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CARE4TRAUMA

IMPROVING GENDER-BASED VIOLENCE VICTIMS SUPPORT SERVICES AND THE ACCESS TO JUSTICE THROUGH TRAUMA-INFORMED CARE

Trauma Informed Care

HANDBOOK OF PRACTICES

MONDO DONNA ONLUS

GROUP ABD

Union of Women Members' Associations of Heraklion Prefecture

Women's Support and Information Center
There is a way out of violence!

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CARE 4 TRAUMA

Improving Gender-based Violence Victims Support Services and the Access to Justice through Trauma-informed Care

HANDBOOK OF PRACTICE

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Women who experience violence suffer a range of health problems and their ability to participate in the public life is diminished. [...]

Violence impoverishes women, their families, communities and nations.

It lowers economic productivity, drains resources from public services and employers and reduces human capital formation

(Istanbul Convention: article 33, 35 and 42)

Gender-based violence and other forms of trauma affect individuals throughout the lifespan, with effects accumulating to impact biopsychosocial functioning across all domains of the socioecological model. We need effective proximal and distal trauma-informed/trauma-responsive interventions for all age groups to prevent and interrupt negative sequelae.

There are many opportunities to intervene; it is better to intervene as proximally to the trauma/GBV as possible, and the younger the better in the life cycle.

Distal intervention is possible but hampered by the development of mental health sequelae, maladaptive coping, concurrent/subsequent adversities/traumas and other challenging life circumstances.

(Sperlich, Logan-Greene & Finucane, 2021)

The Care4Trauma Project

Victims' Rights Strategy 2020-2025 pays particular attention to the specific needs of victims of gender-based violence. In its two-strand approach the EU highlights how one of the main objectives presented in the strategy is the empowering of victims of crime to improve their capabilities of reporting crimes, participate in criminal proceedings, claim compensation and recover, as much as possible, from the consequences of crime.

An approach capable of providing a safe environment and promote a culture of empowerment and understanding for the victims of GBV is an approach which can lead to a more consistent access to justice for traumatized women and to an improvement in the area of reporting GBV, whose real numbers still remain unclear.

Trauma-Informed Care (TIC) is an approach which recognizes the presence of trauma symptoms and acknowledges the role trauma may play in an individual's life. On an organizational level, TIC aims at changing organizational culture to improve the response to the effects of trauma at all levels. TIC has been used to combat the effects of unaddressed trauma and secondary victimization within organizations. Secondary victimization or system-oriented trauma, is a form of re-traumatization which, as also stated by the Victims' Right Strategy, is often faced by GBV victims in the process of receiving support and protection and in accessing the judicial system.

Therefore, the Care4Trauma project aims improving the access to justice of victims of GBV by:

1) strengthening the services for traumatized women provided by victim support organizations
2) encourage the adoption of a trauma informed approach in a larger number of supporting organizations
3) enlarging the understanding of the benefit offered by TIC approach.

Partner Organizations

Name – acronymus	**Country**	**Website**
Associazione MondoDonna - AMD	Italy	http://www.mondodonna.onlus.it
Società Italiana per lo Studio dello Stress Traumatico - SISST	Italy	http://www.sisst.it
Autonomna Zenska Kuca Zagreb - Zene Protiv Nasilja Nad Zenama - AZKZ	Croatia	https://www.azkz.hr
Women's Support and Information Centre NPO - WSIC	Estonia	https://www.naistetugi.ee
Syndesmos Melon Gynaikeion Somateion Irakleioy Kai Nomoy Irakleioy - UWAH	Greece	https://www.kakopoiisi.gr
Asociación Bienestar y Desarrollo - ABD	Spain	https://www.abd.ong

Composition of the Project Scientific Committee

Name	Position	Appointing Partner
Vittoria Ardino *Secretary*	Adjunct professor of *Psychology of emergencies and trauma*, University of Urbino Carlo Bo – SISST President	SISST - *Italy*
Rossella Selmini	Associate professor of *Sociology of law, deviance and social change*, University of Bologna Alma Mater	AMD - *Italy*
Una Mikac	Postdoctoral Researcher on *Psychometrics,* Department of Psychology, University of Zagreb	AZKZ - *Croatia*
Hector Charles Pagan	Higher education teaching professional University of Tartu - Skytte Institute of Political Studies	WSIC - *Estonia*
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Joana Badia	Labor lawyer, consultant and expert in gender discrimination	ABD - *Spain*

Foreword

The purpose of the **Handbook of Practice** was to develop a framework to address Gender-Based Violence with a Trauma-Informed-Lens and with a particular focus on access to justice. Furthermore, the handbook represents the final synthesis of the Care4Trauma Project.

Care4Trauma Project sought to widen the implementation of Trauma-informed approaches in services and institutions supporting women victims of violence. All five project partners – Croatia, Estonia, Greece, Italy and Spain - have initially mapped the level of awareness about GBV- related traumatization into national legal and policy documents to further venturing in assessing the state-of-the- art of Trauma-Informed-Care with key stakeholders and to implementing trainings to raise awareness about the topic.

Partners collected data through surveys and semi-structured interviews with professionals and policy-makers to better identify existing gaps and barriers for the implementation trauma-informed-care with the goal of stimulating the onset of a trauma-informed national policy framework.

All project actors participated in a *Train the Trainer* initiative to structure and disseminate a specific curriculum about trauma and gender-based-violence through capacity building actions.

Trauma -informed approaches are policies and practices that recognize the connections between violence, trauma, negative health outcomes and behaviors. These approaches increase safety, control and resilience for women who are seeking an access to justice and services in relation to their experiences of violence and/or have a history of experiencing violence.

Policies and procedures across countries varied widely and often reflected misunderstandings of the administrative context and complex regulatory environments in which these policies exist.

The Handbook of Practice aims to be a guideline in the provision of trauma-informed processes with the specific goal of enhancing access to justice and to reduce harm to women victims of violence Throughout the Handbook, project partners make the case for the following three facets of an holistic response to Gender-Base-Violence:

a) trauma-informed procedural fairness;
b) trauma-informed practice;
c) harm reduction when women access to justice.

In so doing the system strengthens and reinforces the institutional response and it contributes to healing, learning, and resilience; it reduces long-lasting negative effects of both the GBV itself. Another reflection refers to preventive strategies that require coordinated action across multiple sectors, in which health is one of the most relevant. All women who have been exposed to violence have increased risks of mental and physical health problems, indicating that violence can be considered a social determinant of health. All women who have been exposed to violence should be able to obtain comprehensive and gender-sensitive health services where to address the physical and mental health consequences of their experience and all women should be helped in their recovery from a long-lasting traumatization.

It is also known that cases of GBV are significantly underreported, and new strategies should be evaluated to help women and their children to find safer and welcoming environments to report their experiences of violence. In this context, interesting results have been obtained by providing specific training to healthcare professionals.

Finally, the existence of international protocols and guidelines with clear trauma-informed procedures and the creation of a network of experts involved in the issue of violence both locally and nationally and internationally is crucial for bringing out the phenomenon—mostly underreported and underestimated—and guaranteeing support, listening, acceptance, and protection to women.

Chapter 1
Trauma and Gender-Based-Violence

Violence against women is considered a universal, complex and multidimensional phenomenon that affects all social classes and the economic consequences contribute to high societal costs supporting policy and advocacy efforts for investment in violence prevention and response programming. Existing studies have, in fact, drawn attention to the high financial losses resulting from violence, which are borne by individuals, households, businesses, and societies and by governments. At the individual level, there may be medical expenses to treat injuries caused by violence as well as mental health and legal costs for those who seek these additional services and protections. Household economies may be impacted, for example, by work loss or a need to replace damaged property, in general, and violence-related absenteeism and poor job performance cost businesses and societies. Finally, violence affects the work of governments that have to provide services, such as medical care, possibly diverting resources from other development objectives and from lost tax revenues because of lower household incomes (Vyas et al., 2023)

Women victims of violence describe their emotional responses as mostly those of fear, anger and shame about what has happened to them. With respect to the long-term psychological consequences of violence, victimisation by partners or other persons made victims suffer from a loss of self-confidence, and it left them feeling vulnerable and anxious potentially falling into a process of traumatization.

The United Nations recognized in 1995 that violence against women is an obstacle to achieving the goals of equality, development and peace and violates and impairs the enjoyment of human rights and fundamental freedoms.

1.1 The definition of Gender-Based-Violence

The Council of Europe defines violence as a "*violation of human rights and a form of discrimination against women and shall mean all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life*". Furthermore, the same source defines domestic violence as *"all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has*

shared the same residence with the victim "(Council of Europe, 2011, Art., 3a).

Violence against women is considered a universal, complex and multidimensional phenomenon that affects all social classes (Menéndez, Pérez, & Lorence, 2013). Although there is a widespread mentality of rejecting the justifications for violence throughout the world, it is still a major problem (Pierotti, 2013)

At the Fourth World Conference in Beijing in 1995, the United Nations recognized that violence against women is an obstacle to achieving the goals of equality, development and peace and violates and impairs the enjoyment of human rights and fundamental freedoms. In addition, they broadly define it as a manifestation of historically unequal power relations between women and men (EU Commission, n.d.; World Bank, 2015).

In Europe, most relevant international Law that defines gender-based violence against women and requests adequate measures for its elimination and prevention, as well as for the protection

Definitions of the six forms of gender-based violence used in UniSAFE Survey

Physical violence is any act which causes physical harm as a result of unlawful physical force, e.g. somebody threatened to hurt you physically or pushed you.

Psychological violence is any act which causes psychological harm to an individual, e.g. somebody directed abusive comments towards you, interrupted you or spoke over you.

Economic violence is any act or behaviour which causes economic harm to an individual, e.g. harmed your work/studies through restricting access to financial resources.

Sexual violence is any sexual act performed on an individual without their consent.

Sexual harassment includes unwanted verbal, nonverbal or physical conduct of a sexual nature, such as comments on looks or body, sending of images with sexual content, making sexist jokes or touching you.

Online violence can take many forms, for example, cyberbullying, internet-based sexual abuse, non-consensual distribution of sexual images and text.

of victims of violence, is the Council of Europe Convention on preventing and combating violence against women and domestic violence, adopted in 2011 (henceforth Istanbul Convention).

The interest in the prevention of violence and gender equality is common in all the countries of the European Union (EU-28).

In 2006 the European Institute for Gender Equality, EIGE (European Parliament, 2017) was created, with the goal of collecting, analysing and disseminating information on equality and gender violence.

In 2011, the Council of Europe Convention on the prevention and fight against violence against

women and domestic violence, known as the Istanbul Convention (Council of Europe, 2011) was established. The Article 3 sets out the definition of GV and domestic violence that must be included by all the countries that ratify the Convention.

1.2 Prevalence of Gender Based Violence in Europe

Violence against women and girls is a global pandemic that has or will affect **1 in 3** women in their lifetime (World Bank, 2015). The consequences of violence are diverse, and they range from chronic mental and physical health problems, injuries, exclusion from the labour market, community or other parts of society, poverty, threatened security and even loss of life (see Chapter 3).

The 2014 survey on violence against women (VAW) of the EU Fundamental Rights Agency (FRA) showed that violence against women is a widespread problem in the EU. The report based on interviews with 42,000 women across the 28 Member States of the European Union (EU) showed that violence against women, and specifically gender-based violence that disproportionately affects women, is an extensive human rights abuse that the EU cannot afford to overlook. The survey asked women about their experiences of physical, sexual and psychological violence, including incidents of intimate partner violence ('domestic violence') and also asked about stalking, sexual harassment, and the role played by new technologies in women's experiences of abuse. In addition, it asked about their experiences of violence in childhood. What emerges is a picture of extensive abuse that affects many women's lives, but that is systematically under-reported to the authorities (FRA, 2014).

An estimated of 13 million women in the EU have experienced **physical violence** in the course of 12 months before the survey interviews. This corresponds to 7% of women aged 18–74 years in the EU. Moreover, 3.7 million women have experienced **sexual violence** in the course of 12 months before the survey interviews – corresponding to 2% of women aged 18–74 years in the EU.

Overall, one in three women (33%) has experienced physical and/or sexual violence since she was 15 years old**.** Out of all women who have a (current or previous) partner, 22% have experienced physical and/ or sexual violence by a partner since the age of 15. One third of victims of partner violence (33%) and one quarter of victims of non-partner violence (26 %) contacted either the police or some other organisation, such as a victim support organisation, following the most serious incident of violence. The higher reporting rate for partner violence may reflect a common situation where women have experienced several incidents of violence in a relationship before they decide to report

the most serious incident in an effort to stop the violence from recurring or escalating, whereas non-partner violence is more likely to involve isolated incidents with less risk of reoccurrence. In total, victims reported the most serious incident of partner violence to the police in 14% of cases and the most serious incident of non-partner violence in 13% of cases. For about one quarter of victims, feeling ashamed or embarrassed about what has happened was the reason for not reporting the most serious incident of sexual violence by a partner or a non-partner to the police or any other organisation.

2 in 10 women have experienced physical and/or sexual violence by a partner or a friend

3 in 10 women by a relative or family

10 in 20 women have experienced sexual harassment

At least 2 women are killed everyday by a relative or family in EU

1.3 Definition of trauma

Women victims of violence describe their emotional responses as mostly those of fear, anger and shame about what has happened to them. With respect to the long-term psychological consequences of violence, victimisation by partners or other persons made victims suffer from a loss of self-confidence, and it left them feeling vulnerable and anxious potentially falling into a process of traumatization.

Trauma is part of our human experience as individuals and as a collective. It is the very history of humanity and its evolution. In essence, they are adaptive processes to vital or exceptional circumstances to survive adversity. They are the intelligent response of our brain and our body that, with various strategies, seek to survive. Traumatic events happen to all people, at all ages, and in all socioeconomic strata of our society. These events may cause terror, intense fear, horror, helplessness, and physical reactions. Sometimes the impact of these events does not simply go away when they are over. In contrast, some traumatic events are deep experiences that may change the way women see themselves and the world.

A traumatic event can be a single experience or long-lasting repeated or multiple experiences that completely overwhelm the individual's ability to cope with or integrate the thoughts and emotions involved in that experience. Trauma and identity are interrelated because trauma is fixed in memory as an organized experience part of personal identity, depending on the social, historical, and cultural context, incidence, intensity, and form of expression.

Finally, although we have the perception that trauma is something personal, from a wider systemic perspective, there are transgenerational and collective traumas; they are the shared ground of the adaptive experiences of our ancestors that are also inscribed in the biological basis. They are different dimensions of human experience related to each other, although, as we will see later, they present different languages and dynamics.

Definition of trauma with a trauma-informed lens

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma as “an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life threatening with lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being” (SAMHSA, 2014). Such a definition expands the definition of trauma provided by Official Diagnostics Manual and shifts the focus on subjective experiences.

The **event** refers to a significant adverse episode or trauma exposure as a witness. **Circumstances** may include the fact or threat of extreme physical or psychological harm (i.e., natural disasters, violence, etc.) or significant neglect that puts a child's life at risk or threatens healthy development. These events and circumstances may occur as a single occurrence or frequently. Finally, the **experience** represents the individual's subjective experience determines if it is a traumatic event.

A particular episode may be experienced as traumatic for one individual and not for another. Trauma does not occur in the event itself, but because of the impact the event and its circumstances have on a person's life and the emotional and physical response it generates. How it "makes sense" of the story behind what happened.

The lasting effects of the event are a critical component of trauma. These side effects may occur immediately or may have a delayed onset. The duration of effects can be short to long term. In some situations, the person may not recognize the connection between the traumatic events and the consequences. Examples of adverse effects include the inability to cope with the everyday stresses and strains of daily life, managing cognitive processes, such as memory, attention and thought, regulating behavior, or control the expression of emotion

1.4 The impact of trauma on women victims of violence

The associations between sexual victimization and adverse psychological outcomes have been well documented. Experiencing gender-based-violence may increase the risk of onset of mental health disorders (Dillon, Hussain, Loxton, & Rahman, 2013; Sugg, 2015; Thurston & Miller, 2019). Short-term effects include feelings of shock, disbelief, confusion, shame, guilt, self-blame, withdrawal, flashbacks of the assault, and insomnia (Basile & Smith, 2011; CDC, 2019). Reports of emotional numbness, hypervigilance and avoidance of reminders of the event, as well as disruptions to daily routines, are also common (Koss et al., 1994). Frequently, survivors report intense fear of the perpetrator, fears related to another attack, and suffer anxiety regarding issues related to disclosure (Basile & Smith, 2011). Of great concern are the negative changes in world view reported by survivors and the effect these negative shifts in belief systems have on survivors' subsequent experiences (Basile & Smith, 2011).

National data and meta-analyses suggest that victims of violence are at increased risk for the development of numerous long-term adverse psychological outcomes, including posttraumatic stress disorder (PTSD), depression, generalized anxiety disorder, substance use disorders, eating disorders, sleep disorders, anxiety disorders, and suicide attempts, regardless of the age of the victim at the time of the assault (Chen et

al., 2010; Sarkar & Sarkar, 2005; Zinzow et al., 2012).

There is evidence that the development of some psychiatric disorders, including depression and PTSD, may vary according to circumstances surrounding the violence; for example, the type of coercion or rape tactic the victim experienced (Basile & Smith, 2011). Violence tactics refer to the methods a perpetrator uses to coerce a victim into engagement in or exposure to a behavior (Basile et al., 2014). As for trauma-related syndromes, that appear to be the most common mental health problem that female survivors of violencemay develop. An important factor that may facilitate the onset or aggravation of PTSD symptoms is the severity of the violence experienced (Lagdon, Armour, & Stringer, 2014).

By utilizing SAMSHA's (2016; 2017) trauma-informed care framework and feminist theory, clinicians are afforded a comprehensive approach in understanding of the impact of trauma on women's overall health and how best to help them deal with the aftermath. Many of the hallmark concepts of feminist theory are encapsulated within SAMSHA's trauma framework. SAMSHA's six principles of trauma-informed care include: 1. Safety; 2. Trustworthiness and Transparency; 3. Peer Support; 4. Collaboration and Mutuality; 5. Empowerment, Voice and Choice; and 6. Cultural, Historical, and Gender Issues (SAMHSA, 2017) (*please see the following chapters in this Handbook*).

