic or procedural that is causing her to feel stuck, disempowered, or burned out.

You arrange regular supportive meetings with your staff member to understand whether the approaches are working and making her feel better. Due to your observations, you decide it would be a good idea to explore vicarious trauma and burnout across the whole service, and commission/arrange an internal anonymous survey to understand the experiences of everyone.

Key issues to consider for comms and marketing leaders:

1. Do your teams have a solid understanding of effective and appropriate language when writing/talking/creating digital media about VAWG?
2. Have there been any campaigns or comms that have been criticised for victim-blaming women, or using inappropriate language? What was learned from these complaints?
3. Could you work with a specialist VAWG organisation and/or group of victims/survivors to peer review your comms/campaigns before rolling out?
4. Could you also work with a diverse group of the public who are not connected to VAWG at all, in order to understand how average people see/perceive/notice the comms/campaign if they have no knowledge or experience of VAWG or trauma?
5. Have you checked that you are not using professional language or acronyms such as 'VAWG' or 'DA' in your public messaging?
6. Have you checked that you are not using outdated theories of crime, psychology, or victimology when creating VAWG prevention campaigns?
7. Are your comms/campaigns translated into common languages in your area?
8. Do your comms/campaigns have alternative copies for people with disabilities?
9. Before using the term 'trauma-informed' in your comms/campaign, are you sure that the service/product/event is 'trauma-informed', or is it being used as a buzzword?
10. Have you removed all jargon from your comms?
11. Have you assumed that professional comms can include acronyms and professional language, because they already understand it? Would it be better to be clearer in your language and not to presume that professionals do understand acronyms or professional terms?
12. Do you have a clear set of guidelines about 'what to say' versus 'what not to say' when discussing VAWG crimes and trauma in comms?
13. Do you have a clear set of guidelines which bans the use of traumatic imagery, videos, descriptions, and disclosures in your comms about VAWG and trauma? This is a common issue (images of women crying on the floor, with a man above her with a clenched fist, for example), have you provided alternative approaches and images?
14. Have you made sure that messages in the comms are accurate and evidence-based?
15. Do you have a clear set of guidelines about how to avoid victim-blaming, shaming, oppressive language, guilt-tripping and pressured language in comms about reporting VAWG crimes?

Best practice example of comms about VAWG employing a trauma-informed approach

A new strategic VAWG group has been set up in a large city in the UK. Over the course of several meetings, the group discuss how best to create and roll-out comms about their purpose and goals.

The original ideas included posters, emails, business cards, leaflets, and radio adverts about 'VAWG' and 'ending VAWG'. They also decided to begin a campaign called 'No excuse for domestic abuse' and '#TellSomeone'.

For Christmas, they decided to develop a digital advent calendar which included a daily piece of advice to help women to protect themselves from VAWG.

The strategic group decided to review their ideas using a trauma-informed lens, to see if they aligned with the ethos they were working towards.

Whilst these ideas were being reviewed, several members of the group disputed the approaches, and raised concerns that they were not appropriate or aligned to trauma-informed approaches.

They raised that the use of acronyms such as 'VAWG' and 'CSE/CCE' were not widely recognised outside of the sector and would alienate the majority of professionals and public.

Second, they suggested that most women who are being abused do not recognise or self-define their relationship as 'domestic abuse', and so professional terminology might need to be avoided in some of the comms to the public. Instead, they suggested being specific in the comms, and giving real examples such as, 'Does your partner check your social media? Does your partner tell you what to wear? Does your partner stop you from seeing your family? Does your partner hit you or slap you? Does your partner make you have sex with them when you don't want to?'

Finally, they disagreed with the idea of the advent calendar because it could encourage victim blaming of women and girls. The professionals suggested that giving advice to 'protect yourself from VAWG' is not trauma-informed and should not be the focus of comms about their work.

The group worked together to create comms that aligned with their trauma-informed principles, used accessible language, avoided any victim blaming narratives or ideas, and continually asked for peer review and advice from local women's services, and from unrelated members of the public to explore how their comms are received by people with no knowledge of VAWG at all.

Following on from their discussions, they decided to hold trauma-informed VAWG comms training courses for all marketing and comms staff, to support their development.