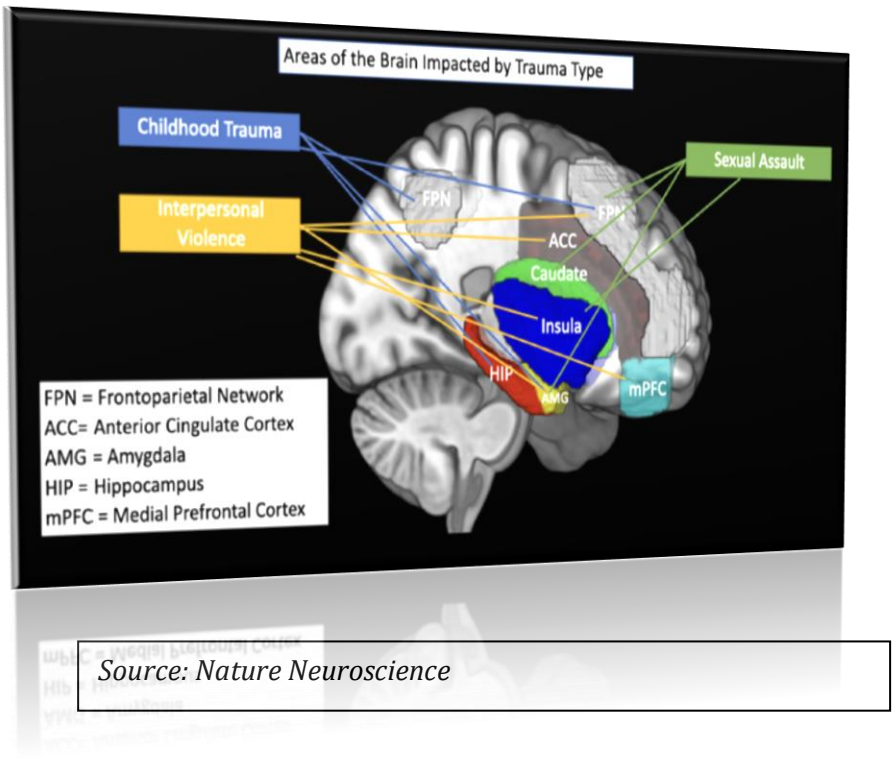
Trauma-Related Syndromes

Post-Traumatic Stress Syndrome (PTSD) refer to the set of symptoms (what the person reports feeling) plus the set of signs (what is observable) after exposure to an unexpected event, out of control and for which the person is not prepared. Some scientists affirm that PTSD is not a disorder in itself, but – within a trauma-informed perspective – it should be considered a rearrangement of neural networks and sensory patterns to survive a situation that the nervous system has assessed as dangerous for survival and whose responses has been activated to protect the system. It is important to emphasize that not all women exposed to the same trauma can develop PTSD: it will depend on genetic and environmental factors, previous experiences of safety, and emotional and cognitive resources.

Neurophysiological responses of violence-related trauma

A neurobiological perspective to understand the impact of trauma enable the recognition of how trauma affects the brain and nervous system, and explains the psychological and physical implications of trauma that can influence how a woman experiences, responds to the process of care and access to justice (Haskell & Randall, 2019; Peña, 2019). This

can help to contextualize seemingly contradictory behaviours and responses that complainants may exhibit (Smith, 2017). Incorporating this knowledge into complaints process policies, procedures, and practices allows for investigators and other decision-makers to avoid assumptions, biases, and discriminatory stereotypes that impede fact-finding and fair decision-making.



Source: Nature Neuroscience

Human brain is formed by three systems that respond to the evolution of the human brain. The most instinctive, the reptilian brain seeks to survive, and its response mode is binary: it activates for defense, attack, or disconnect. Phylogenetically, then comes the limbic system, the amygdala, and the hippocampus, linked to emotions and memory, and, more recently, the neocortex whose predominant functions are reasoning, planning in time, organization, and modulation of impulses. Trauma affects the three systems in different ways; when they face the traumatic stimulus, the outcome is an adaptive socio-emotional answer to an experience that the brain has perceived as an emergency and risk. The activated responses may differ throughout the process; they are not voluntary and depend mainly on each person's structure, history, and character. Negative feelings or feelings of being overwhelmed or upset, on their own do not constitute trauma. It is the unique partnering of these feelings with a loss of control and (perceived) threat to security or survival that creates trauma.

A woman may have PTSD if they “have experienced a shocking, scary, or dangerous event” and they do not “recover from initial symptoms naturally” (National Institute of Mental Health, n.d.).

There are four characteristics of PTSD:

1. flashbacks or persistent intrusive thoughts about the traumatic event;
2. avoidance of anything related to the event (e.g. music, pictures, people, locations, etc.);
3. negative thoughts leading to behaviours such as emotional numbing, addiction, detachment or disassociation;
4. increased or decreased arousal or reactivity, such as hyper- or hypovigilance, exaggerated startle response, irritability or outbursts of anger (Peña, 2019)

Where a person experiences "repeated trauma over months or years, rather than a single event" they may develop Complex PTSD (C-PTSD). C-PTSD can manifest in lack of emotional regulation, changes in consciousness, negative self-perception, difficulty with relationships, distorted perceptions of an abuser or person causing harm, and loss in system of meaning (Gilles, 2018).

When a person experiences trauma they may also have a subconscious or autonomic response with or without experiencing conscious feelings of fear. At the subconscious level, a person's protection mechanisms or "defence circuitry" are triggered, which results in a chain of automatic physiological and behavioural responses (Haskell & Randall, 2019).

Having a basic understanding of how the defence circuitry works provides the necessary context for identifying some of the common signs, symptoms, and responses to trauma. "The defence circuity dominates brain functioning once activated" (Haskell & Randall, 2019), releasing a flood of chemicals and hormones and triggering the body's fight, flight, or freeze response (Smith, 2017). This response is automatic and not a conscious decision by the person, which is why it may not align with how we might expect a person to act when analyzed outside the trauma context. The release of stress hormones impairs the brain's prefrontal cortex, the part of the brain in charge of executive functioning, managing reason, logic, problem-solving, planning and memory. This makes it difficult for a person who is under stress to respond rationally or in expected ways.

Understanding these complex yet common psychological and neurologically based responses to traumatic and threatening experiences such as sexual assault helps to explain why some women victims of violence don't exhibit "fighting back," "yelling," "escaping," or taking some other kind of expected action for which they are later judged or blamed (Haskell & Randall, 2019, p. 15)

The effect of trauma on the brain has implications for how an individual will behave. It is important to be cognizant of a complainant's possible experience of trauma and recognize that they may be exhibiting trauma response behaviours rather than assuming that they are acting irrationally or at odds with how you might expect a person who has been subjected to GBV to act.

Some behaviours that a person who has experienced trauma may display include, but are not limited to:

- poor mental health, including anxiety and depression
- anger (at self or others)
- unhealthy relationship formation
- denial
- poor academic performance
- avoidant behaviours
- risky sexual behaviours
- self-medication through drug and/or alcohol abuse
- disordered eating (Haskell & Randall, 2019; Katz & Halder, 2016; McCauley, 2015)

A person who has experienced trauma may also behave in seemingly "counterintuitive" ways as a result of the ways the brain's defence circuitry impacts executive functioning and decision-making (Haskell & Randall, 2019). For example, they may freeze while experiencing the violence, begin or continue a relationship with the person who caused them harm, or engage in risky sexual behaviours. Without an understanding of how trauma influences a person's behaviour, these behaviours may reinforce common but inaccurate myths and stereotypes about survivors of GBV.

Traumatic memories

Trauma also has a significant impact on a woman's memory. "Traumatic events such as Gender-Based-Violence are encoded (converted) differently than more routine, everyday experiences in life" (Haskell & Randall, 2019) which has significant implications in a complaints process where memories of the events are often relied on for evidence.

Understanding how memory is affected by trauma can support more accurate information gathering by allowing investigators and other decision-makers to ask questions in a way that supports a person who has experienced trauma to access more complete and accurate memories. Like behaviour, the defence circuitry plays an important role in how a person encodes, stores, and accesses their memories. When a

person is experiencing trauma, their brain registers a threat, which triggers “bottom-up attention”: surviving the threat becomes the dominant focus; any details that the brain does not identify as important to survival in the moment do not receive attention from the brain, meaning there is less chance that it will be accurately encoded and stored (Wilson et al., 2016). Those details central to survival may not be the same details when women access to justice are asked for, making the collection of reliable evidence challenging in the absence of a trauma-informed approach.

Traumatic memories are typically focused on sensory information, rather than information about the order of events or time period (Haskell & Randall, 2019). New information that is captured at this time is encoded in fragments, sometimes without contextual and sequential details. The brain then turns away from encoding to consolidate the information, which limits its ability to encode new information (Wilson et al., 2016). Given the challenges inherent in encoding information during a traumatic event, how a person recalls that event is also impacted by trauma. If the person is experiencing stress when they are asked about the event, they will have a more difficult time recalling information (Haskell & Randall, 2019). This has implications for how information is best collected by the justice, health and social care systems.

A strictly neurobiological approach, however, offers an incomplete understanding of trauma and its impacts, risks pathologizing and individualizing what may be better understood as structural violence, and does not allow for the human rights aspect of GBV complaints, all of which undermine the ability to gather the most complete information without bias.

How a person experiences and responds to trauma will be influenced by individual and social contexts (Katz & Haldar, 2016). A person’s past experiences, worldview, and position in society, along with social, cultural, institutional, and historical contexts, will shape their behaviour and must be recognized to avoid bias rooted in misunderstanding, stereotyping, or discriminatory beliefs. It is necessary to understand that a person’s behaviour may be shaped by the trauma of the GBV experience as well as their past experiences – this can include previous experiences of GBV; a history of trauma experiences; and/or childhood GBV, abuse, or neglect – and the ongoing systemic oppression upheld by institutions and inflicted on individuals and communities.

This requires a race and gender analysis, recognizing systemic and societal violence that is inseparable from the violence that, particularly, women coming from certain areas of the world, are subjected to (Garnett, 2016).

The body's adaptive response to trauma

The human body can cope or maintain stability during changes and excessive exposure to stress and/or traumatic events such as GBV. This body's adaptive response can occur through complex neuronal, neuroendocrine, and immune responses (Durik et al., 2006). It is nonspecific as, whatever the nature of the stressor, the mechanism triggered is always the same. The threat evokes a physical and emotional reaction (also known as fight or flight); the sympathetic nervous system (SNS), the hypothalamic–pituitary–adrenal (HPA) axis, and the cardiovascular system are activated and these, in turn, affect the immune system. When the danger is perceived as overcome, the parasympathetic nervous system (PSNS) acts to return to a state of normal basal equilibrium. Prolonged exposure to trauma, such as violence or painful memories, can prevent the body's adaptive response from switching off.

When the trauma pain is deep and its impact persists, increased production of stress hormones can wear down the body, keeping it in an unstable or weakened state. When this happens, the body is more susceptible to adverse health conditions such as cardiovascular disease, chronic pain, pregnancy complications, PTSD, and anxiety.

The inability to minimize or stop adaptive response activity can lead to serious long-term health consequences (see box).

Gender-based violence has long-term health effects

Among the long-term effects, victims of violence are at high risk of many physical diseases:

- Asthma
- Irritable bowel syndrome, frequent
- Headaches, chronic pain, diabetes
- greater odds of cervical cancer
- sexually transmitted infection such as human papilloma virus
- higher risk of noncommunicable diseases
- Mental health problems:
    - chronic mental illness
    - post-traumatic stress disorder (PTSD), depression, anxiety
    - alcohol and drug abuse, smoking, eating disorders.

The social context and social determinant of health

Women who grow up and live in environments with limited social, educational, and economic opportunities, in addition to being at greater risk of multiple forms of violence,

have fewer opportunities to access the process of healing and recovery.

GBV has immediate and long-term health effects, but socioeconomic factors can influence (and in some cases worsen) the health outcomes of specific groups of people based on their social position. Social and economic factors between countries and within the same country, in addition to put women at greater risk of multiple forms of violence, can determine the unequal treatment of women victims of violence where women belonging to less advantaged people may not have adequate psychological and health support for the recovery and/or treatment of trauma.

Health is the result of multiple factors or determinants of health that significantly influence health, whether positive or negative. In addition to biological characteristics, social factors are just as important to health outcomes and the likelihood of generating diseases.

WHO defines social determinants of health (SDH) as “the conditions in which people are born, grow, live, work, and age SDH perspective is based on all factors that can make people healthy or not healthy, including education, income, labor market position, ethnicity, and gender bias (Marmot, 2003).

Extensive research has shown that people who are less advantaged in terms of socioeconomic position have worse health (and shorter lives) than those who are more advantaged. Disparities in social, educational, and economic opportunities are the fundamental cause of health inequalities. Health inequalities are widely recognized as a public health problem as they determine a significant share of potentially avoidable mortality and morbidity. The 2008 report of the WHO Commission on Social Determinants of Health (CSDH) “*Closing the gap in a generation”* provided a comprehensive synthesis of knowledge and evidence on health inequalities and a set of recommendations to develop comprehensive and integrated policies to contrast them (WHO, 2008).

Women who are less advantaged in terms of socioeconomic position and/or living in contexts where GBV victims are not supported by recovery interventions often face GBV trauma by using drugs, drinking alcohol, smoking, or overeating, further worsening their health condition.

Chapter 2

Access to Justice for Women victims of violence

Justice is an ideal but women have a range of cultural and rights expectances as it collectively desired but individually experienced and it represents an ethical restoration. Access to justice has come to mean an approach that is concerned with ensuring "that legal and judicial outcomes are themselves 'just and equitable', with a greater emphasis on reforming the justice institutions themselves "in order to simplify them and to facilitate access to them." The concept of 'access to justice' is not limited to the efficiency of the justice system. It encompasses processes to ensure that the whole system is sensitive and responsive to the needs and realities of both women and men and empowers them throughout the justice chain.

The Council of Europe has underscored the fact that access to justice has a gender dimension. Violations of women's rights themselves impede gender equality, but when women are denied access to justice to remedy human rights violations, they are also denied.

2.1. The view of current legislation about trauma informed care and access to justice

Care4Trauma Project provided an initial analysis of all partner countries exploring how national legislation included trauma-informed approaches to favor access to justice. All national reports highlighted the need to define in a more precise way the process of traumatization; furthermore, all the analyzed documents did not refer systematically to trauma-informed-principles.

Overall, current legislation and best-practices propose a victim's rights approach, with a particular concern for the detection, intervention, and healing of women victims of violence. Furthermore, the intentions of policy-makers was gradually more focused on a solid and coherent framework consistent with international recommendations for Gender-Based-Violence.

There is an underlying concern regarding the effects and consequences of GBV, not only for the women but also for their children. who are, directly or indirectly, exposed to this type of violence in their family environment. Nonetheless, there is a lack of a systemic perspective to integrate trauma and violence within a TIC framework to propose more

effective legal and policy guidelines to prevent and empower women survivors of violence.

Current legislation gaps are mirrored in the perception of key stakeholders (professionals working with women victims of violence). All stakeholders provided insights about key actions to favour the implementation of Trauma-Informed-Care in services, institutions and other organizations working with women victims of violence.

In general, participants highlighted the need of focusing on quality training programmes that should be trans-sectorial and multidisciplinary. More specifically, they envisioned the importance of training as a tool to contaminate institutions and services with TIC principles. A key issue was the aspect of sustainability; in other words, according to participants "one shot" trainings are not useful to produce stable changes. A "continuous professional development" approach was crucial to support the community of practice over time. In terms of actions they suggested multi professional labs to reflect upon case illustrations to develop a common understanding and language and to achieve more role awareness; for example, in Italy the Anti-violence educator is not well defined. Working in multi-professional labs could help in this direction.

Stakeholders are particularly concerned with the two principles of *Safety and re-traumatization b*ecause they foresee the importance of their implementation to favor access to justice Related to the aforementioned principles, stakeholders envisioned the need of *empowering women* by recognizing individual differences in processing their experiences and by facilitating information collection only once so that women are not in the position of repeating for many times their experience of violence. Empowering women means to welcome all their emotions and to create a relationship with them.

Furthermore, institutions should be more careful about the social portray they are keen to disclose as this could have a strong impact in terms of how trauma-informed is the system of care. In terms of actions, a specific communicative strategy should be implemented to address properly how violence is represented. Services should be more trauma-aware and sharing a similar methodology to address the issues women bring to their attention (see chapter 3)

2.2 Barriers to justice

Women face persistent inequalities in both national and international legal systems. Some of the obstacles that women face in accessing justice are not specific to their sex but are experienced by groups of people who are marginalized, "who are particularly subject to discrimination and [who are] also less likely to know their rights and existing remedies".

Justice systems tend to reflect the power imbalances inherent in any society, and they "reinforce the privilege and the interests of the powerful, whether on the basis of economic class, ethnicity, race, religion or gender" (UN Women, 2011). Because women do not hold the same power and privilege as men, they do not have the same protection of the law. Other barriers to justice, however, impact women exclusively. Women encounter obstacles with respect to access to justice within and outside the legal system. In order to better understand the barriers that women face, it can be useful to divide them into those of a legal/ institutional nature and those of a socio-economic and cultural nature.

Gender stereotypes at the cultural level also appear and have an impact at the institutional level. Attitudes and norms about what can be considered 'appropriate' for women and men may act as a deterrent to women seeking justice (see box).

At the legislative level, barriers are created by discriminatory provisions in legislation. For example, in some countries, including those in the Eastern Partnership, women are legally excluded from certain forms of work based on stereotypical assumptions about the characteristics and roles of women.

TYPES OF OBSTACLES TO WOMEN'S ACCESS TO JUSTICE
1. The legal/institutional level
Discriminatory or insensitive legal frameworks (including: legal provisions that are explicitly discriminatory; gender blind provisions that do not take into account women's social position; gaps in legislation concerning issues that disproportionately affect women)
Problematic interpretation and implementation of the law
Ineffective or problematic legal procedure (the lack of gender-sensitive procedures in the legal system)
Poor accountability mechanisms (this category can include corruption)
Under-representation of women among legal professionals
Gender stereotyping and bias by justice actors
2. The socio-economic and cultural levels
Lack of awareness of one's legal rights and legal procedures or of how to access legal aid (which can stem from gender differences in educational levels, access to information, etc.)
Lack of financial resources (including the means to pay for legal representation, legal fees, judicial taxes, transportation to courts, child care, etc.)
Unequal distribution of tasks within the family
Gender stereotypes and cultural attitudes

The definition of certain crimes may also be problematic, such as the case of rape in which one of the elements is force rather than consent. While one way to address these problems is to amend the laws, the judiciary can also contribute to dismantling these barriers.

One of the major barriers to access to justice for women is discriminatory or gender insensitive interpretation of laws. An example of gender insensitive interpretation of law is the insistence on requirements of proportionality and immediacy in interpreting self-defense in proceedings for the murder of a violent partner, without taking into account the specificities of the offenders' behavior or past experience as a former victim of domestic violence. Further, the best interest of the child in the context of custody proceedings is often interpreted as to require contact between a parent and a child, even when there is a history of domestic violence against the partner, and indirectly the child.

Gender-insensitive legal procedures are another major obstacle for women to access justice. First, it is questionable how responsive the institutional and conceptual settings of justice systems are to women, particularly to the victims/survivors of gender-based violence.

Criminal proceedings are often extremely traumatizing for victims, whose characters and behaviors are frequently scrutinized with reference to stereotypical assumptions about the 'ideal victim,' whereas victims of other crimes, including inter-personal violence, are not subjected to the same type of examination. **Not all jurisdictions have legal provisions aimed at minimizing trauma and protecting the privacy of victims of gender-based violence**. Proceedings are often lengthy, which not only prolongs the trauma, but can have financial implications and may clash with women's childcare responsibilities. Hence, in order to comply with international standards on non-discrimination and access to justice, states should ensure that proceedings are handled in a gender-sensitive manner whereby victims and witnesses are protected from harassment, and women's voices are given weight.

2.3 A trauma-informed perspective

Provision of a trauma-informed perspective to access to justice requires the ability of women to receive from justice systems viable protection and meaningful redress for any harm that they may suffer.

Justice systems should be contextualized, dynamic, participatory, open to innovative practical measures, gender-sensitive, and take account of the increasing demands for justice by women. A trauma-informed lens requires that all justice systems are secure, affordable and physically accessible to women, and they are adapted and appropriate to the needs of women, including those who face intersectional or compounded forms of discrimination. As already

illustrated in the previous chapter, women victims of may be in shock and are generally under stress. Some will have experienced severe trauma. They may well find it difficult to sleep and to concentrate. All of these emotional and psychological reactions can impact how a victim interacts with the justice system and her ability to make decisions about her case.

There is no 'typical' victim, and each person has different coping mechanisms. Some victims are very emotional (they may cry during interviews or in court) while others appear ambivalent or detached. Victims can seem to be uncooperative, but others may be active and engaged in legal proceedings. No assumptions should be based on how the victim behaves. Her apparent ambivalence should not be interpreted to mean that the incident did not take place or the case is not serious. Nor should a victim's engagement in legal proceedings be taken to mean she is 'too eager' and is trying to gain something for herself.

It is also necessary to remind that a fair number of violence victims will have had previous negative experiences dealing with the law enforcement and justice systems. For example, it is not an uncommon situation for a victim to have reported incidents previously, but the police did not take any action. Or a protective order could have been issued, but the perpetrator was not prosecuted for violating the terms of the orders. Prosecutors and judges should not be surprised if victims appear distrustful and skeptical of the legal system or have low expectations about the assistance they will receive from the state. It is the role of legal professionals to assure the victim that they State will provide an effective remedy.

Victims should not be viewed as passive.

Most are resilient and have found ways to keep themselves and their children safe. Justice professionals must understand that when a victim stays with a perpetrator of violence, this is a coping mechanism. Victims face a very high risk of repeated violence when they attempt to end the relationship and this, as well as other important factors (such as financial or other dependency on the perpetrator, pressure from family and the community, feelings of shame, stigmatization etc.) are powerful motivators for women to remain in abusive relationships and not to report incidents of violence. In fact, victims tend to report violence when it is most severe and they feel most in danger.

Victims are also the most likely to cooperate in criminal prosecutions when they feel that they are safe, their children and other family members are safe, and they are not at risk from further abuse from the perpetrator. Perpetrators of domestic violence can be manipulative both in and out of court (for example, by delaying court dates, intimidating the victim/witness in court). In fact, this is the tactic they employ in order to manipulate the victim. Perpetrators use violence

to exercise power and control over the victim and thus violence will often increase in severity and intensity once a case enters the legal system, in an effort to regain control. When in court, the perpetrator may appear calm and reasonable. Neighbors who serve as witnesses often report that perpetrators "seem nice" or calm. Legal professionals must rely on accepted criteria to assess risk, such as evidence of prior abusive behavior, evidence about the severity of the violence, abuse of drugs or alcohol, etc.

Victim safety is an utmost concern in cases of VAW, but safety measures should also be given consideration in civil cases that are especially contentious, such as family disputes or employment discrimination claims. In civil cases, safety refers not only to the risk of physical violence but also to protection of the plaintiff from harassment, threats, hostile reactions and even potential secondary victimization during investigation and trial processes (for example, subjecting women to repeated and intrusive questioning, pressuring women to drop cases or reconcile with violent partners, etc.). Safety precautions can be categorized as immediate measures and on-going processes that improve the overall management of cases in which women are in high risk situations. Prosecutor and judges should not be afraid to express empathy to the victim and to demonstrate an understanding of the trauma she has endured. It is possible to express such empathy without violating obligations to remain impartial by not commenting on the merits of a case. Instead prosecutors and judges demonstrate empathy by explaining that efforts will be made to minimize trauma and delays in the proceedings and to ensure her safety

Justice actors should refrain from assessing the credibility of a victim on the basis of how emotionally expressive she appears to be when testifying. The assessment of a victim's evidence should not be guided by stereotypical expectations of victim behavior. Judges and prosecutors should remember that victims may have a range of reactions to the investigative and judicial process, and so the victim's demeanor in the courtroom needs to be assessed with this consideration in mind.

Understanding of the dynamics of gender-based violence is imperative when children are involved, as is very often the case with incidents of domestic violence. Prosecutors and judges should not assume that because children were not directly physically harmed by the abuser that they were not also victimized or that they are not at risk for violence in the future. As noted, there is a heightened level of danger when domestic violence cases come before the legal system, and perpetrators may intensify the violence or direct the abuse towards the children. Legal practitioners must be skilled in carefully weighing the risks of violence against the best interest of the child and also the parental rights of both parties.

CEDAW Committee (2015) outlined interrelated components that are essential in establishing functional justice systems that implement women's rights:

1. Justiciability
    - Unhindered access by women to justice.
    - Women's ability and empowerment to claim their rights as legal entitlements. The prevention of, and response to GBV, requires coordinated action across multiple sectors, in which health is one of the most relevant. All women who have been exposed to violence have increased risks of getting sick, indicating that violence can be considered a social determinant of health. All women who have been exposed to violence should be able to obtain comprehensive and gender-sensitive health services. All women should be able to address the physical and mental health consequences of their experience and all women should be helped in their recovery from the traumatic event. GBV is a multicausal problem influenced by social, economic, cultural, psychological, legal, and biological factors. Particular attention should be given to interventions for the assistance of GBV victims within each country to avoid that the unequal distribution of economic, social, and environmental conditions could penalize less advantaged women in society.
2. Availability
    - Establishment and maintenance of Courts and all quasi-judicial bodies in urban, rural and other areas.
3. Accessibility
    - All justice systems must be secure, affordable and physically accessible to women.
    - All justice systems must be adapted to the needs of women, including those subjected to intersectional or compounded discrimination.
4. Good quality
    - International standards of competency, efficiency, independence and impartiality must be met.
    - Justice systems must be contextualized, dynamic, participatory, open to innovation and gender sensitive.
5. Access to remedies
    - Appropriate and effective remedies, including protection from and meaningful redress to the harm suffered, must be provided and enforced in a timely manner.

6. Accountability
    - Monitoring of the justice system, including justice system officials, must be undertaken in accordance with the other assessment outlined above and ensure the legal responsibility of any justice system officials when they violate the law.

Alongside the above recommendations, a specific focus on the understanding trauma of women subjected to violence should be central to the justice system according to the European Agency for Fundamental Rights: *"Police officers and other authorities who intervene in cases of intimate partner violence against women need to understand the impact that living in a violent relationship has on the mindset and mental status of victims. For example, a victim may refuse intervention by the police or support services. Lack of understanding of these situations can add to a victim's trauma instead of supporting the victim to overcome the consequences of victimization. It is suggested that EU Member States ensure that police officers and others – ranging from lawyers and judges to victim support services – are trained to understand the consequences of partner violence, and accompanying abusive and controlling behavior, on the mindset and reactions of victims."* (FRA, 2014).

2.4 Trauma-informed court practices

A trauma-informed court practice enables all parties and witnesses to participate in civil and criminal legal proceedings. Knowing about trauma and how it affects people will help courts respond to reasonable requests of accommodations for participation in legal proceedings and determine credibility of parties and witnesses more accurately.
Judges and prosecutors should remember that victims may have a range of reactions even to judicial process.

The trauma that people experienced can affect the outcome of their cases in two key ways:

1. **Participation in legal proceedings** can be difficult for victims and witnesses who have experienced trauma, because they can be easily reminded of the crime by seeing the people, pictures of the places or scenes of the incidents of violence. This can bring up the feelings and sensations associated with those traumatic events, which can cause a literal re-experiencing of the incident. This kind of re-experiencing may cause feelings of panic, anger, disorientation, physical pain, grief, or numbing and shutting down. These traumatic reminders are referred to as "**triggers**" and these triggers during a court proceeding can disrupt the victim and witness testimony, cross examination or make it too hard for them to participate at all. Lawyers and legal

advocates find legal proceedings compromised or interrupted when their client and witnesses are triggered. In many cases the trigger can lead the victim or witness to recant or change their testimony. Moreover, hearings give the opposing party the opportunity to exploit a victim's or witnesses' mental state to gain an advantage in the courtroom. This can make a participation very challenging.

2. **Credibility determinations** are often made in legal proceedings without recognizing the impact of trauma on victims and witnesses. Judges and juries determine whether a person is truthful based on that adjudicator's sense of what a reasonable person can remember, or how they believe a client should look or sound when testifying about life threatening events. However, **traumatic events can alter the way a person thinks, talks and even remembers an incident**, which is in conflict with the linear, logical manner a judge or jury expects, and can leave judges and juries finding it hard to believe a client that is showing some signs of trauma. Rather than discounting victims or witnesses as unbelievable, judges knowledgeable about the after-effects of trauma will see these symptoms of the trauma itself.

Moral pain and injustice are relevant dimensions of trauma.

One of the predominant feelings in the victim is the **lack of security** and support against the feeling of vulnerability. It is the law, through justice, that can provide a security structure through which correct human relationships can be restored and trauma transcended. Trauma damages personal identity, and one of the deepest pains of the victims is the violation of their dignity.

Justice has an essential role through ethical restoration. The elementary fact of reestablishing what is fair in a given situation reconnects the victim with his identity and sense of dignity. It affects his environment and community, thus reestablishing the natural flow of the human rights experience as protection of life.

Chapter 3

Defining Trauma-Informed-Approaches in Gender-Based-Violence

The *trauma informed* approach is an emerging transdisciplinary field and recognizes how violence and trauma are connected and requires attention to the signs and symptoms of trauma. A trauma-informed lens must be applied to all policies, procedures, and practices to avoid re-traumatization and mitigate harm to any person engaged in the system.
Health and social care and the justice systems should integrate their tools in a trauma-informed way to reflect on trauma, emotions, regulation systems, and trauma integration processes.
This approach requires an organizational change process that focuses on principles to promote healing and reduce the risk for re-traumatization for vulnerable people, including GBV victims.

3.1 Defining a Trauma-Informed-Approach (TIA)

This model of complex approach is born from the meeting of different disciplines that, in their dialogue, build bridges to understand trauma in its complexity and point out human-centered approaches and trauma integration. New disciplines, such as neurosciences, provide valuable knowledge to understand the map of trauma in the human brain, its socio-emotional responses to the traumatic event, and its consequences in the medium and long term.
A trauma-informed approach should be implemented in institutions by taking into account the need for:

1. Providing human services and institutional contexts that recognize and understand the impact of trauma and its consequences.
2. Reassessing, considering and integrating the understanding of violence, abuse, and mistreatment in the lives of victims, perpetrators, and the community itself in all institutional instances.
3. Having appropriate referral systems for evidence-based and culturally sensitive assessments and treatment for post-traumatic stress
4. Maintaining work environments for staff that increase their resilience and address, reduce and treat secondary or indirect traumatic stress.
5. Considering the physical and psychological safety of victims and professionals.

6. Avoiding practices that can re-traumatize youth and their families.
7. Evaluating, monitoring, and modifying potentially stressful judicial procedures.
8. Activating alert systems to recognize when the experience of the judicial process can be traumatic.
9. Establishing clear institutional frameworks about the limits of professional conduct, including confidentiality and ethical considerations, as well as strategic case planning.
10. Providing adequate frameworks for intra-institutional operations with protocols and good practice guides.
11. Having monitoring and supervision instances.
12. Establishing practical interinstitutional articulations frequently evaluated and updated.
13. Allocating roles and responsibilities within the organization chart, with the careful distribution of the workload of direct assistance to victims.
14. Providing institutional support to professionals and agents through an adequate supply of logistics supplies and psychosocial support.
15. Including specialized professional human resources, adequate techno- logy, and facilities to take the victim's testimony only once and in a safe environment.
16. Promoting and planning vertical interdisciplinary articulation within the organization and horizontally with other institutions and manage the flow of information between them.
17. Monitoring and assessing the Trauma-informed decision-making process.
18. Access to services related to traumatic stress, specifically in youth, must be offered to reduce inequity. Some young people may have specific needs related to their gender and sexual orientation and need careful interventions not stigmatizing.

In the policy arena, a trauma-informed approach recognizes how violence and trauma are connected and requires attention to the signs and symptoms of trauma – specifically acknowledging how it can impact behavior, communication, and memory (Khan, Rowe & Bidgood, 2019; American College Health Association, 2020). It is an approach to processes, procedures, and service provision that understands and responds to the impact of trauma (Ardino, 2022).

3.2 Trauma-informed Approach: access to justice for GBV victims

Although the physical and mental impact of GBV both generally and in specified forms

has been well documented (Heise et al., 2002), many women choose not to disclose or seek help for their GBV experiences (Fugate et al., 2005; Saint Arnault & O'Halloran, 2016). For example, in a multinational survey of 42,000 women across 28 European Union Member States, it was found that help-seeking rates for GBV ranged from 4-27% depending on the country (European Union Agency for Fundamental Rights, 2014). Reasons why survivors were not seeking help from formal resources included the perception that violence was "normal/not serious," feeling burdened by their symptoms, emotional investment in the relationship, protecting the children, and shame (Fugate et al., 2005; Murray, Crowe, & Overstreet, 2018; Saint Arnault & O'Halloran, 2016). Other reasons included believing they should "deal with it alone," feeling frozen, and feeling internalized stigma, manifesting as feelings of weakness, helplessness, or blame (Fugate et al., 2005; Murray et al., 2015; Saint Arnault & O'Halloran, 2016). Internalized barriers such as previously mentioned can cause an increased symptom burden, inhibiting the help-seeking and recovery process (*see the previous chapter of this Handbook*). The ongoing and chronic traumatization is often at the core of the aforementioned issues having, as a consequence, an enormous cost in human, social, and economic suffering bringing with them multiple legal interventions and massive loss of social capital.

For this reason, the system of care and the justice system are called to recognize the signs and symptoms that indicate that a woman may have experienced trauma with the understanding that trauma is only equivalent to an experience and not a diagnosis. Such a framework would help women GBV victims to deal more effectively with stressful court proceedings and to recognize when they may be having a traumatic reaction. Furthermore, such a framework could make available interventions that are not re-traumatizing and to count the trauma in the person's cultural environment and help make sense of the process women are going through enabling them to feel in control and safe, minimizing the risk of re-traumatization, when in contact with the judicial system.

Both the health and social care and the justice systems should, therefore, integrate new tools to reflect on trauma, emotions, regulation systems, and trauma integration processes.

Furthermore, there should be a focus on self-care and that of professional teams that work with trauma to prevent the effects of secondary trauma.

Reframe the understanding of women experience within a trauma-informed approach

Trauma-informed practices are increasingly being recognized as essential elements when addressing and responding to gender-based violence (GBV). There is a multitude

of frameworks for defining trauma-informed practice based on established and emerging research, as well as promising practices from those who engage in GBV response and investigation work.

Each framework defines its own principles for trauma-informed practice, and all overlap under the following two overarching themes applicable to health and social care and justice systems initiatives and strategies:

1. Knowledge of trauma and its impacts must be integrated into all policies, procedures, and practices to support procedural fairness, allow for evidence to be collected in a fair and impartial manner, and fair and just outcomes.
2. A trauma-informed lens must be applied to all policies, procedures, and practices to avoid re-traumatization and mitigate harm to any person engaged in the system.

A trauma-informed process allows for all professionals to collect information in a manner that accounts for trauma's impact on memory and behavior. Integrating knowledge of trauma into policies, procedures, and practices does not mean treating trauma (Khan, Rowe & Bidgood, 2019; Klinic Community Health Centre, 2013). It is about focusing on the traumatic nature and effects of the violence, response to the violence, and understanding how a woman's experience informs how she responds and behaves in the aftermath of the events.

To best recognize and understand trauma in the context of GBV it is necessary to take an expansive view of trauma (Wesley-Esquimaux & Smolewski, 2004) requiring:

- knowledge of emotional, psychological, and physiological responses to trauma;
- an understanding of how trauma responses are shaped by social, cultural, institutional, and historical contexts;
- an understanding of how trauma responses are shaped by a person's past experiences, worldview, and position in society; and
- power-consciousness.

This approach can help to encapsulate the range of experiences and subjectivities that influence whether a person will consider an experience to be traumatic and how trauma may or may not manifest (Peña, 2019).

3.3 Trauma-Informed Care principles in GBV context

The Substance Abuse and Mental Health Services Administration (SAMHSA) identify the principles of Trauma-Informed Care (TIC) as:

- *Safety*: Service providers should work with young people to ensure they feel physically, culturally, religiously, socially and psychologically safe. It's important to let young people know that your service is a safe space and give them permission to open up and talk with you, whilst being mindful of mandatory reporting requirements.
- *Trustworthiness:* Service providers should be transparent, and seek to build and maintain trust among young people. Building trust can take time, but is crucial to trauma informed care. It requires trust with not just the young person, but also their families and communities. Transparency and honesty are also crucial, this means following through on actions and never "promising" anything that cannot be achieved.
- *Peer support*: peers are those with lived experience of trauma. Using peers can help to develop trust, safety and a sense of mutual self-help. Peer workers are common in the fields of mental health and the drug and alcohol sector, however, need to be considered in all areas of health and community work.
- *Collaboration and mutuality*. Collaboration and mutuality aim to balance the power of those making decisions, and recognizes that healing occurs in relationships where there is shared power in the decision-making process. This can help to return the control that trauma likely removed from the individual. Empowerment, voice and choice: the strengths and agency of children and young people, and their families, carers and significant others need to be recognized, built upon, and validated both in direct service provision and organizational management. Educating young people about sexual health leads to empowerment, and empowerment leads to awareness, higher self-value, and choice.
- *Choice and control over one's own behaviors* are crucial when it comes to sexual health. Culture, gender, history and identity Services must be responsive to a young person's culture, gender, religious background, sexual orientation and ability, and recognize and address historical trauma, genocide and institutional racism. Services should also leverage the healing value of traditional cultural connections.

TIC is, therefore, an organizational change process that focuses on principles to promote healing and reduce the risk for re-traumatization for vulnerable people. SAMSHA approached this framework by integrating trauma research findings, practice-generated knowledge related to trauma interventions, and lessons learned from survivors of trauma, including IPV survivors. Bowen and Muurshid (2016) argued that many health and social problems are linked to trauma, suggesting TIC is relevant to a broad range of policies across systems.

Many of the characteristics of TIC, such as a respectful, holistic, and strengths-based approach, overlap with what have become general expectations for competent clinical practice. However, since its inception, TIC has also identified and developed specific practices - for example, universal screening for trauma history, prioritization of physical and emotional safety throughout the program, and the training of all staff in the nature and effects of current and lifetime trauma - that were not identified by these other related movements (Harris & Fallot, 2001).

TRAUMA INFORMED PRINCIPLES AND GBV

1. Recognize the impact of violence and victimization on coping strategies.
2. Identify recovery from trauma as a primary goal.
3. Employ an empowerment model.
4. Strive to maximize women's choices and control.
5. Interventions are based on a relational collaboration.
6. Create an atmosphere that is respectful.
7. Emphasize women's strengths.
8. Minimize the possibility of re-traumatization.
9. Strive to be culturally competent.
10. Solicit consumer inputs in designing services and interventions.