Key issues to consider for commissioners:

1. Do you have a good understanding of what it would mean for a service to be trauma-informed? Have you undertaken training for commissioners on this topic?
2. Do you have a good understanding of how VAWG services work on a day-to-day basis, and how they measure outcomes?
3. When assessing bids or applications for funding, would you know how to differentiate between genuine trauma-informed services, and those who use the term as a buzzword to gain funding?
4. Do the services you commission understand trauma-informed service design and delivery in VAWG? How could you check this?
5. Trauma-informed services often require more funding, and longer time periods to work with each client. Have you considered this when assessing bids/applications for funding?
6. Trauma-informed services often refuse to use pathologising labels, language, referral methods, gatekeeping, and criteria about their clients. Do you know how to measure outcomes and KPIs in a trauma-informed VAWG service if these traditional methods are not used?
7. Trauma-informed VAWG services may need to be highly flexible in the way they engage with, work with, communicate with, and support women and girls subjected to violence and abuse. Have you considered this when designing/commissioning services or allocating funding?
8. When developing commissioning documents, tender invitations, and project briefs, have you been clear about what you mean by 'trauma-informed', and how you expect to see that manifest in the service (and their finances/bid/KPIs/outcomes)?
9. When interviewing or meeting with potential services/bidders, are you confident in discussing and challenging their understanding of trauma-informed VAWG services? Would you know how to spot the use of buzzwords, or a misuse/misunderstanding of the term?
10. Are you aware of the best practice examples, academic research and evidence base in other areas and countries that have successfully (and unsuccessfully) implemented trauma-informed approaches to VAWG? Could you use this knowledge to guide your discussions?
11. Do you have enough knowledge of trauma-informed theory and philosophy to understand when a service ethos or design could not possibly be 'trauma-informed' due to the environment or the type of work they undertake? (E.g., Is there really such thing as a trauma-informed prison? Can a service which advocates for the psychiatric diagnosis and medication of traumatised women/girls really be trauma-informed?)

Best practice example of commissioning VAWG services with a trauma-informed approach

A local authority is looking to commission a new service for women subjected to domestic abuse. The commissioning team begin to design the brief, and one member of the commissioning team suggests that the new service should be trauma-informed.

Before the brief is designed, the commissioning team undertake a short training course about what it means to be trauma-informed, and how that could be implemented in VAWG services.

Once the commissioning team feel confident that they understand how this would be implemented, they build the brief and tender documents to clarify the underlying principles of the ideal service they wish to commission. They notice that this would have a cost implication, and therefore explore whether the budget needs to be bigger to support trauma-informed working with women subjected to domestic abuse.

The service brief is then released alongside invitation to tender documents, which encourages applications from organisations and providers who can demonstrate authentic trauma-informed working.

Services are encouraged to explain how they would measure KPIs and outcomes using a trauma-informed approach, and instructed to demonstrate how this would work in place of more traditional forms of outcome measurement. Services are also encouraged to describe how their services are trauma-informed, and what makes them different from traditional service approaches. Further, the tender asks the service to explain how they will work in partnership with, or alongside services that are not yet trauma-informed, or do not want to work in a trauma-informed manner.

At application/interview stage, the scoring and assessment of the tender includes a thorough assessment of knowledge and skills. Interviews deliberately test the ethos and understanding of the applicant around what being trauma-informed means, and how this would be achieved whilst running a service for women subjected to domestic abuse.

Bid assessors/interviewers would be trained to notice buzzword use and shallow understanding of trauma-informed approaches. Where it is suspected that the bidder is not trauma-informed, or could not reasonably provide a trauma-informed service to women subjected to domestic abuse, the applicant is notified that they are not suitable/have been unsuccessful.

When appointing a successful bidder to begin the service, the commissioning team will work with the new service to ensure that they commit to delivering a trauma-informed service, and have suitable, effective outcome measures to demonstrate the way the funding is being used to achieve trauma-informed provision for women and girls.

Approaches that are not trauma-informed

On this page, you will find a handy checklist of approaches and frameworks that are not trauma-informed approaches to VAWG. We have included these here so the trauma-informed approach is not diluted or misused. It is common for services to advertise or describe themselves as 'trauma-informed', but also use approaches that are retraumatising, or oppressive.