Even where TIC does seem to overlap with general best practices, proponents of TIC have argued that these practices take on new meaning and import when they are grounded in a deep understanding of trauma (Elliott et al., 2005).

TIC model applied to GBV victims maintains the aim to put the basis for a multidisciplinary care of victim and context (see box).

In the context of Gender Based Violence, many programs have espoused the goal of empowerment or helping to restore the sense of choice and control that perpetrators have tried to take away (Goodman et al., 2014; Kasturirangan, 2008). Yet, over the last decade, scholars and practitioners have expressed growing concern about the degree to which that goal is achieved in practice (Kulkarni, Bell, & McDaniel-Rhodes, 2012). Some have observed that GBV programs have moved away from a survivor-centered, social change-oriented approach toward a service-driven model where support is

constrained by predetermined definitions of success (Davies & Lyon, 2013; Goodman & Epstein, 2008). Others have observed that shelters, once seen as the heart of the movement, often establish stringent policies that can replicate coercive patterns of abuse. Some scholars have even exposed blatant experiences of humiliation, marginalization, and exclusion of survivors within programs themselves, particularly low-income single women of color, LGBT women, or women with severe mental illness (e.g., Nagao, Koyama et al., 2006; Sokoloff & Dupont, 2005).

At the same time, TIC has integrated new concepts (e.g., historical trauma) and approaches (e.g., psychoeducation) that are meant to support the trauma-related mental health needs of survivors. Over the past decade, institutions and services and researchers have begun to articulate how TIC principles can be translated to the GBV context. For example, the National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH) has published numerous tip sheets, webinars, and reports for working with survivors. These resources emphasize that trauma-informed work is social justice driven and closely linked to advocacy work in that it is about “understanding the effects of trauma and what can be done to help mitigate those effects, while at the same time working to transform the conditions that allow for violence in our world” (Warshaw, 2014, p. 15). That is, a social justice-oriented approach to trauma-informed care prioritizes reducing and ultimately eliminating violence by advocating for survivors and working toward social change.

These efforts have resulted in a framework of principles and practices that expands on more general conceptualizations, and includes, for example, reducing further harm; establishing empowering, transparent, caring, and respectful relationships; and being responsive to individual and collective needs (Warshaw & Zapata-Alma, 2022). In addition, a growing number of programs are integrating research and clinical insight to bring TIC to the GBV context (e.g., Ferencik & Ramirez-Hammond, 2019).

It is critical to note that the implementation of a comprehensive trauma-informed approach requires an organizational paradigm shift that entails buy-in from all levels of leadership, extensive training and supervision for staff, and a significant investment of time and resources (Harris & Fallot, 2001; Huntington et al., 2005).

Chapter 4

The central role of professional well-being

The impact of working with traumatized individuals – moreover GBV victims - has an impact on health and work of professional caregivers as empathy allows to feel most of the emotional experience they are referring to. Dealing with trauma can stress as trauma manifests itself: feelings of helplessness and hopelessness, diminished work attention, chronic exhaustion, cynicism, hostility and more. To keep from being overwhelmed, the professional caregiver needs to respond to suffering in a thoughtful, intentional way integrating empathy and developing a quality of compassionate care. If the professionals internalize the other suffering without thinking in a framework such as TIC offers, this can lead to a work-related trauma exposure syndrome called Vicarious Trauma.

4.1 The definition of vicarious trauma

Working with victims and witnessing the pain, suffering, cruelty, and devastating effects on people's lives has an enormous impact on those who work with these situations because through empathy, our neural system is also activated and often we experience the same emotions as the people we assist. Vicarious trauma is the transformation that occurs in us when exposed to the suffering of other living beings (Van Dernoot Lipsky, 2010)

Vicarious trauma describes the state of tension and concern that is experienced in a variety of ways by practitioners when directly or indirectly exposed to their clients' trauma. On the other hand, burnout addresses the consequences that such exposure to trauma can have, describes its symptoms, and gives us tools to prevent it.

It is a secondary effect of helping-professions: an occupational challenge for people working in the fiends of victim services (e.g. law, medical services, psychosocial services) and represents the experience of absorbing others' pain in times and emotions of their distress so deeply – or for prolonged time – that it affects the professional caregiver's well-being and work capability and her/his relational contexts.

The impact of Vicarious Trauma can affect professionals and their contexts of life and/or work (see following table)

SIGNS AND SYMPTOMS OF SECONDARY TRAUMA

Emotional exhaustion	Abandonment of personal fulfillment	Lack of clear rules to operate in the field
Progressive loss of vital energy and disproportion between work and experienced fatigue	Self-demanding and high ideals	Lack of collaboration, and competitive environments
Loss of joy and the ability to enjoy, both at work and personally	Low tolerance to failure and frustration	Lack of external supervision
Discontent and irritability	Need for perfection and control	Limited resources needed for victim's assistance
Extreme sensitivity	Feeling of omnipotence	Distortions in communication
Interpersonal relationships are impoverished	Burnout symptoms	Lack of institutional and community appreciation
Feelings of loneliness, impotence, and defenselessness	Rigid institutional designs	Accelerated changes. Lack of psychological time to process changes
Cognitive problems: forgetfulness, gaps, dullness, memory deficits	Inadequate or unhealthy physical spaces.	Continuous contact with suffering, pain, and death
Hyperactivity that increases exhaustion	Work overload	Legislative and institutional changes without adequate training
Depression and sadness or harassment	Lack of appreciation for the task	Factors of power in interpersonal relations

Pines and Aronson (1983; 1988) define burnout as a state of physical, mental, and emotional exhaustion caused by being permanently involved in emotionally demanding situations. It is based on three elements: emotional deplete, depersonalization, and distancing which occurs when the professional's emotional reactions are exhausted by chronic needs, demands, and expectations of their clients, superiors, and institutions.

As a result, long-term burnout weakens the professional's internal and emotional system and increases vulnerability to psychological suffering and the development of physical illnesses.

It is essential to understand that it is directly linked to the professional function and that developing it will depend on the institutional context, personal aspects, and conditions.

Professionals who do not have adequate trauma training may also unknowingly experience forms of indirect trauma (e.g., secondary trauma, vicarious trauma, compassion fatigue) (Harr and Moore, 2011; Pill et al., 2017).

Indirect trauma is defined as the negative consequences associated with working with trauma survivors, such that the emotional well-being of practitioners becomes damaged through their therapeutic work with trauma survivors (Ben-Porat and Itzhaky, 2011). Prolonged exposure to and lack of knowledge of the effects of indirect trauma can also lead to burnout, or the decision to leave the field (Baird and Jenkins, 2003).

Supervision can provide professionals with strategies in dealing with the adverse effects of exposure to trauma. In some cases, supervision has been shown to serve as a protective factor for indirect trauma (Carello and Butler, 2015). However, supervision can also be a risk factor for indirect trauma in situations when supervisory interactions are not beneficial (Didham et al., 2011). Supervisors may also overlook or miss the signs of indirect trauma of their supervisees. In some cases, social workers who disclose indirect trauma to supervisors may be perceived as weak or vulnerable which can further stigmatize their experiences.

Exposure to trauma survivors can challenge the emotional stability of the most experienced of professionals working with traumatized individuals.

4.2 Strategies for mitigating Secondary Trauma symptoms

Evidence exists that organizational climate can mitigate some of the effects of vicarious /secondary Trauma Syndrome. Professionals who describe their work environments as

supportive report less secondary trauma. Organizations should include information about STS symptoms, resources, referrals, and the process for accessing them.

In-service trainings should regularly feature self-care strategies, including how to manage difficult emotions. Aa sense of physical safety is essential in the prevention of STS, the health and social care systems should make this a core element of training, skill development, policies, and practices. Administrators should routinely survey staff about their sense of safety and their confidence in their ability to manage explosive or risky situations with clients.

Staff who feel that they are increasing competency in job skills—especially if they are employing evidence-based practices—also generally experience less STS. One's feeling of compassion satisfaction, that is, the positive emotions that come through helping others, is another protective factor against secondary traumatic stress. However, the high-stakes nature of GBV work means that the system's attention is often on the things that could or do go wrong—while the many things that go right are overlooked.

Developing this kind of "negative lens" is a common outcome of trauma exposure. Helping professionals to stay attuned to their motivations for working in the field and intentionally recognizing the positive impact they have on women 'lives can help mitigate secondary traumatic stress.

Organizations should also have a defined protocol for managing the emotional well-being of professionals directly following critical incidents, such as the death of a woman. The response should include a discussion of common reactions for staff to self-monitor, an opportunity for all to deal with difficult emotions, and a plan for addressing difficulties that may arise. The approach should encourage mutual support among team members, but also respect individual coping styles.

Agency practices based on valuing and promoting self-care (e.g., taking a lunch break, asking for help, schedule flexibility, maintaining work-life boundaries) can help workers shift their focus from what they cannot control to what they can.

Even agency leadership should "practice what they preach" by not only modeling these things themselves, but also by ensuring that they are not sending inconsistent messages to staff by, for example, talking about the importance of home-work boundaries while still expecting staff to respond to routine emails at night and over weekends. Offering supportive services after critical incidents - in addition to consistent recognition of staff, agency, and system achievements - can also promote a sense of empowerment and connection between agency management and line staff.

Chapter 5

Case studies across different Countries

Care4Trauma Project involves actions of capacity building to disseminate widely Trauma-Informed-Care approach and vision when working with women victims of violence. As a part of the capacity building effort, a *"Train the trainers"* initiative was included in the work packages. After the initiative, all professionals organized their training and discussed cases with participants. The overall goal of the *Train the Trainers* initiative was to ensure that TIC approaches are used appropriately in interactions with women survivors of violence through available and effective training of staff.

The **Italian Society of Traumatic Stress Studies (SISST)** developed a core basic TIC curriculum for professionals of different backgrounds a similar more specific curriculum for psychologists and psychotherapists.

The discussion for the development of **case and/or service studies** aimed at comparing the system as is in each partner Country – *with strength and weakness points* - with how the system would be if they were trauma-informed.

In this chapter, the national outcomes and reflections are presented through a comparison between the system as is and how the system would be if it was more trauma-informed. Specific simulated scenarios are also presented to illustrate the possible pathway of a woman – victim of violence-into the system.

5.1 The System "as is"

CROATIA (AZKZ)

In Croatia, social Services carries out activities in the field of social welfare, family law and criminal law protection of children, foster care, and other administrative areas in accordance with the Law and other regulations. Working with families (all family members) where GBV is present is just one segment of their work.

Services are organized locally, with branches in each town (or neighborhood, depending on the size of the city or town); however, some service is centralized.

Women report to the office based on their registered place of residence, and that office

is responsible for their case. If a woman officially changes her residence but does not change it for her children (as this requires the consent of her partner, which she often does not have), her case is handled by one center, while her children's case is handled by another. It is funded by the State budget.

Only statistics for the year 2022 are available, and they are not maintained in a way that allows for the requested breakdown. Of all the services they offer, 48% of the users are female, and in the category of single parents, 86% are women. The equipe involves social workers, psychologists, legal experts.

Strength points - Generally, these are professionals who are motivated to learn and are willing to improve their work.

Weakness points - Experts are not systematically educated about GBV or TIC. Organizations are not structured to provide care based on TIC principles. It lacks of a gender-neu approach to violence. Structural violence against women who have survived GBV is often present.

Ministry of Labour, Pension System, Family, and Social Policy organises education for professional workers within their projects, sensitising them to recognize trauma and to understand the behaviour and the thought processes of a person who has experienced trauma, emphasising the need to observe a person's entire behaviour in the context of the trauma they experienced. The Centre for Social Welfare organises additional training for professional workers who encounter violence at work. The Office of the Ombudsperson for Gender Equality organises training on support for victims of GBV and attends training organised by other relevant stakeholders. Judges, on the other hand, mostly do not attend education organised by CSOs but get their education through Judicial Academy. Judicial Academy is an institution specialised for the training of judges and state attorneys, advisers, and senior expert advisers of the extra-legal profession in all courts of the Republic of Croatia. Academy’s training program for 2023 includes topics such as:

- *Individual assessment of the victim* with an emphasis on the assessment of the victim's needs, including the necessary measures to help the victim who has experienced trauma.
- *Taking the victim's statement and examining the victim with special emphasis on vulnerable groups*
- *Communication skills*
- *Techniques for dealing with stress*.

All education and training of employees of the Department for Protection of Victims and Witnesses in Zadar, for example, need to be approved by the Office of the President of the County Court in Zadar. Department employees attend education organised by the Judicial Academy, CSOs, and the Department of Psychology of the University of Zadar. The interviewee from the Department pointed out that, at the system level, employee education and training needs, including budgetary needs, are not planned in advance, and are more available to persons located in Zagreb County, the City of Zagreb, and Istria region.

ESTONIA (WSIC)

Estonian criminal law does not specifically address domestic violence. In some cases, such as physical abuse under section 212 of the Penal Code, the close relationship between the victim and the offender is considered an aggravating circumstance, but this does not constitute domestic violence as defined by the Istanbul Convention, as it only covers cohabitation. The Victim Support Act defines domestic violence in line with the Istanbul Convention. However, misunderstandings persist, both among the general public and professionals, regarding the definition of domestic violence.

In December 2023, four ministries (the Ministry of Social Affairs, Ministry of Justice, Ministry of Education and Research, and Ministry of the Interior) signed an agreement to combat domestic violence from 2024 to 2027. An action plan, attached as an annex to the agreement, sets out targets and activities for violence prevention. The goals include strengthening violence prevention, enhancing the response to domestic violence, and improving services for both victims and perpetrators.

Victim Support Services are accessible whether or not criminal proceedings have been initiated. Victim support professionals provide emotional support, information on accessing help, and guidance on contacting other agencies. Anonymous consultations are also available. Victim support services are located in all major cities, and in some areas, they share premises with the police. Victims of domestic violence can also receive mental health care supporting recovery from trauma if needed, with costs covered by the Social Insurance Board (Sotsiaalkindlustusamet).

The Victim Support Crisis Helpline 116 006 (Ohvriabi kriisitelefon) provides assistance for individuals who have experienced violence, loss, or traumatic situations, as well as for their loved ones or acquaintances. The helpline is available 24/7 in Estonian, English, Russian, and Ukrainian, and support can also be accessed via an online chat.

The Social Insurance Board also offers a service aimed at helping individuals cease violent behavior. This service aims to prevent and deter violence through interventions targeted at perpetrators.

There are 17 support centers specifically serving victims of violence against women. Most centers are operated by NGOs (16), with one managed by a municipality. These services are monitored and funded by the Social Insurance Board. Support centers in each county operate under the Victim Support Act, offering 24-hour primary psychosocial support, crisis counselling, psychological counselling, psychotherapy, and legal assistance (with some centers offering legal representation). If needed, they provide safe temporary accommodation for up to 6 months for women and their children when staying at their current residence is unsafe, and no other safe alternatives are available.

Contact with Women's Support centers can be made anonymously.

There are four Sexual Violence Crisis Centers located in hospitals and staffed by specially trained health professionals. These centers provide victims of sexual violence with information, support, medical examinations, and evidence collection, which can later be used in investigations.

Since 2019, the MARAC (Multi-Agency Risk Assessment Conference) model has been used for high-risk domestic violence cases. The MARAC meets monthly and includes a range of stakeholders, such as victim support services, the police, the prosecutor's office, women's support centers, and child protection and social services. Additional professionals may participate as needed. Currently, there are 21 MARAC teams across Estonia. For lower-risk domestic violence cases, there is no specific model, but the Social Welfare Act requires case management when multi-agency coordination is necessary. Estonia's case management approach involves active participation by the victim throughout the process.

In summary, Estonia has established a solid foundation for supporting victims of domestic and sexual violence, with legal frameworks, multi-agency cooperation, and specialized services. However, to better support victims in a trauma-informed way, more needs to be done. Greater emphasis is needed on consistent understanding and application of the definition of domestic violence among both the public and professionals. Expanding trauma-informed training for frontline responders—such as police, social workers, and health professionals—would ensure that victims are treated with sensitivity and care at every stage of the process. Additionally, developing a comprehensive approach for lower-risk cases, similar to the MARAC model for high-risk situations, could fill gaps in support and ensure that all victims receive adequate help.

Continuous investment in specialized mental health care and long-term support services is crucial for aiding recovery from trauma and preventing re-victimization. These steps would help create a more cohesive and compassionate system that truly centers the needs and well-being of survivors.

GREECE (UWAH)

The current management of cases involving gender-based violence and abuse significantly differs from the principles espoused by a trauma-informed care approach. Today, support is often provided by services lacking the corresponding expertise in recognizing and addressing cases of domestic violence and abuse. Consequently, there is frequently an inappropriate response, failing to consider the new data and unique characteristics of the phenomenon. The core principles of the trauma-informed care approach, which include empathy, respect, holistic support, confidentiality, and cultural sensitivity, appear to be underutilized in managing cases of gender-based violence and abuse. The application of various approaches by professionals and the lack of specialized skills or techniques lead to cognitive vulnerability, insufficient sensitivity, and hinder the recognition and disclosure of violence, especially in its subtle forms. This often results in the potential mishandling of cases of domestic violence and abuse.

Additionally, the inadequate training of professionals and specialization in issues related to gender-based violence and abuse result in a reduced understanding of trauma and its impacts. Consequently, practices often used to benefit survivors, due to ignorance and poor management, can re-traumatize them. At the same time, the lack of specialized services and the fragmented presence of services across regions, for example, in rural areas where there may be one or no social support services, complicates access and discourages individuals from seeking and receiving support.

Moreover, the lack of coordinated response and institutional collaboration among services results in many cases being recorded in multiple services. The procedural detachment and fragmented support push survivors to receive overlapping services. Furthermore, a lack of awareness can lead to incorrect response practices to the trauma experienced by women who have suffered violence and abuse, resulting in beneficiaries losing trust in Support and Protection Agencies. This trust issue disrupts the individuals' sense of safety and their consideration of the possibility of reacting and adapting to a new reality free from violence and abuse.

Bureaucratic obstacles, long waiting times for actions to be carried out, reduced

workforce, and non-specialized services for the implementation and defense of survivors' rights, combined with the understanding, respect for the experiences and feelings of survivors, push towards services that do not meet the individualized needs of survivors. Consequently, the trauma-informed care approach, which is not just a practice but a continuous response as behavior and attitude of professionals, is not applied, both professionally and personally.

The provision of services by the Agencies is often sterile and imposed in a way that does not align with an approach that respects the personal choices and trauma of survivors. Survivors often face disruption to their personal and family lives and are called to cope with various socio-economic difficulties. In many cases, they are forced to make changes that do not respect their personal choices, capabilities and individual needs, such as staying in shelters, protective restrictions within the necessity of housing, changing residence, changing children's schools, jobs, etc. The system focuses on the problems survivors face rather than their potentials and needs or the numerous challenges they have due to new developments and changes in their lives.

At the same time, in Greece, the protection and defense of women survivors of violence are defined by laws 4500/2006 and 4531/2018 (which also ratifies the Istanbul Convention on Preventing and Combating Violence Against Women and Domestic Violence), as well as by law 5090/2024 (Government Gazette A 30 - 23.02.2024) "Interventions in the Penal Code and the Code of Criminal Procedure for the acceleration and qualitative upgrading of the criminal trial - Modernization of the legislative framework for the prevention and combating of domestic violence." These laws provide amendments aimed at maximizing the safety of the survivors of gender-based violence, combating impunity and speeding up the judicial process with the faster administration of Greek justice. All the measures provided in the legislation have a repressive nature. The laws explicitly state the necessity of ensuring all necessary legislative and other means for survivor's access to services that will facilitate recovery from the consequences of violence, while providing for support services for survivors of violence. However, legal procedures often prevent the immediate support of survivors, sharpens their already burdened psychological state, and create re-traumatization and secondary victimization.

Moreover, especially in cases involving children, frequent contact or the use of children, based on the legal rights of the perpetrator as a father, often leads to new expressions of violence or potential retaliatory actions, resulting in secondary trauma for the survivor.

In conclusion, despite all laws, guidelines, and policy practices advocating for the design,

development, and implementation of measures that maximize survivors' safety and prevent further exposure to adverse conditions, ensuring both their safety and the provision of effective assistance through comprehensive support services such as counseling, legal representation, social support, and employment reintegration, the practical implementation of specific procedures shows that survivors are exposed to new trauma. The basic principles of trauma-informed care in handling cases of gender-based violence and abuse, with sensitivity to the survivor, respect for survivor's dignity, and protection of personal and family life, ensuring both their safety and the highest quality of life are highlighted. The above points demonstrate that existing practices lead to disempowerment and a sense of insecurity for survivors, lower quality of life and heightened fear, contrasting with the sensitive handling, empathy, and formulation of actions aimed at healing from trauma required by the trauma-informed care approach.

ITALY (AMD)

There will be exposed two different systems of MondoDonna Onlus: "GEA" and "Oltre la Strada".

GEA System - Severe Adult Marginalization – is a network of services that tries to respond to social and health needs of the homeless people in Bologna area. This is done at first to ensure basic needs (food and recovery for the night) and to taking in charge mental disease or substance abuse, sharing the most complex cases with the Social Services. Through a network of facilities, with distinct levels of coverage and assistance, shelters and support are provided by GEA System. Most of the people in GEA services are man, but it is estimated that all homeless women have experienced GBV at some time in their lives. For that reason, having in mind that women survivors need special care and protection even in emotional sense, two dedicated places are reserved to them in a shelter with specific characteristics. In this way, since 2021, a collaboration between GEA and MondoDonna' anti-violence Center has been running. Finally, to fight against the homelessness stigma and to facilitate encounters and knowledge between homeless and non-homeless people, are organized workshops and activities in specific Centers in Bologna.

AIMS AND GOALS: In GEA Services most of homelessness women in charge are victims of violence whit complex traumatization, mental distress and substance abuse. One of the greatest complexities concerns the need of protection from the perpetrator for two main reasons. First, the abuser is also in most of cases a beneficiary of

homelessness services and host in the same shelter. Second, because of mental distress and substance abuse, homelessness women can't access to antiviolence protection shelters (Case rifugio). For that reason, is not easy to assure physically protection from the perpetrator because in several cases they shared the shelter in which they live. Furthermore, the homelessness network is strict, therefore it is very difficult to guarantee a safe condition inside facilities for homeless people. So, the first step is to explore with the woman the level of risk. In these situations, more than in others, it is indispensable to work on housing security. Homeless women suffering IPV presents different levels of complexity, because they usually come from a poor educational background, may have alcohol and substance abuse and have a complex health situation. It is extremely important to consider all their needs and to draw up a priority list, in order to activate all the services in the network that could take charge of a specific aspect of the women's care and empowerment. In these cases, have a high level of communication between services and work in trauma informed prospective is essential. Moreover, is important to assure legal protection to these women and guarantee them the access to justice fighting the stigma and understanding the impact of violence and trauma on them.

The **Oltre la Strada** project (OLAS) is a regional project part of the national network of anti-trafficking projects that actively collaborates with the Trafficking Interventions Observatory - Anti-Trafficking Toll-Free Number 800 290 290. OLAS promotes the implementation of specific assistance measures for victims of serous exploitation and trafficking of human beings as required by national legislation. In the Bologna area, the Project is coordinated by the Municipality and implemented by four third sector entities. Oltre la Strada provides a path of emergence, assistance, social and work integration for people who are victims of trafficking and/or serious exploitation. The regulations to which the project refers are above all: Legislative Decree 286/98 "Consolidated text of the provisions concerning the regulation of immigration and rules on the condition of foreigners" and Law no. 228/03 "Measures against the treatment of people". The program includes three specific phases:

1. *Emersion* of the exploitative condition: the person is identified as a victim of trafficking through a series of protected interviews. During the meetings, the anti-trafficking operator reconstructs the history of trafficking and/or serious exploitation and violence; a space for listening and emotional support is offered. The current situation is also assessed, legal guidance is provided if necessary, and basic needs are met.

2. Protection and access to a special program called “Programma Unico di Emersione, Assistenza a Integrazione Sociale” (Programme of emersion, assistance and social integration) anti-trafficking projects art.18: the person identified as victim of trafficking and serious exploitation could ask for protection and access to one of OLAS shelter.
3. Social and job inclusion: the person is supported in a path of social and work reintegration through a work orientation process and the activation of training and traineeship to achieve economic and housing autonomy.

The woman generally accesses to Oltre la Strada project in these ways: through referral from a service (Reception Centers and Social Services) or Territorial Commission for the recognition of International Protection; upon notification from the national toll-free number “*Numero Verde anti tratta*” 900290290; through free access to anti-trafficking services.

In the first case, the woman is sent for an emersion path through protected interviews into a *referral* process. The anti-trafficking operator could identify the person as victim of trafficking, and she sends a feedback report to the service who refer her. During the process, the women are informed about the possibility to join a protection project to escape exploitation. Second and third option forecasts that the woman already recognizes herself as a victim of trafficking and she has asked for help via the national toll-free number or directly to anti-trafficking service.

As soon as the woman arrives at the anti-trafficking service, project’s goals and functioning are explained to her according to the various services offered: path of emerging from exploitative conditions, adherence to an “*Article 18*” protection program, request for networking with another Italian Region for protection reasons, support and assistance for social and job reintegration. Subsequently the role and the aim of the anti-trafficking operator and the OLAS project are explained. The woman is informed that the interview is protected by professional confidentiality, that the whole process consists of a series of meetings to assess the situation -recontructing the experience of violence and exploitation- and give all the detailed information about available and specialized services and, in particular, about a special program called ‘Programma Unico di Emersione, Assistenza a Integrazione Sociale’ (Programme of emersion, assistance and social integration). If the woman agrees to undertake the path, the taking charge is signed through access to the SIRIT program - Computerized system for the collection of data on trafficking and exploitation in Italy - where track is kept not only of the person's path within the program but also possibly access to others on the national territory. It involves

psychologist, educators, mediator and anti-trafficking operator. Furthermore, it is possible to involve other professionals depending on woman's need, like: doctors, nurses and lawyers

AIMS AND GOALS: Holistic management with respect, not imposed from above but drafting a project co-built with the persons and "tailored to them". To provide different kind of intervention according to empowerment, emancipation, protection, integration, support, and autonomy needs. Mapping other services and organization already active or to be activated in the area - for example, for children – and provide the additional and ad hoc services based on the experience of trafficking.

Specific Goals: Care of all women experiencing abuse, mistreatment, violence according to TIC principles. Prevention Awareness-raising, interception of expressed and latent needs.

SPAIN (ABD)

Gender based violence (GBV) in Spain has been subject of concern from the part of public policy since the restoration of democracy in the country (1975) but it was only comprehensively legislated in 2004. With over 1160 women killed at the hands of their partner or ex-partner since Spain started recounting these numbers in 2003, and many more having suffered all forms of violence, GBV still affects thousands of women each year in this country. The inherences of the Francoist regime, which enforced much differentiated roles for men and women in society and clearly normalized their social oppression, are not the only justification found for the prevalence of GBV. Also, young generations are continuing to perpetuate practices, both symbolic and material, which enforce the dominance of men towards women to its latest consequences: the use of violence in its several forms. Another implication of this legal diversity is the work developed by law professionals on each Autonomous Community. Often, because the form of GBV suffered by the victims is not recognized in the Penal Code, the lawyers' task consists in translating the violent event into another category of event that is typified on the Penal Code, understanding that many GBV acts are never judged as GBV but as generic violence, generic harassment. There is, though, an article in the Spanish Penal Code (Art. 22, 4th) which enforces that any crime is aggravated if it is motivated by reasons of discrimination, among them, gender discrimination. This aggravating circumstance is a modifying one of the responsibility that determines an increase in the

penalty corresponding to the crime for assuming a greater dangerousness of the subject or a greater unlawfulness of his conduct.

In September 2004, the Spanish National Health Service (NHS) approved the creation of the Commission Against Gender-based Violence. This was the first step towards coordination of health programs and care actions that were already being undertaken in some of Spain's regions (autonomous communities). Subsequently, and over time, the NHS took action to implement the specific commitments made in the 2004 Law on Gender-based Violence. It was approved by parliament at the end of 2004. The law included, among other things, training for health professionals.

All Autonomous Communities include in their Statutes od Autonomy the principles of equality between women and men as well as the obligation of the public powers to ensure and guarantee their constitutional rights, the adoption of the necessary measures to achieve real and effective equality between individuals, and guarantee participation in community, social, political, economic and cultural life for all.

The Autonomous Community of Madrid has a comprehensive law to tackle GBV (Law 5/2005) with a comprehensive action against gender violence, which represents a new step to prevent and combat this type of violence in a broad and comprehensive sense, attending to all possible situations in which GBV exercised by men towards women is manifested, as an expression of inequality. The law focuses on awareness and prevention actions, among which are included: measures in the field of advertising and the media; measures to detect situations of risk; prevention in the educational field, and in the workplace, training of health personnel, teachers, social services and other professionals. On the other hand, the law also focuses on actions of protection and care such as: special systems of protection; information and legal guidance; right to free legal assistance and popular action. Regarding actions for the comprehensive recovery of women, the Law establishes temporary shelter strategies; access to housing with public protection; a system of economic aid; psychological and social care; measures in the educational field; health preventing measures extended to workplace and employment.

Finally, it establishes actions for institutional coordination and cooperation such as coordination with Security Forces; the principles and circuits that govern the action of the Community of Madrid; the coordination with local entities; the Regional Observatory for GBV; it establishes the Autonomous System of Assistance to Victims of Gender Violence and the collaboration with private entities and non-profit associations.

In relation to violence against women, important steps were taken to harmonise actions across all of the autonomous communities through the development of a common

protocol for a health care response to gender-based violence. Similarly, a set of common indicators on health care provision in cases of gender-based violence were developed Indicators included, for in the NHS: e.g. the number of cases detected within primary and specialist care levels, and others relating to the demographics of abused women and the type of care received. These served to: facilitate planning of the health care provided, promote improvements in quality and equity in health care provided to survivors of gender-based violence, and to facilitate the exchange of experiences and good practice among those involved in providing health care for women suffering from violence. development of a common protocol for a health care response. Moreover, and most importantly, quality criteria for training health professionals on the response to gender-based violence were developed and substantial amounts of resources were dedicated to building the capacity of providers in primary health care and in specialist services, such as those for mental health and emergency care.

In Catalonia, another autonomous region in Spain, in 2008, Law 5/2008, of 24 April, on the right of women to eradicate sexist violence was approved, which marks a fundamental step in tackling violence in the territory and represents a qualitative improvement in relation to the Organic Law of Comprehensive Protection Measures against Gender Violence approved by the Spanish Congress of Deputies in December 2004. While this state law recognizes the rights of women affected by gender-based violence strictly within the framework of the couple or ex-partner, the Catalan law expands the scope to incorporate all forms of violence against women because of being women, calling it sexist violence and thus abandoning the exclusive scope of the couple. In addition, this is the law that defines and structures the Network for Attention to Gender-Based Violence in Catalonia, which will be explained in point 3 of this first part of the report.

In 2020, Law 17/2020, of December 22nd, amending the so-called Law 5/2008, on the right of women to eradicate sexist violence, was approved. This law aims to expand, strengthen and update the Law 5/2008, as well as to protect the rights of transgender women and non-binary people, in order to respect gender diversity.

This law also updated the **forms of violence** that were established in 2008 to contemplate the following: Psychological violence; Physical violence; Sexual violence; Economic violence; Obstetric violence and the vulnerability of sexual and reproductive rights; Digital violence; Second order violence; Vicarious violence.

5.2 Overcoming the barriers

CROATIA (AZKZ)

At the level of the relevant ministry, a decision should be made to incorporate Trauma-Informed Care (TIC) principles into the mission and vision of care provision.

Organization of social services work should be carried out with full consideration of TIC principles. Systematic education on Gender-Based Violence (GBV) and TIC principles should be provided at university level and at the level of lifelong learning. It would be necessary a selection of professionals who are sensitized to the topic so they can become specialists in this field. Moreover, it would be useful working on gender stereotypes and biases, regular case study presentations, and peer support among professionals ever ensuring systematic and regular supervision for all staff.

The social welfare institution (hypothetical service) would have as its primary goal to provide comprehensive support to every woman. This institution should be a place that offers a safe and supportive environment that takes care of the emotional, psychological, and legal needs of women who have experienced intimate partner violence. It is focused on ensuring the physical and emotional safety of women, and together with the woman, finding a secure space free from further violence or re-traumatization. The final goal is to facilitate the recovery and empowerment of women through trauma-informed care that acknowledges the impact of trauma and focuses on resilience-building and personal growth.

The goals of such an institution include providing integrated services, including psychological counselling, legal aid, housing support, and job placement, all based on trauma-informed principles. Tailored care plans for each woman will be created, addressing her specific needs and goals in recovery, healing, and rebuilding her life. Trauma-informed practices will be implemented in every aspect of care, ensuring that all staff understand the complexities of trauma and provide services that are sensitive, respectful, and non-judgmental. The institution will connect with other institutions that provide services with the aim to develop social support network in order to foster a strong support network of peers, counsellors, and community resources, offering continuous care and a sense of belonging beyond the immediate recovery process.

The institution will focus on continually refining their services based on new insights and evidence-based practices. This institution would focus on creating an environment where women can regain their autonomy and build a future free from violence.

ESTONIA (WSIC)

Transitioning from “As Is” System to the “Care4Women approach” for addressing GBV involves comprehensive changes at multiple levels.

It requires strong leadership to secure commitment from organizational leaders and policymakers to prioritize GBV support and TIC. Comprehensive legislation must be advocated for, specifically targeting domestic violence, sexual assault, and harassment. Existing laws need stringent enforcement, holding authorities accountable. Policies should be regularly reviewed and reformed to align with best practices and new insights on gender-based violence. Clear policies, and sufficient funding and resources for implementing relevant strategies are crucial. Providing comprehensive training and ongoing education for all staff on TIC principles, GBV dynamics, and empathy-driven interactions, as well as on cultural sensitivity and the diverse needs of GBV survivors from different backgrounds supports the implementation of the survivor-centered approach. Creating physically and emotionally safe and supportive environment, including areas for consultations, helps survivors to feel heard, respected, and validated. It also promotes confidentiality and privacy. Public awareness campaigns are crucial to educate and shift societal attitudes. Multi-agency cooperation should be fostered to ensure a coordinated response. Oversight mechanisms and regular audits should be established to monitor the social services response and ensure transparency. Promoting gender sensitivity and addressing implicit biases within the social system is vital. Shift in organizational culture towards promoting empathy and compassion and stressing out staff well-being has significant effect on supporting GBV survivors. By implementing these strategies, the system can become more effective, compassionate, and responsive to the needs of GBV survivors, ultimately fostering healing and empowerment.

GREECE (UWAH)

Moving from As Is System to the Care4Women approach for addressing domestic and intimate partner violence requires comprehensive changes at multiple levels. More specifically, strong leadership to secure commitment from organizational leaders and policymakers to prioritize domestic and intimate partner violence support and TIC is needed. Comprehensive legislation must be advocated for, specifically targeting domestic violence, sexual assault, and harassment; while restorative justice and penal

mediation, through which perpetrators of domestic and intimate partner violence will be hold accountable for their violent actions, should be fostered. Policies should be reformed and updated to reflect gender-sensitivity and trauma-informed-care, as well as cultural competence. Sufficient funding, staffing and the corresponding resources for implementing the relevant strategies are necessary. All professionals involved need specialized and ongoing education on domestic and intimate partner violence, cultural competence and on TIC specifically, in order to increase their knowledge and skills; while emphasis should be given to secondary victimization of survivors of domestic and intimate partner violence by the interventions, processes and the system itself. Multiagency cooperation should be fostered to ensure a holistic, effective and coordinated response; stipulated by institutionalized protocols that would establish an organizational culture characterized by collaboration, empathy, compassion and staff well-being. In this way, empowerment and healing would be feasible as the main principles of the whole ecosystem, that will in turn be effective, compassionate, and responsive to the needs of survivors of domestic and intimate partner violence.

Adopting a trauma-informed approach requires changes at many levels and involves different professionals, like judges, lawyers, mental health experts, social workers, doctors, and nurses etc. It's important to create a system where everyone, from frontline workers to senior officials, works together with a common understanding and language. This helps ensure that survivors get the support they need, based on trauma informed care awareness, at every step of their interaction with the system. Strictly following existing laws, protecting survivors' personal information and respecting their trauma can improve the quality of services. This empowers survivors to claim their rights and holds perpetrators accountable.

Training and continuous education for professionals about gender-based violence and abuse are essential. This helps develop better procedures and services, ensuring that professionals respond with empathy and respect. It also promotes cultural sensitivity and addresses the unique needs of each survivor, allowing them time to heal and creating supportive environments where they feel heard and respected. Developing procedures that act as a "safety net" for survivors is also important. This includes having supervisory and control mechanisms to ensure that professionals follow the rules and act in the best interest of the survivors. If a professional breaches confidentiality, informs the perpetrator, or fails to properly support the survivor, there should be systems in place to address these issues. Finally, regular monitoring, evaluation, and follow-up can ensure that the trauma-informed care approach is consistently applied and highlight its

importance as a standard method of response in all areas of support for survivors of domestic violence.

ITALY (AMD)

To implement Trauma Informed Care and to support the transition from the service “as is” to Care4Woman service we identified three different level: economic resources, staff training/constant supervision and written protocols shared with the network of other services. For the first aspect, Care4Trauma could active a fundraising, even involving other partners and participate to national and European calls. The training should involve all the professionals, not only about trauma but also GBV and specific approach. Lastly, to fight fragmentation of knowledges, it could be useful to create written protocols in which to share policy and procedures and providing common workplaces.