If you are working towards becoming a trauma-informed service, but notice that you do use approaches listed below, you may need to explore this in more depth. We have included an explanation of why each approach is not trauma-informed, or why it would conflict with trauma-informed principles. This list is not exhaustive, and the best way to understand if an approach is trauma-informed or not, is to learn as much as you can about trauma-informed theories and practice, and then to consider whether the approach aligns with the ethos.

The following approaches to VAWG are not trauma-informed:

- [ ] 1. **Women and girls being encouraged or forced to accept psychiatric diagnosis, intervention, or medication in order to access a service, or to be placed on to a therapy waiting list. This includes the assertion that women and girls must be taking antidepressants to access therapy.**
- [ ] 2. **Women and girls being entered into a diagnostic process when they have clear trauma responses and histories that should be seen as the root.**
  Women are girls who are traumatised and have been subjected to abuse, violence, trauma, oppression, or discrimination should never be diagnosed with a mental health issue, psychiatric diagnosis, or behavioural problem. In any case, it is impossible to accurately/ethically 'assess' someone from a baseline, if they are traumatised at the time of the assessments. The trauma itself is a confounding variable in any diagnostic process.
- [ ] 3. **Women and girls being perceived to be responsible for, and in control of, whether they are subjected to violence and abuse – and are therefore encouraged or forced to protect themselves from perpetrators. Women and girls being encouraged to modify appearance, location, or behaviour to stop abuse/violence being committed by a third party. Any kind of 'prevention approach to VAWG' which requires the woman or girl to change herself in some way.**
- [ ] 4. **The use of ACEs (adverse childhood experiences) and ACE 'scores'.** ACEs is a deficit-based, misused approach to adversity with no validity. The original authors of the ACE questionnaire used in 1998 have asked that we stop misusing their ten items used in their epidemiological study on global population effects and illnesses. ACEs cannot and should not be used to categorise, classify, risk assess, predict, or support children or adults. There is no such thing as an 'ACE Score' in trauma-informed working.

- [ ] 5. **Women and girls being defined by the crimes and abuses committed against them.** This is deficit-based working and is therefore not compatible with the preferred strength-based, trauma-informed approaches to VAWG

- [ ] 6. **Women and girls being treated or perceived as unreliable witnesses because they have been historically or recently diagnosed with psychiatric disorders, mental health issues, or personality disorders.** Within a trauma-informed approach to VAWG, women and girls must have full access to justice processes no matter what their medical files may say.

- [ ] 7. **Children being removed or threatened with removal from women who are being subjected to domestic and sexual abuse by a third party.** Trauma-informed approaches to VAWG would include the understanding that women struggle to escape domestic abuse, even when, and especially when, there are children involved. A trauma-informed approach would clearly view and support Mum as a victim, and not as a barrier or a risk to her children who are also being subjected to the abuse.

- [ ] 8. **Women and girls being punished, prosecuted, or reprimanded for being repeat clients/callers to 999, 111, 101, or any other emergency service where they have disclosed VAWG.** The High Intensity Network Model is an example of this kind of punitive approach to complex distress, which was adopted by almost half of NHS trusts by 2021. It specifically cited women with BPD as a target group for this intervention. This has currently halted, pending further investigation. Any kind of approach which seeks to prosecute or reprimand people for seeking repeated support from emergency services is not trauma-informed

- [ ] 9. **Women and girls being expected to disclose repeatedly, in detail, to many services.** Trauma-informed services to not expect repetitive disclosure, and do not gather unnecessary levels of detail about the woman or girl in order to provide a service.

- [ ] 10. **Women and girls being denied single-sex provisions where they have been subjected to trauma, abuse, oppression, violence or injury.** Trauma-informed services must include the understanding that women and girls may need to request female professionals, female specific services, or female sex provisions including refuges, hostels, wards, therapies and groups. Some women will not need/want single-sex provisions, but this is not reason to remove or stop these services where they are commonly needed. VAWG (where majority of crimes are committed by males) is a common area where single-sex provisions are necessary and trauma-informed.