SPAIN (ABD)

The Care4Women model closely aligns with the current practices in place. For the case study, work has been conducted on the implementation of the Trauma-Informed Care (TIC) Model in CAPSEM, that support women victims of gender-based violence, as well as their children, within the Madrid City Council. The "Care4Women" service aims to provide a trauma-informed intervention model specifically designed for women who are victims of gender-based violence and their children. The primary goal is to ensure that users feel safe and secure during their interactions with the service. This is achieved by giving them access to intervention protocols, reports, and models of action, fostering transparency and trust. The service is committed to a strengths-based approach, empowering women by encouraging their active participation in their recovery process. It also emphasizes the importance of mutual support by creating spaces where both users and professionals can find help and solidarity. Additionally, the service integrates cultural and gender perspectives into its interventions to provide more personalized and relevant support. A critical focus of "Care4Women" is to prevent retraumatization, ensuring that both users and professionals are protected from further psychological harm during the intervention process.

5.3 Pathways into a Trauma-Informed-Care System: Care4 Women

CROATIA (AZKZ)

CASE 1: AZKZ SERVICE

This organization is structured in a way that places women who have survived GBV (Gender-Based Violence) at the center of care. All employees have completed training related to TIC (Trauma-Informed Care) principles and are trained to apply them in their daily work with women. Additionally, the organization itself has embraced TIC principles within its mission and vision. TIC principles are applied in the consideration and organization of the initial contact, care for women and children who have survived GBV, collaboration with the local community, NGOs, and with the police, justice system, and medical care. For a woman who has survived GBV, it is not possible to come to Social Services unannounced. If she does come without an appointment, she is most often given only a scheduled time to meet with one of the social workers. She must notify the reception office about her needs, and this is only after she has passed the security guard. Women often talk about discomfort and a very unpleasant reception if they come unannounced. It is possible to schedule an appointment by phone or email, but even then, they are frequently faced with waiting, calls not being answered by professional services, and similar issues. Another way a woman can come to Social Services is if they contact her after receiving a report from the police about domestic violence. In such cases, Social Services send the woman an invitation for a meeting, either by phone or by mail.

In any case, the first impression women have is that the institution is not very welcoming, and they don’t feel comfortable or welcomed. Once a woman gets an appointment, she usually meets either with just a social worker or with both a social worker and a psychologist at the same time. In theory, she should go through three interviews—with a psychologist, a social worker, and a legal expert. This is referred to as teamwork or a "team assessment." However, due to time constraints, it is often the case that only one team member meets with the woman and then informs the others about the findings.During the first meeting, women are offered shelter, and a safety plan should be made if the woman does not want to go to the shelter. If the woman is not ready to leave her partner and their shared home, she is often met with a lack of understanding and is sometimes accused of being complicit in the abuse and neglect of their children.

In recent years, two major problems have been somewhat reduced: attempts to reconcile the partners, even when GBV was present, and sending them to mediation to arrange child custody. Although attempts to reconcile the couple have decreased, mediation is still frequently recommended. Mediation, as they explain, can be conducted separately, but very often after the first separate sessions, joint sessions are organized. During these, it is explained to the couple that their unwillingness to cooperate in mediation and attempt to come to an agreement regarding child custody is undesirable behavior, and that it is in the best interest of the children for them to cooperate. Statements are often heard such as “the past is in the past” and that they should focus on the future, all of course in the best interest of the children. An additional problem is the presumption of innocence with which the abusive partner is approached, and in all proceedings, they are treated as completely equal, with their experiences being valued equally. As a result, it is increasingly common that after reporting violence, women are faced with a series of accusations from their partner within Social Services procedures, accusing them of child abuse and neglect.

One of the procedures that Social Services conducts is the psychological assessment of the parents and their parenting competencies. If the parents do not come to an agreement on a joint parenting plan, one of them initiates a court process for divorce and child custody, and Social Services provides their opinion on how child custody should be arranged.

PATHWAY ENTERING - CARE4WOMEN ORIENTED

The social welfare institution (hypothetical service) would have as its primary goal to provide comprehensive support to every woman. This institution should be a place that offers a safe and supportive environment that takes care of the emotional, psychological, and legal needs of women who have experienced intimate partner violence. It is focused on ensuring the physical and emotional safety of women, and together with the woman, finding a secure space free from further violence or re-traumatization. The final goal is to facilitate the recovery and empowerment of women through trauma-informed care that acknowledges the impact of trauma and focuses on resilience-building and personal growth. The goals of such an institution include providing integrated services, including psychological counselling, legal aid, housing support, and job placement, all based on trauma-informed principles. Tailored care plans for each woman will be created, addressing her specific needs and goals in recovery, healing, and rebuilding her life. Trauma-informed practices will be implemented in every aspect of care, ensuring that all

staff understand the complexities of trauma and provide services that are sensitive, respectful, and non-judgmental. The institution will connect with other institutions that provide services with the aim to develop social support network in order to foster a strong support network of peers, counsellors, and community resources, offering continuous care and a sense of belonging beyond the immediate recovery process.

The institution will focus on continually refining their services based on new insights and evidence-based practices. This institution would focus on creating an environment where women can regain their autonomy and build a future free from violence.

ESTONIA (WSIC)

CASE 1: WSIC SERVICE – ANNA'S JOURNEY

Anna had lived with her children's father, Oscar, for nearly 15 years and they have three children together, aged 12, 7 and 5. By the time she contacted specialists, Anna and her children had moved out of their shared home. For years, Anna has been subjected to threats, physical violence and other forms of DV from the father of her children. There were incidents of Oscar threatening her with physical violence and/or a weapon, and episodes of sexual violence. Oscar does not have a firearms licence but has several guns at home. Children often witnessed violent episodes. During the period of cohabitation, Oscar did not hit or threaten the children, but rather ignored the children's activities and did not participate in their upbringing. When Oscar was irritated, he would shout at the children. All the child-related responsibilities during the period of the partnership were on Anna's shoulders. The episodes of DV continued after the separation. Oscar continued to abuse and threaten Anna. Anna suspected that Oscar was stalking her. Anna wanted to support the relationship between the children and the father after the separation. Anna encouraged the children to have contact with the father as they wished and the arrangements were to meet every other weekend. Anna noted that the father often left the children alone or in the care of an intoxicated acquaintance. There were occasions when the children refused to visit their father, one of the reasons given by the children was that their father spoke ill of their mother, shouted at them and hit them.

"As Is" Law Enforcement System

Anna went to the police on the advice of a friend and wanted to make a report about the episodes of DV. Anna contacted the district police. Anna explained that she wished to make a statement about the various episodes of DV, including sexual violence, threats,

abuse, neglect and ill-treatment of children. The district police officer explained to Anna that sometimes women imagine DV, and a woman might think that maybe she is letting her children manipulate her. The police officer explained that this might not be the case with Anna, but it was something to think about. For matters related to children, the district police officer advised Anna to contact the Child Welfare Department as the police do not deal with civil disputes. The officer also said that family mediation service could help settle disputes between parents. Anna had heard that family mediation was neither mandatory nor recommended in DV cases and explained this to the district police officer. The district police stressed that it was in the best interests of the children to seek family mediation and the police is not only is not only a punitive institution but also guides people towards reconciliation. Anna felt a failure as a mother and as a partner, and guilty for going to the police for help. However, the district police officer took initial statement from Anna. The interview with the police investigator lasted six hours. The investigator asked Anna to come back the next day, as the testimony was not yet finished. When she left, Anna felt guilty about what had happened. Based on Anna's statement, criminal proceedings were opened, but Anna does not know on what grounds. When Anna asked the investigator about it, she was told that the information was confidential. A year has passed. Anna has tried to find out the state of progress of the investigation but is told that the information is confidential. No statements have been taken from the children. Anna feels anxious and scared and she fears retaliation from the children's father. Oscar continues to ridicule and belittle Anna. Even though, to Anna's knowledge, Oscar's unregistered guns have been taken away, Oscar is still hunting and Anna suspects that he still has a gun. Drones are flying around Anna's house, but the police say there is no evidence that they belong to Oscar. Anna has heard that a restraining order can be applied for the duration of the criminal proceedings. Anna takes the matter up with the investigator. The investigator explains that Oscar has not done anything that could justify a restraining order. Anna does not understand the explanation, she feels insecure and guilty.

“As Is” Social Service System

After the separation, Anna did her best to make sure that the children could communicate with their father in the way they wanted. The eldest stayed with her father because she wanted to stay at home. The younger children had stayovers with their father every other weekend. The children were happy to go to their dad's, but often wanted to come home that evening or the next morning. They complained that there was nothing to eat at their father's, that their father spoke badly of their mother, shouted at them and hit them in

anger. A few months later, also the eldest child moved in with Anna. Anna knew the best way to protect her children was to contact a Child Welfare Specialist. Anna felt that she did not want to take the father away from the children but wanted the children to feel safe and secure being with their father. Anna and the specialist met at Anna's home. Anna explained the situation to the specialist - mental and physical violence, negligent storage of weapons. The Specialist checked that the home met the children's needs and interviewed Anna. During the home visit, Anna expressed her concerns to the specialist about the quality of the relationship between Oscar and the children, and asked for help in resolving the situation in a way that would be safe for the children. The specialist recommended that a family mediator be contacted to find a solution. The specialist explained that the children do not decide on their own arrangements, but the parents do. Anna should not let the children manipulate her but must come to an agreement with Oscar about the children. Anna had heard that family mediation was neither mandatory nor recommended in DV cases and explained this to the Specialist. The Specialist stressed that it was in the best interests of the children to seek family mediation and that it was Anna's duty as a mother to her children. The Specialist also explained that this is a pre-action proceeding at court and she will have to go through a family mediation anyway. Anna felt a failure as a mother and as a partner, and guilty for complaining about the situation and for blocking communication between the father and the children. So Anna applied for family mediation, stating in the application that it was a DV case. The mediation was unsuccessful. Anna felt that it was her fault.

Oscar approached the Child Welfare Specialist after the failed family mediation and complained that Anna, who works in the medical field, is a drug addict and mentally unstable. The Specialist contacted Anna, informed her about the complaint and that she would like to come for a home visit to check on Anna's home situation. Anna was disturbed as the specialist had visited her home 3 months earlier at her invitation but agreed to the visit. Once, when Oscar sent the middle child to a week-long children's camp without a change of clothes, Anna tried to explain the situation to Oscar. Oscar ridiculed Anna and called her a whore. After the incident, Oscar complained to a child welfare specialist that Anna was interfering in his private life and damaging his relationship with the children. The specialist carried out a home visit to Anna and explained that Anna should not interfere in the father-children relationship.

Anna can see that the children do not feel safe with their father and has contacted a child welfare specialist for help on a couple of other occasions. According to the specialist, the children are not in danger with Oscar and Anna needs to let the children communicate

with their father. Anna feels anxious and scared and she fears retaliation from the children's father. She feels that no one understands her concerns and feels powerless. She stops turning to professionals for help. She tries to challenge Oscar's behavior as little as possible. Oscar continues to ridicule and belittle Anna.

DOUBLE PATHWAYS (A-B) ENTERING - CARE4WOMEN ORIENTED

PATHWAY A: LAW ENFORCEMENT

Step 1: Initial Contact and Safety Assessment. When Anna approaches the district policeman, he listens calmly and without judgment, recognizing the importance of the initial contact to make Anna feel safe and supported. He reassures Anna that she did the right thing by seeking police help and conducts an initial risk assessment to determine any imminent threats to Anna and her children. The officer explains the services offered, confidentiality policies, and what Anna can expect. He discusses options for contacting the Victim Support and Child Welfare Unit, seeking Anna's consent to share information. Anna is introduced to the Women's Support Centre, a service specifically for victims of violence against women. If Anna agrees, the officer involves a victim support worker in the initial meeting. He also informs Anna that the case will be reported to a child welfare specialist due to the involvement of children. Later the officer contacts the child welfare specialist to provide initial information and ensure immediate support for Anna and her children. He explains Anna that DV cases can be challenging to prosecute and not all incidents may be criminally relevant. However, it's essential to record all episodes. The officer supports Anna in making a statement and outlines the subsequent procedures, clarifying that while a police investigator will handle the case, he remains available for ongoing issues.

Step 2: Welcome and Intake. Anna is contacted by a police investigator who explains the importance of her evidence and schedules a time for her to come in. Upon arrival, Anna is warmly welcomed into a calming environment. The intake process involves a collaborative conversation that respects her autonomy, involving her in decision-making from the start. The investigator, specializing in domestic violence cases, discusses involving a victim support worker in the interview, clarifying the worker's role to assist Anna emotionally without interfering in the proceedings. Anna decides if she needs this support. To avoid chance encounters, Anna enters through a separate entrance. The investigator guides her to a safe-feeling interview room, assuring her she can take breaks if needed. The investigator supports Anna's decision to report the abuse, acknowledging

her courage and explaining that multiple testimonies might be required for thorough documentation.

Step 3: Comprehensive Assessment. Comperhensive Assessment is carried out by social services who involve a variety of relevant professionals for input. As the case relates to child welfare, the case manager is the child welfare specialist. Later she is also responsible for drawing up the care plan. Anna's legal, emotional, psychological, and social needs are thoroughly assessed, considering her cultural background and gender-specific issues. A multi-agency approach is used, involving legal professionals and other relevant experts. The district police officer and police investigator collaborate to assess the threat posed by Oscar to Anna and her children and plan necessary actions for their safety. Anna is actively involved in the risk assessment process. In the case of a high-risk case, as is Anna’s case might be, the case will be referred to the high-risk model.

Step 4: Immediate Support and Safety Planning. If immediate safety concerns arise, a personalized safety plan is developed in collaboration with Anna. This plan includes strategies such as legal protections, temporary housing arrangements, and medical care provisions. Every aspect and action is discussed with Anna, and the safety plan and case plan reflect Anna's wishes and thoughts. The police investigator understands Anna's concerns about security. Well aware of the dynamics of violence, he/she understands the underlying reasons for Oscar's behaviour and Anna's feelings in this situation. A restraining order is applied to ensure the safety of Anna and children.

Step 5: Development of a Personalized Legal Plan. Anna's case requires multi-agency cooperation and a personalized care plan, including a tailored legal plan addressing short-term needs like legal representation and court support, and long-term goals such as advocacy and peer support. Peer support groups foster community and solidarity. Anna can access legal advice from a Women's Support Centre, specializing in domestic violence cases, free of charge. She can also apply for a state-appointed lawyer for the criminal proceedings involving her ex-husband. The lawyers involved are part of the multi-agency cooperation network, contributing their specialized knowledge to support Anna. Each member of the Multi-Agency network, including Anna, has a specific role to play in implementing the plan.

Step 6: Ongoing Support and Services. Anna has ongoing support according to the personalised care plan. She receives continuous, integrated support that adapts to her evolving needs, ensuring regular check-ins and adjustments. All services are delivered with cultural sensitivity, honouring her background and identity. The plan is regularly evaluated and changes are made to the plan as and when necessary. Every aspect and

action is discussed with Anna, and the safety plan and case plan reflect Anna's wishes and thoughts. Depending on the case-management model, either the standard model or the high-risk model, different representatives of the criminal-justice system may be involved. In any case, the regional police officer is involved.

Step 7: Monitoring and Feedback. Anna's progress is closely monitored, with her strengths and resilience continually acknowledged. Feedback mechanisms are encouraged to improve service effectiveness. The police investigator provides feedback when criminal proceedings begin, explaining the case's basis and any excluded episodes empathetically. Although some episodes may not be relevant to the criminal case, they are important to discuss. The investigator strives to resolve the case effectively and updates Anna on its status. If feedback cannot be provided due to legal constraints, the investigator explains why and clarifies the criminal proceedings, helping Anna understand the situation better.

Step 8: Transition and Follow-Up. As Anna achieves her goals and prepares to transition from the service, she receives assistance to establish long-term safety and stability. She is given clear guidance on follow-up support and resources, ensuring continuous support on her path to recovery. With her immediate safety concerns addressed and criminal proceedings underway, a detailed transition plan, including ongoing legal support, case updates, and access to community resources such as housing, employment, and healthcare, is developed. Anna continues to receive emotional and psychological support, including counseling and support groups. Her safety is regularly monitored, and protective measures are enforced. Feedback from Anna helps improve services, and she is connected to a long-term support network to ensure stability and empowerment.

PATHWAY B: SOCIAL SERVICE SYSTEM

Step 1: Initial Contact and Safety Assessment Anna is contacted by a child welfare specialist. She introduces herself and explains her role. She will explain the child welfare services, confidentiality policies, and what to expect, building trust from the outset. She speaks and listens calmly and without judgment, recognizing the importance of the initial contact to make Anna feel safe and supported. The specialist explains that she received the information from the district police officer and is obliged to make contact if there is a DV case involving children. The specialist explains that domestic violence is always violence against children, even if the children are not the direct victims but witness the DV. Anna and the specialist agree on a meeting, Anna can choose the place of the first meeting according to where she feels safe. The specialist explains that this is unlikely to be their last meeting and that at some point the specialist will have to carry out a home

visit. The Specialist will assess for any immediate threat to Anna and her children. She evaluates Annas emotional state and offers help, if needed.

Step 2: Welcome and Intake On arrival, Anna is greeted warmly in a calming environment. The intake process involves a collaborative conversation, respecting her autonomy and involving her in decision-making. The specialist provides information about available services, resources, and support network. She outlines next steps in the process, including appointments and actions Anna needs to take. The specialist is aware of the dynamics of GBV, including DV, the motives of violent behaviour, and impact on both the direct victim and children. The specialist is aware that the family mediation service may not be suitable for DV cases, as the parties are not equal, and also that the legislation does not obligate DV cases to be referred to the family mediation service in pre-trial proceedings. She also explains this to Anna, adding that it is up to Anna to decide whether she wants to participate in family mediation process or not. The specialist uses trauma-sensitive language and avoids probing into traumatic experiences. Anna feels empowered by provided choices and respecting her autonomy in decision-making.

Step 3: Comprehensive Assessment Anna's emotional, psychological social, and legal needs are thoroughly assessed, considering her cultural background and gender-specific issues, including risk assessment. A multi-agency approach is used, involving legal professionals and other relevant experts. Anna is actively involved in the risk assessment process. In the case of a high-risk case, as is Anna’s case might be, the case will be referred to the high-risk model.

Step 4: Immediate Support and Safety Planning Anna will be offered initial crisis counselling and, if necessary, immediate psychological support. If immediate safety concerns arise, a personalized safety plan is developed in collaboration with Anna. This plan includes strategies such as legal protections, temporary housing arrangements, and medical care provisions. Every aspect and action is discussed with Anna, safety planning and support reflect Anna's wishes and thoughts.

Step 5: Development of a Personalized Care Plan On the basis of the data collected and the safety planning, a personalized care plan is developed for Anna and the children. As the case relates to child welfare, the case manager is the child welfare specialist. She is also responsible for drawing up the care plan. The plan seeks to reflect Anna’s needs, strengths, and challenges within the context of her and children trauma history, promoting safety, empowerment, and healing. Depending on Anna's needs, the plan foresees different types of interventions, such as psychological counselling for Anna and

her children, a victim support service, a women's support centre service, assistance in finding accommodation, legal aid, etc. Anna plays a key role in the development of the case plan, as she is the person most familiar with the circumstances and with her own and the children's needs. The case manager will discuss all key aspects with Anna. Each member of the network, including Anna, has a specific role to play in implementing the plan.

Step 6: Ongoing Support and Services She receives ongoing, integrated support according to the Personalized Care Plane tailored to her evolving needs, with regular check-ins and adjustments. Services are delivered with cultural sensitivity, respecting her background and identity. The plan is regularly evaluated and changes are made to the plan as and when necessary. Every aspect and action is discussed with Anna.

Step 7: Monitoring and Feedback Anna's and childrens progress is closely monitored by the case manager, with her strengths and resilience continually acknowledged. Feedback mechanisms are encouraged to improve service effectiveness.

Step 8: Transition and Follow-Up As Anna achieves her goals and prepares to transition from the service, she receives assistance to establish long-term safety and stability. She is given clear guidance on follow-up support and resources, ensuring continuous support on her path to recovery. With her immediate safety concerns addressed and criminal proceedings underway, a detailed transition plan, including ongoing psychosocial support, case updates, and access to community resources such as housing, employment, and healthcare. Anna continues to receive emotional and psychological support, including ounselling and support groups. Her safety is regularly monitored, and protective measures are enforced. Feedback from Anna helps improve services, and she is connected to a long-term support network to ensure stability and empowerment

GREECE (UWAH)

CASE 1: UWAH SERVICE

Mrs. Marianna is 39 years old and comes from Albania. In her home country, she studied pedagogy, but as soon as she finished her studies, she was forced to come to Greece, following - against her will - her parents and her three older brothers, mainly for financial reasons. She crossed the borders illegally, facing many dangers and hardships. However, she does not want to talk about these. Instead, she often reminisces about her life in Albania, even though many years have passed. She misses the place where she grew up and her grandmother (alive, 90 years old), who took care of her while her parents

were working in Greece. She believes that if she had stayed there, despite the difficulties and often lacking even the basics while growing up, she would have a better life there.
Two years after coming to Greece, she met a friend of her eldest brother, also from Albania. Disagreeing with their relationship, her family forced her to marry him. She was opposed to it as she barely knew him. Mr. Edi was ten years older than Mrs. Marianna, a builder by profession. From the beginning, he made it clear that he did not want his wife to work, which saddened her greatly. So, having no other choice, she dedicated herself to raising their three children (currently 14, 12, and 7 years old).
All these years, there were many tensions in their relationship. Mr. Edi often came home from work having consumed alcohol, resulting in him speaking to her derogatorily, insulting her, and threatening her. With the economic crisis, she had to go work at a supermarket near their home as they struggled to make ends meet. At that point, her husband became particularly jealous, possessive, and controlling, and there were many times when he grabbed her by the hair or slapped her. Often, he forced her to have sex with him against her will. When she sought help from her family, they essentially "closed the door" on her, telling her that she was always "*dreamy and snobbish*" and that "*it is her duty to calm her husband down and keep her family together*."
For the past six months, Mrs. Marianna has been seeing a public psychiatrist for her panic attacks, who has also prescribed her antidepressant medication. Two months ago, seeing the marks on her face, the psychiatrist referred her to our Women's Counselling Centre to receive support. Although she seems to be helped, she often misses her appointments as no one knows she comes to us. At the same time, she is reluctant to report the incidents of violence to the police because she cannot support her three children financially or practically on her own

PATHWAY ENTERING - CARE4WOMEN ORIENTED

Step 1: Initial Contact and Safety Assessment - Mrs. Marianna has been referred to the Victims' Support Service. The professional should firstly introduce herself, the organisation she works in, her professional role and the goals of the organisation. Introducing the therapeutic contract, she will explain the way they work: the therapeutic alliance, the confidentiality policies, the process, the rights and obligations of both parties, and what to expect. She should use the basic principles of counseling, and most of all active listening, without making interpretations or using critisism or victim-blaming. She should keep in her mind secondary victimisation and make all required actions in order to prevent it. She should also be warm (in behaviour and way of talking), calm and

welcoming in order Mrs. Marianna to feel safe. In order to feel that she has the control of her life and she can make her own choices, she should be provided all the necessary information and the space to make any question or express her doubts or negative feelings. All the following steps, including the next meetings, should be mutually agreed in terms of building trust and alliance. Last but not least, she should evaluate Mrs. Marianna's emotional state and offer support, if needed.

Step 2: Welcome and Intake - The environment should be warm and calm, free of stressors and triggers, in order to welcome Mrs. Marianna and make her feel safe and welcomed. Iniatilly, a collaborative conversation between her and the professional takes place, full of understanding and empathy. Her rights, needs, vulnerabilities and strengths are being respected both at the inial stage and at the following process. Information are being provided regarding the available services and procedures (including legal processes e.g. restrictive measures), supportive networks and resources both by the community and in general. The next steps are being deeply discussed and Mrs. Marianna is actively taking part in the decision making, in terms of her empowerment. The professional has knowledge of all aspects of domestic violence and intimate partner violence, including their types, dynamics, motives, impact on the victim and on children and of the risk factors as well. Following this knowledge, psycho-education takes place in order Mrs. Marianna to get fully aware of her victimisation and to provide an accurate risk assessment. Gender and trauma-sensitive language and approach in general are being used, avoiding stereotypes, victim-blaming and probing into traumatic experiences.

Step 3: Comprehensive Assessment - At the third step, a comprehensive assessment of all survivor's needs takes place, namely: emotional, psychological, social, and legal needs. Special attention is being paid to her cultural backgroud, due to her coming from another country. Gender-related issues are also being addressed, while a thorought risk assessment takes place. A multi-agency approach is used, involving legal and mental health professionals (e.g. her psychiatrist) and other relevant experts.

Step 4: Immediate Support and Safety - Mrs. Marianna receives specialised counseling for victims of domestic and intimate partner violence, including psychosocial support. Following the risk assessment, safety planning takes places including her active participation and engagement in the whole process. The intervention includes legal information provision and counseling and motivational interviewing in order to proceed to the necessary actions that would ensure her and her children's safety and wellbeing,

as well as the accountability of the perpetrator. The professional focuses on her own strenghs and resilience, as part of empowerment.

Step 5: Development of a Personalized Care Plan - Based on the data collected from the risk assessment and the safety planning, a personalised care plan is developed for Mrs. Marianna and her children. As a result, the case manager is the professional from the victim support service. She is responsible for developing the care plan, which reflects Mrs. Marianna's needs, strengths, and challenges within the context of her and children trauma history, promoting safety, empowerment, and healing. Depending on the assessed needs, the plan foresees different types of interventions, such as psychosocial counselling for her, victim support service, immigrant integration center, mental health care, assistance in finding accommodation, legal aid, police and child protection services for her children. Mrs. Marianna plays a key role in the development of the case plan, as she is the person most familiar with the circumstances and with her own and the children's needs. The case manager will discuss all key aspects with her. Each member of the network, including Mrs. Marianna, has a specific role to play in implementing the plan.

Step 6: Ongoing Support and Services - Reflecting Mrs. Marianna needs, the provided support will be ongoing, flexible and adjustable –if required- as the time goes, according to the corresponding regular evaluations. Every change will be discussed with Mrs. Marianna. All services provided will be sensitive towards her and her children's trauma history, gender, identity and cultural background.

Step 7: Monitoring and Feedback - The case manager will be responsible for monitoring Mrs. Marianna's and her children's progress. Towards this end, the goals will be assessed, while their strengths, resources and resilience will be acknowledged, through the feedback that would assess, and thus improve, the service effectiveness.

Step 8: Transition and Follow-Up - Having fullfilled the goals of the programme and the intervention of the victim support service and maintained safety, Mrs. Marianna will be transited to the follow-up phase. During this phase, the outcomes will be generalised, stabilised and assessed. The professional will accompany her during this process by offering follow-up support and resources, ensuring continuous support on her path to recovery and providing emotional and psychosocial support. Her safety will be regularly being assessed and monitored and protective measures will be enforced. Feedback will be also be asked for so as to continue improving the interventions and provision of services.

ITALY (AMD)

CASE 1: GEA SERVICE

Marika is 29 years old and comes from Poland. She became a homelessness woman when she decided to leave her husband because of the violence he acts on her. She didn't work and she haven't family members here in Italy. For that reasons she's in charge to social services and she's host in a female shelter in Bologna. Marika suffers to mental distress and has developed an eating disorder. She joins MondoDonna' anti-violence Center sending by her social assistant; at first, she asks help to setup her legal position in Italy and to get a residency permit. She won't report against the perpetrator because she's afraid about the consequences. The anti-violence operator realized from the beginning her vulnerability and how damaged she had been by violence. Marika is unable to provide a detailed and coherent narrative of the episodes of ill-treatment and to focus on the pathway out of violence. Many aspects of suffering are mainly linked to the betrayal of cultural expectations on marriage and the idea of "perfect" family.

PATHWAY ENTERING - CARE4WOMEN ORIENTED

The woman is welcomed at the entrance by a low-threshold service worker who introduces herself, explains her role and accompanies her to the room where the interview will take place. It is explained to the woman that the Care4Trauma service collaborates with other services and professionals to assist and support her in the best way possible. In her case are involved: territorial social services, Anti-Violence Centre, civil and penal lawyer, educators, medical personnel like psychiatrist and psychologist. Each professional involved in taking care of M. should be female.

In the whole pathway the woman is an active subject and is putting in the middle of the network of services. She's supported to recognize the protective role of the network and is supporting in the repairing process of the traumatic events suffering in her life. Each figure will constantly inform the woman of the next steps without ever taking her place.

The team will share specific training moments using the peer-to-peer mode to adopt a common language so that the woman receives clear, transparent and non-confusing communication. During the project, the integrated team will hold monitoring meetings to be aligned. The team will have a case manager who will coordinate the various nodes of the network and will be the woman's daily reference point. The woman is always at the centre of the network and can decide who and when starting the intervention.

According to this, first and second TIC principles – Safety and Transparency - are closely interconnected, and they inform the whole path, especially the first meeting, fundamental to create a relationship based on trust and transparency.

Step 1: First Contact and Establishing Safety - Before Marika arrives at Care4Women GEA the operator will already know whether there is a need for cultural-linguistic mediation and, if so, she will activate it for the first meeting with the woman. At the very beginning of the meeting, the operator will explain why is present another person to reassure Marika. Both the operator and, in case, the mediator, are female, and they will be the ones who will accompany the woman throughout the whole path, interfacing with internal and external staff. They go to a private and non-noisy room, comfortably furnished and equipped with food, beverage and tissues. First, the operator must ensure that the woman understands the language and feels comfortable. Then she starts with Risk Assessment to understand, primarily, if the woman needs physical protection and how to active the legal process concerning documents: if she is no resident, she cannot make use of basic services such as health and economic benefits. After that, the operator will review the housing solutions that best meet Marika's protection needs.

Step 2: Transparency and Woman's Path - The operator clearly explains project's functioning, the staff and the role of each emphasising absolute confidentiality, non-judgement and freedom in making decision. She explains to Marika that her consent is essential in every step and intervention. The operator knows the timing of the project couldn't match with Marika times, so she works to follow woman's need and to bring them back to the integrated staff,

Step 3: Peer support - A dedicated service professional maps the territory by identifying realities where self- and mutual aid groups are active to find project who can support women supporting other women. Usually, there are different possibilities and this, beyond supporting psychologically Marika, could help to socialising and creating an informal support network.

Step 4: Collaboration and Mutuality - All the staff members are aware of power differences implicit in every relationship, especially in GBV and even more homeless people. So, they're careful of recognizing that they could unwittingly replicate the same power dynamic, substituting themselves, not listening and thinking that their own ideas are the most suitable for the well-being of women. Specifically in homeless people, concepts such as *home, trust, protection* may be unfamiliar; therefore, the first goal is to make the woman feel comfortable and build a relationship of trust.

Step 5: Empowerment, Voice, and Choice - According to previous principles, whether they are all integrated and implemented in the care pathway, the woman is given back the opportunity to have her voice heard and be heard, which in turn restores a sense of competence. This is done concretely by restoring an active role to the woman without replacing her, for example, once the priorities have been identified, ask the woman the order in which she wants to address them; provide her with a map of the city and offer to accompany her but do not take it for granted that she has to do so; explain to her how the different services in the area work, but let her experiment in discovering them; ask her what job she would like to do before activating the job counter.

Step 6: Cultural Historical and Gender Issues - Cultural and GBV lens characterize the entire care pathway. The staff is genuinely curious about life habits, ranging from nutrition to self-care and childcare - if there are any. We inquire about the role of women in different cultures, how health and thus mental illness is culturally understood and what possible treatment paths can be activated.

CASE 2: OLAS SERVICE

Endrienne is a 32-year-old woman, she comes from Cameroon and arrived in Italy via the Mediterranean Sea. She is an asylum seeker, and she is hosted in a CAS (Centro di Accoglienza Straordinaria) in Bologna municipality. Endrienne is forced into marriage with a man much older than her. Within the forced marriage, because of the rape and violence, she gets pregnant and gives birth a baby girl. To escape her husband's violence, she runs away with her daughter and takes refuge to her uncle’s house who offers to give her hospitality. One day, her uncle drugs and rapes her. Before the abuse Endrienne wakes up and finds herself naked on the floor with her daughter beside her. The uncle threatens her with a knife not to tell anyone about the rape. Endrienne still confused manages to escape with her daughter. She gets in touch with a friend in Libya who agrees to help her.

Endrienne is a victim of violence and trafficking for sexual exploitation. She is forced into prostitution in transit countries and in Libya. Her daughter dies during the crossing to Italy. Arriving in Italy Endrienne starts the procedure for recognition of international protection. She is sent to the anti-trafficking project by the Territorial Commission as part of the examination of her application for international protection. During the referral process, Endrienne struggles to tell her story of violence and exploitation. A condition of strong fragility and suffering immediately emerges; during interviews she dissociates and goes into flop mode. Identified as a victim of GBV and trafficking for sexual exploitation,

she joined the OLAS project and was placed in an anti-trafficking shelter. She starts psychotherapy and she is supported by the anti-trafficking operators about all matters concerning her health (including sexual and reproductive health) and social and job reintegration.

PATHWAY ENTERING - CARE4WOMEN ORIENTED

The woman is always at the centre of the network and can decide who and when starting the intervention. According to this, first and second TIC principles – Safety and Transparency - are closely interconnected, and they inform the whole path, especially the first meeting, fundamental to create a relationship based on trust and transparency.

Step 1: First Contact and Establishing Safety - Endrienne arrives at Care4Women, and she is welcomed by a female operator - who will be the one who will accompany her throughout the whole path, interfacing with internal staff and any external services. They go to a private room, comfortably furnished and equipped with food, beverage and tissues. The operator starts with Risk Assessment to understand, primarily, if the woman needs physical protection: they discuss together the option (shelter, mother and children community and so on) to find the best solution to meet woman's need. Then, the operator will explore with the woman other needs like food, clothes and all the things she needs. Then they say goodbye to each other and book another appointment.

Step 2: Transparency and Woman's Path - The operator clearly explains her role, the staff and the project by emphasising confidentiality, no judgement and the absolutely woman's freedom to decide for herself. Her consent is fundamental, and nobody is going to force her or to make decision for her. The operator will leave room for questions and any woman doubt. Every proposal is shared with the woman and every action is taken only with woman consent.

Step 3: Peer support - The Service Care4Woman will propose group activity run by trauma – trained staff and professionals skilled in expressive/somatic approach – like theatre, expressive arts that in the literature are indicated as effective in healing of trauma. Also mindfulness activities and working on windows of tolerance are useful to make women who experienced violence aware of how their bodies feel. Mirroring themselves in the experiences of others, recognising common elements in their stories and experiences in a protected and non-judgmental environment combats loneliness, stigmatisation and experiences of shame and fear. Women can organize by themselves using techniques learnt from the facilitators on the previous activity.

[From Step 4 (Collaboration and Mutuality) to Step 6 (Cultural Historical and Gender Issues): see Case 1].

SPAIN (ABD)

CASE 1: CAPSEM SERVICE

For the case study, work has been conducted on the implementation of the Trauma-Informed Care (TIC) Model in CAPSEM, that support women victims of gender-based violence, as well as their children, within the Madrid City Council.

The "Care4Women" service aims to provide a trauma-informed intervention model specifically designed for women who are victims of gender-based violence and their children. The primary goal is to ensure that users feel safe and secure during their interactions with the service. This is achieved by giving them access to intervention protocols, reports, and models of action, fostering transparency and trust. The service is committed to a strengths-based approach, empowering women by encouraging their active participation in their recovery process. It also emphasizes the importance of mutual support by creating spaces where both users and professionals can find help and solidarity. Additionally, the service integrates cultural and gender perspectives into its interventions to provide more personalized and relevant support. A critical focus of "Care4Women" is to prevent retraumatization, ensuring that both users and professionals are protected from further psychological harm during the intervention process

PATHWAY ENTERING - CARE4WOMEN ORIENTED

The Care4Women model closely aligns with the current practices in place. However, there are areas that require strengthening, such as the explicit inclusion of Trauma-Informed Care (TIC) principles in the organization's official documents and enhancing work with women to increase their understanding of these principles, the impact of past and present trauma, and their active participation in the recovery process.

Pathway requires 5 phases.

Phase 0: Reception and Welcoming - Explanation of the purpose of the service and the procedures that ensure the user's safety (fulfilling the principles of safety, trust, and transparency). First appointment with the assigned professional. Assessment of whether the user fits the service profile. If the user comes through a referral, she is not asked

again about her history of violence; the goal is to detect indicators and avoid re-victimization (principle of safety). If the user meets the service criteria: Informed consent is signed, including the TIC concepts. The intervention pathway is explained, and the Individual Care Plan (PAI) is signed. Documents are adapted (fulfilling the principles of safety, trust and transparency, empowerment, voice and choice, and cultural considerations).

Phase 1: Stabilization (trust and transparency, peer support) - Multidisciplinary work to stabilize the woman socially, emotionally, and legally. Inclusion of children and dependents in the intervention. Inclusion in mentoring groups with women who have completed their process.

Phase 2: Trauma Intervention (safety, collaboration, and mutuality) - Establishment of a specific trauma-focused psychological intervention program with evidence-based treatments.

Support during judicial proceedings, if any. Coordination with various social agents involved in the case, implementing the TIC approach. Supervision of cases and self-care sessions for the team to prevent burnout.

Phase 3: Reconnection (safety and peer support) - Group intervention aimed at establishing support networks.

Phase 4: Evaluation (collaboration and mutuality) - Satisfaction questionnaire.

There is also a need to improve and promote channels for user participation.

To prevent burnout, it would be beneficial to conduct an evaluation of the contributing factors, allowing for more effective solutions. Lastly, the establishment of a monitoring committee is essential to review and ensure the proper implementation of the model.

CASE 2: ABD SERVICE

For the case study, work has been conducted on the implementation of the Trauma-Informed Care (TIC) Model in ABD Service. Care4Women is a service dedicated to providing holistic, trauma-informed support for women affected by gender-based violence. The service's mission is to empower women through comprehensive care that addresses their physical, emotional, psychological, and social needs. The core values of the organization—safety, empowerment, transparency, cultural sensitivity, and collaboration—guide its approach to ensure that each woman receives compassionate, respectful, and effective support. Care4Women offers a range of specialized programs, including welcoming and socio-educational support, psychological therapy, and legal

guidance, all delivered through a trauma-informed lens to prevent revictimization and foster healing.