Reflection questions for leaders

Now that you have read this guide, you may wish to discuss it with other leaders in your organisation, or you may wish to take some time to reflect on what you have read. Moving towards trauma-informed approaches is a big undertaking, and it is important that it is fully understood before implementing.

Below are some reflective questions for leaders to use in discussions or private reflection when considering service design and strategy.

1. How are you feeling about trauma-informed approaches after reading this guide?
2. Do you think your service could achieve trauma-informed working?
3. What do you do already which is trauma-informed, strengths-based, and anti-victim blaming?
4. Do you think that your service will have difficulty moving towards trauma-informed working? If so, what barriers/difficulties do you foresee?
5. Would your service need to be redesigned or significantly changed to achieve trauma-informed working? If so, how?
6. If you did move to trauma-informed working, would it cause any problems/tension with your partners or collaborators?
7. If you did move to trauma-informed working, would you need to seek different/amended funding/budgets? Would your commissioners/funders understand the change in service provision? How could you approach this conversation with them?
8. How could you work with partner agencies to create trauma-informed change together, instead of working in silos?
9. On reflection, do you feel that your service is heavily influenced by the medical model of mental health? If so, how will you create ideological/paradigm change in your service?
10. Do your teams understand trauma-informed working, or is it being used as a buzzword in your service?
11. Do your SLT understand trauma-informed strategies, and how to implement the change across the organisation?
12. Do you have any fears or reservations about trauma-informed approaches to working with women and girls subjected to abuse and violence?
13. Has this guide challenged anything for you personally? How did you respond to that challenge? How do you think your staff will respond to personal challenge (think about how they might personally respond to the alternative understanding of mental health, disorder, medication and pathologisation, for example)?
14. Have you considered how you might address vicarious trauma, burnout, and compassion fatigue in your teams, and how you can implement trauma-informed approaches throughout your organisation?

About VictimFocus

VictimFocus works in the UK and internationally to challenge, change, and influence the way victims of abuse and violence (predominantly women and girls) are perceived, stereotyped, and blamed. We achieve this through delivering training, undertaking commissioned research and evaluation projects, developing resources, E-learning, guides, reports, and factsheets. We work with police forces, government, health services, education provisions, private companies, charities, military, and social care services.

VictimFocus is committed to free and affordable services, research, resources and training courses. All funds received from commissioned work and purchases are reinvested into free modules, research reports, events and resources.

We are a team of trauma-informed, anti-victim blaming, anti-pathologisation, anti-racist, and anti-oppressive professionals including academics, practitioners, and trainers.

About the author of this guide

The author of this report is Dr Jessica Taylor (PhD, FRSA).

Jessica is the Director of VictimFocus. She is a Chartered Psychologist, FRSA Fellow, and Sunday Times Bestselling Author. Specialising in the psychology of victim blaming and trauma of women and girls subjected to male violence, Jessica has written two books which specialise in the psychology of victim blaming women and girls subjected to VAWG, and the pathologisation and harmful labelling of trauma arising from VAWG. Jessica currently sits on several strategic boards and groups which specialise in trauma-informed approaches to misogyny, VAWG and anti-victim blaming.

Services and resources

VictimFocus provide helpful services and resources for organisations looking to develop their trauma-informed strategies and services:

- CPD Accredited trauma-informed training courses for staff and leadership in all sectors
- Train the Trainer Programmes – learn how to roll out training to your own staff
- Research and evaluation projects to explore common issues, or to improve practice
- Hampers of trauma-informed educational resources, flashcards, books, and guides
- Free webinars, research sharing events and networks for professionals
- E-learning for professionals working with children and adults in any capacity

Join our free Leadership AVBTI

VictimFocus hosts a monthly international AVBTI Network (Anti-victim blaming trauma-informed network) meeting which is currently attended/supported by over 1500 professionals globally.
In conjunction with this guide, we are launching a Leadership AVBTI network for senior leaders who wish to network with other national and international leaders who are also moving their services towards trauma-informed, anti-victim blaming practice and strategy.

To enquire about joining the free network, please email:

AVBTI@victimfocus.org.uk

In the subject line or email body, please make it clear that you wish to enquire about the **Leadership AVBTI.**

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