The organization is staffed by a highly specialized team, including social workers, psychologists, legal advisors, and educators, all trained in trauma-informed care. Care4Women also maintains strong connections with community services to provide a coordinated approach to recovery. With a robust support infrastructure and active community engagement through education and partnerships, Care4Women aims to create a safe, empowering environment where women can rebuild their lives with autonomy and resilience. The service continually seeks feedback and invests in ongoing training to adapt and improve its offerings, ensuring it meets the evolving needs of the women it serves.

Reception and management of requests: Direct request, direct contact from the woman with the service. From this moment, establish the principles of safety, trustworthiness, and transparency with a cordial and respectful tone.

External Referral: When referrals come from other services (family medicine, social services, women's services, etc.), and the woman is contacted by the center, briefly explain the purpose of the call to the woman. The administrative staff introduces themselves and provides the woman a brief explanation of why we have her name. Next, the service is presented, and an appointment is given. The woman is guided on the location of the service. All of this facilitates best practices based on the principles of safety, trustworthiness, and transparency.

Welcoming and socio-educational program: The woman's first visit to the service is the Welcoming visit. The professional introduces themselves to the users, explaining their role, what they do, and how they do it (this way, the user is provided with tools to take control of her life). These are best practices based on the principles of emotional, physical, and psychological safety of the women.

Data about the woman is collected, and the operation of the service is explained (principle of trustworthiness and transparency). Finally, in this phase of the process, the woman is listened to, and her request for our service is addressed (principle of Empowerment, Voice, and Choice). At all times, revictimization and retraumatization are actively avoided, meaning avoiding the woman having to recount or provide detailed information about her traumatic experience (again or because she is not yet ready). It is also important to consider the user's culture and needs to ensure her recovery (principle of cultural, historical, and gender considerations).

At this point, the woman signs the consent form for the treatment of her data, and the content of this document is explained (principle of trustworthiness, transparency, and safety). Similarly, it is considered essential to be mindful of the woman's culture, translating documents into a language she can understand to exercise her rights.

The woman will be informed of the need to coordinate with other services involved to help her move forward (principle of trustworthiness, transparency, collaboration, and mutuality).

During the assessment process, needs are identified in different areas, and objectives are set, facilitating best practices based on the principles of safety, empowerment, voice, choice, collaboration, and mutuality. If at any point the woman needs legal advice, this will be available through the program as part of our service (principle of safety). Women can also participate in a group format where they will receive advice on topics that may be useful in a peer environment (principle of peer support and facilitating relational connections).

Psychological Program: In the first session, the professional introduces themselves, listens to the woman's request, and frames the psychotherapeutic process. In this initial interview, it is important to explain what this process involves and provide feedback (principle of safety, trustworthiness, and trustworthiness).

At this stage, the possible traumatic experience is not addressed. First, potential ACEs (Adverse Childhood Experiences) are analyzed, and an emotional safety space is provided, ensuring that the woman feels secure and the emotional impact of the violence can be detected (principle of safety, avoiding victimization and re-traumatization).

Possible ACEs are recorded. Once a traumatic experience is identified for the woman, her overall health and stabilization are prioritized. If necessary, various coordinations with other services are made (principle of safety, collaboration, mutuality, and cultural considerations). The woman is an active participant in her process at all times (principle of Restoring decision-making capacity and control over one’s life), deciding what she wants voluntarily with psychological support.

In the case of PTSD treatment, observable indicators are assessed, and each psychologist works from their intervention model on the emotional and psychological impact of gender-based violence until the woman can achieve her recovery goals.

The decision to join a group is made through a joint assessment between the woman and the professional accompanying her at that moment, depending on the program.

Regarding child and adolescent psychological care, considering the impact resulting from exposure, whether direct or indirect, to gender-based violence, we are faced with

suffering that can manifest in various systems: affective, behavioral, somatic, cognitive, dissociative, and relational. The child and adolescent program are aimed at specifically and individually addressing the problems derived from exposure to gender-based violence. From the therapeutic intervention, it is essential to provide a context of intervention with a space that offers safety, where the child can express themselves freely. An intervention appropriate to the child's developmental age, taking into account adaptive mechanisms that promote resilience.

Professional Care and Prevention of Vicarious Trauma

The following actions are taken to ensure professional care and prevention of vicarious trauma:

- Balanced Agenda Organization: We structure the work schedule to ensure a balance between direct care hours, internal tasks, and coordination meetings (both within the team and with external services). This approach helps manage workload and reduce the risk of burnout, allowing professionals to handle their responsibilities more effectively.
- Team Spaces: We create dedicated team spaces to discuss cases, share challenges, and express discomforts. These sessions provide an opportunity for mutual support and collective problem-solving, ensuring that professionals feel supported and not isolated in their work.
- Case and Team Supervision: Regular supervision sessions are held for both individual cases and the entire team. This allows for professional guidance, reflection, and the identification of potential areas of vicarious trauma, helping to mitigate its impact.
- Participation in Network Meetings: Professionals participate in network meetings to stay connected with the community, alternating direct care with interactions outside the service. This includes attending meetings with other professionals, engaging in training sessions, and participating in community actions, all of which help maintain a broader perspective and reduce the emotional intensity of direct care work
- Ongoing Professional Training: Throughout the year, professionals engage in continuous training. This ongoing education ensures that they are equipped with the latest knowledge and skills to handle their roles effectively, while also providing a sense of growth and development, which can counterbalance the emotional toll of the work.

These strategies collectively aim to protect professionals from vicarious trauma, ensuring their well-being while maintaining a high standard of care for the individuals they support.

Chapter 6

Policy recommendations

Care4Trauma project produced a throughout analysis of national, regional, and local laws, policies, guidelines, and victim surveys related to trauma-informed care. The research consisted of mapping the relevant documents and assembling documents accordingly and then scrutinize these according to the pre-defined indicators.
Trauma-informed approaches require fundamental changes in how practitioners and institutions engage with women, how organizations function and how systems (such as the health system and the justice system) are reported.

6.1 Actions to better implement GBV TIC in Europe

Care4Trauma project produced a throughout analysis of national, regional, and local laws, policies, guidelines, and victim surveys related to trauma-informed care. The research consisted of mapping the relevant documents and assembling documents accordingly and then scrutinize these according to the pre-defined indicators. The documents were divided into three categories: Strategic level documents (e.g. legislation, national administration guidelines, charters and strategic plans); Organizational level policy documents; and Organizational level procedure documents.
In sum, the mapping highlighted a basic understanding of re- traumatization but not enough comprehension, and cultural competence with administrative/legal bureaucracy barriers and a lack of victim's empowerment.
Professionals mirrored mapping scenarios when responding to survey and to semi-structured interviews reporting several insights to sustain a further implementation of TIC into European policy strategies
Trauma-informed approaches require fundamental changes in how practitioners and institutions engage with women, how organizations function and how systems (such as the health system and the justice system) are designed. For individual practitioners, a change in strategy means attempting to eliminate assumptions about women who experience violence and trauma and their actions. For organizations and systems, it means supporting a culture of learning and capacity-building to create safe environments for women and professionals.

The following information outlines four key principles and sample implementation strategies for service providers and organizations working with women victims of violence in Europe:

1. Understand trauma and violence and their impacts on peoples' lives and behaviors

Service providers

- Acknowledge the root causes of trauma without probing. Women do not necessarily need to disclose what may have happened to them for you to help them
- Pause and reflect when women act or reacts in an unexpected way
- Listen, believe and validate victims' experiences
- Recognize their strengths;
- Express concern

Organizations and systems

- Develop organizational structures, policies and processes that foster a culture built on an understanding of how trauma and violence affect women's lives
    - Develop hiring practices that seek people who understand trauma and violence and reward systems that compensate employees for building their competencies in this area
    - Train all staff on the connections between violence, trauma and health outcomes and behaviors, including vicarious or secondary trauma

2. Create emotionally and physically safe environments

Service providers

- Communicate in non-judgmental ways so that women feel deserving, understood, recognized and accepted
- Foster an authentic sense of connection to build trust
- Provide clear information and consistent expectations about services and programs

Organizations and systems

- Walk through your practice setting to see and assess how a woman might experience each moment. This simulation can help identify where improvements can be made. For example:
    - Travel to the site on bus and see what it feels like to arrive at the service site.

    - Spend time in the waiting area, fill out the forms and experience how long a client might wait to be seen.
    - Go through all client activities, such as being asked to undress/put on a gown, being physically examined or asked sensitive questions.
- Pay attention to welcoming intake procedures and signage, comfortable physical space, consideration of confidentiality
    - Seek women's input for inclusive and safe strategies
    - Create policies and structures to allow women to bring a support person with them to meetings when possible
- Provide support for service providers at risk of secondary trauma and facilitate their self-care.
- Consider peer support, regular clinical supervision, and self-care programs.

3. Foster opportunities for choice, collaboration, and connection

Service providers

- Provide choices for treatment and services, and consider the choices together
- Communicate openly and without judgement
- Provide the space for women to express their feelings freely
- Listen carefully to the women's words and check in to make sure that you have understood correctly

Organizations and systems

- Offer training and professional development opportunities for staff on:
    - the importance of critical self-reflection on power differences between practitioners and women
    - how experiences of violence can influence the way that women engage with providers
- Set expectations, create opportunities and provide the time and space for collaborative relationships

4. Provide a strengths-based and capacity-building approach to support client coping and resilience

Service providers

- Help women identify their strengths, through techniques such as motivational interviewing, a communication technique that improves engagement and empowerment
- Acknowledge the effects of historical and structural conditions on women's lives

- Help women understand that their responses are normal
- Teach and model skills for recognizing triggers, such as calming, centering and staying present

Organizations and systems

- Provide sufficient time and resources to support meaningful engagement between practitioners and women
- Offer a range of services and interventions that respond to women's needs, strengths and contexts
- Foster an organizational culture that recognizes the importance of emotional intelligence and social learning in the workplace

5. Addressing the impact on service providers who work with people who have experienced violence and trauma

Service providers who work directly with people who have experienced violence often hear difficult stories and witness the impact of these experiences. Second-hand exposure to experiences of violence can result in vicarious or secondary trauma, with negative health impacts which are similar to those experienced by people with first-hand experiences of violence, such as:

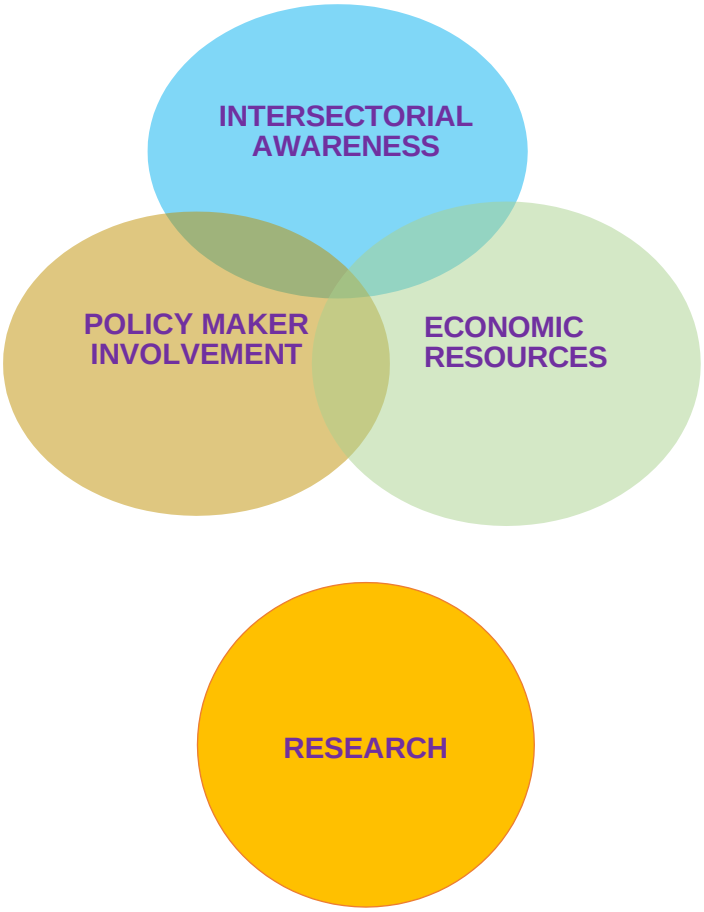
- depression, emotional exhaustion and anxiety
- sleep disturbances and intrusive thoughts
- trigger to external events, some of which may seem harmless to others

Organizations can help reduce secondary trauma for their employees with trauma and violence-informed policies and practices that:

- actively support the well-being and self-care of service providers who are repeatedly exposed to others' stories of violence
- help providers to understand women's responses to violence, including their own
- help to prevent 'trigger responses' for both women and providers

When they are well-supported by trauma and violence-informed approaches and workplace wellness programs, service providers can find satisfaction and growth in their work, despite the challenges.

6.2 Focus table: key implementation policy



KEY STRATEGIES

1. **Training and Education**
2. **Standardization and Monitoring through applied research and evidence-based practices**
3. **Collaborative and multi-professional partnerships at different levels of the system**
4. **Resources and Support**
5. **Advocacy and Awareness-raising**
6. **Gradual implementation of the approach**
7. **Greater Involvement of policy-makers**

Access to Justice

	Strengths points	Development points
1	Women's Support Centers available in all partner countries.	Need for a shared methodology to interview and assess women and for the implementation of a shared monitoring system to measure trauma-informed-care effectiveness when women access justice
2	A basic awareness about the relationship between violence and trauma at an individual level.	Institutions need to sustain consistency over time to consolidate trauma-informed-practices over time.
3	Trainings on GBV, IPV and TIC are gradually made available for justice professionals.	Training should be mandatory, ongoing, and based on evidence-based practices.

6.3 Strategic dissemination actions of GBV-TIC in European Services and Institutions

There are several strategies that can are central for all partner countries becoming, therefore, a European-wide priority:

- **Providing training and education**: Organizations should provide training and education on TIC to their staff and partners. This can help build awareness and understanding of the importance of TIC and provide staff with the skills and knowledge needed to implement TIC principles in their work.
- **Creating policies and procedures:** Organizations should create policies and procedures that prioritize TIC and ensure that it is integrated into all aspects of their work. This can help ensure that TIC is not just a buzzword, but a guiding principle that is incorporated into all decision- making processes.
- **Offering financial incentives:** Financial incentives can be offered to organizations that demonstrate a commitment to TIC. This can include funding for training, implementation support, or other resources that are needed to implement TIC effectively.
- **Creating a culture of accountability:** Organizations can create a culture of accountability around TIC by setting **measurable goals, tracking progress, and regularly evaluating the effectiveness of TIC implementation.** This can ensure that TIC remains a priority over time and that progress is continuously made.
- **Multi-agency collaboration and partnerships:** Organizations can partner with other organizations, government agencies, and community groups to promote TIC and create a more coordinated response to gender-based violence. Collaboration and partnerships can help pool resources, expertise, and knowledge, and promote a shared vision for TIC.

Overall, promoting and favoring the dissemination and adoption of TIC requires a comprehensive approach that addresses the **cultural, organizational, and systemic barriers** that may exist. By adopting these strategies, services and institutions can create a more trauma-informed and woman-centered response to gender-based violence, which can ultimately help improve outcomes for survivors.

Identified actions by TIC principles across Europe

TIC PRINCIPLES	KEY IDENTIFIED ACTIONS	KEY STRATEGIES
RECOGNITION	Recognizing the effects of violence as a form of traumatization and its pervasiveness. Furthermore, being able to interpret trigger-related behaviors to modulate support accordingly .	1. Training staff in trauma and GBV recognition. 2. Using screening and assessment tools based on scientific evidence 3. Using research to inform interventions and organizational setting to better respond to GBV-related trauma
ESTABLISHING EMOTIONAL SAFETY	Set-up daily actions to foster calm when women access to justice and care systems. Physical environments should be also considered in terms of layout, quiet spaces in welcoming women. Providing psychoeducation about practices and procedures	1. Active and non-judgmental listening in a safe environment; 2. Waiting rooms that are noise free and that provide privacy to women 3. Signs to indicate where to find professionals and rooms

RESTORING CHOICE AND CONTROL	Women should be an active part of their recovery and they should be given choice about treatment, life choices and they should be given the opportunity to express what it is in their best of interest.	1. Promoting service-users involvement in designing refuges, services and interventions 2. Women survivors increasingly involved in advocacy initiatives
FACILITATING CONNECTION	Creating a safe and supportive environment where the women feel comfortable to share their experiences, thoughts, and feelings	1. Building supportive relationships 2. Encouraging participation in group activities 3. Courage of nominating traumatic experiences
AVOIDING RE-TRAUMATIZATION	Systems is more aware of how re-traumatization work and attempts to prevent the risk of re-traumatizing	1. Trauma-informed communication 2. Providing choices and control 3. Avoiding to ask many times about the experience of violence 4. Avoiding stigmatizing language
CULTURAL COMPETENCE	Recognition and addressing cultural biases. Provision of language services. Building partnerships with culturally specific organizations	1. Education and training 2. Partnering with community- based organizations 3. Cultural experts to sustain professionals
SECONDARY TRAUMA	Provision of regular supervision and support. Promotion of self-care. Training on trauma-informed care. Fostering a supportive work environment	1. Professionals must prioritize self-care as a key strategy to avoid secondary trauma. 2. Professionals working with victims of violence should receive comprehensive trauma-informed training to develop the knowledge and skills necessary to recognize and respond to trauma in a sensitive and supportive manner.

Conclusions

In sum, to implement Trauma-Informed Care systematic changes are required:

Develop and adopt TIC policies: It is important to develop and adopt policies that prioritize TIC in all areas of service delivery, including health care, social care, and the judicial system. These policies should reflect a trauma-informed approach and provide guidance on **how to provide services that are sensitive to the needs of women who have experienced violence.**

Provide TIC training and education: Staff and professionals working in health care, social care, and the judicial system should receive training on TIC principles and how to implement them in their work. **Training should be mandatory, ongoing, and reflect evidence-based practices.**

Allocate funding for TIC implementation: Funding is needed to support the implementation of TIC principles in health care, social care, and the judicial system. This can include **funding for training, the development of policies and procedures, and the evaluation of TIC interventions.**

Promote interagency collaboration: Interagency collaboration is crucial in providing a comprehensive response to gender-based violence. Policies should encourage collaboration between different agencies to ensure that women who have experienced violence receive the services they need.

Monitor and evaluate TIC implementation: Policies should promote the monitoring and evaluation of TIC implementation **to ensure that services are meeting the needs of women who have experienced violence.** This can include tracking the implementation of policies and procedures, measuring the effectiveness of TIC training, and evaluating the outcomes of TIC interventions.

Support research on TIC: Policies should support research on TIC principles and how they can be effectively implemented in different settings. This can include research on the effectiveness of TIC interventions and the **identification of best practices** for TIC implementation.

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