Responding to Trauma

in Newry and Mourne

A report commissioned by
Newry and Mourne Local Health and Social Care Group

Responding to Trauma in Newry and Mourne

Prepared by
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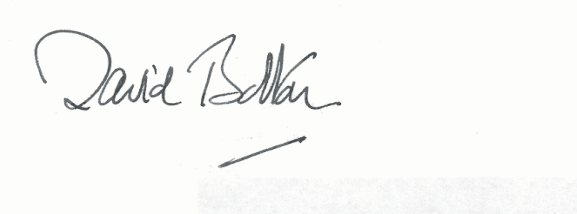
Acknowledgments

In presenting this report I want to acknowledge with warmest appreciation everyone who contributed to the fieldwork which forms its bedrock. In particular my thanks to all who met with me, who spoke to me by telephone, communicated by email, and those who sent me information about their work, their view of the needs of the area and their thoughts and hopes for services.

I want to note especially the members of the Trauma Steering Group, which under the auspices of the Newry and Mourne Local Health and Social Care Group developed the commission for the Report, and offered their own thoughts and guidance, and who together have a vision for improvement and progress in the localities in which they live and serve.

Finally, warmest appreciation to Micéal Crilly, Nikki Girvan and Orlaith Moley from the Local Health and Social Care Group for their practical support and guidance, for facilitating various meetings and for their hospitality.



David Bolton
The Northern Ireland Centre for Trauma and Transformation
Omagh

March 2006

Foreword

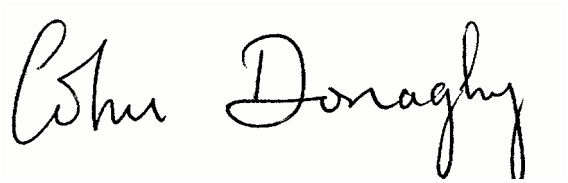
It gives me great pleasure to introduce and endorse this report which documents the support needs of those who have experienced trauma in the Newry and Mourne area.

Whilst there has been an understandable focus on the effects of the Troubles for individuals over recent years, Newry and Mourne Health and Social Care Group identified a need to consider those people who experience trauma caused by non-troubles related incidents. Traumatic experiences such as road accidents, assaults or the sudden death of a loved one can be extremely distressing and, whilst most people overcome these events, others have long term difficulties with the associated changes in their lives.

This report identifies and discusses these issues, highlights the need for a range of actions to be taken and suggests a series of recommendations to strengthen and improve trauma services.

I would commend this report to all those organisations – statutory, community and voluntary who are in a position to implement its findings.

I would conclude by congratulating the commitment of those involved in the writing of what I am sure will be an influential report in this field of work.



Colm Donaghy
Chief Executive
Southern Health and Social Services Board

The Newry and Mourne Trauma Steering Group

The following were members of the Steering Group at the time the Report was commissioned.

Micéal Crilly	Manager, Newry and Mourne Local Health and Social Care Group
Laurence Evans	Mental Health Services Manager, Newry and Mourne HSS Trust
Eileen Murphy	Manager, Newry Women's Aid
Rosemarie McDonnell	Branch Manager, Newry Victim Support
Danny McIlory	Team Leader South Armagh District, Mental Health Department, Newry and Mourne HSS Trust
Dr Liz Neeson	Consultant Clinical Psychologist, Mental Health Department, Newry and Mourne HSS Trust
Teresa Nugent	Project Manger, Rural Health Partnership
Clare Quigley	Trauma Advisory Panel Coordinator, SHSSB
Louise Shields	Counsellor, Just Ask Adolescent Service
Patrick Stott	Children's Services Manager, Barnardos, Newry Family Resource Centre
Aine Thompson	Counsellor, Trauma Counselling Service, Newry and Mourne HSS Trust

1.0 Executive Summary and Recommendations

Newry and Mourne Local Health and Social Care Group (LHSCG) commissioned this Report in the spring of 2004. The LHSCG required an outcome that would identify the most appropriate model of service for people suffering from psychological trauma related needs and disorders. The Report contains an overview of the evidence gathered from fieldwork undertaken chiefly in the Newry and Mourne area, along with a detailed overview of needs, and descriptions of key services. It builds upon current strengths and imaginative developments in the Newry and Mourne area, seeks to identify how current systems and arrangements could be made to work even better to the advantage of individuals and families, and contains a number of developmental recommendations. Those recommendations are embedded in the Report and are drawn from the consultation process and the assessment of research and other literature. They are listed below for convenience.

The Report also contains a strategy for addressing trauma related needs, with three key elements, namely; *prevention*, *early detection* and *the provision of appropriate treatment and support services*. Building on this, the Report contains (in Appendix 6) a development programme, which should form the basis of future action under the direction of a steering body. The areas for development are summarised in paragraph 8.1 and the basis for the draft programme is discussed in Section 11. The programme is extensive and realistically will not be implemented 'in one go'. It offers however, a series of measures, which under the guidance of a steering group could be actioned in accordance with current priorities and opportunities, and inevitably, as resources become available.

Approach Taken

Following discussions with the Manager of the Newry and Mourne LHSCG and members of the Trauma Steering Group (TSG), the initial work involved desktop research and the identification of organisations and people who should or could be contacted about the development of a trauma strategy. The desktop research and input from the TSG revealed general pointers about the needs of the area, and secondary indicators of the needs relating to trauma. Little or no information was available at this stage regarding the levels of needs and information about specific services available was not easily accessible.

Building on this overview and following a series of meetings a picture emerged of the area and its needs, along with the concerns and the hopes of the various individuals and organisations that were consulted. Time limitations did not permit a comprehensive consultation and regrettably some planned meetings did not take place. The process however, brought the issues into sharp relief

and even from an early stage ideas were emerging that were considered and tested in the later stages of consultation. Beyond the direct consultation processes, international ideas about good practice and the work of The Northern Ireland Centre for Trauma and Transformation on developing a public health approach to trauma have been incorporated into the report.

This Report is a synthesis of all of these contributions. The aim was to produce a strategy with a strong local feel that is based on humanitarian values and reflects optimum service standards.

Summary of Principal Recommendations

The principal recommendations are presented below in order of strategic significance. Each should be read in the context of the sections and paragraphs in which they occur, as there are additional details included therein. Other recommendations are included in the body of the Report.

1.1 It is recommended that a strategy for addressing the causes and consequences of trauma is developed through a public health and wellbeing initiative. (Para. 10.1; p.63)

1.2 It is recommended that arrangements be put in place to co-ordinate the unfolding and operationalisation of this strategy and to provide a mechanism for ensuring that key stakeholders are involved (building upon what is already in place in the Newry and Mourne HSS Trust area). (Para. 10.4; p.65)

1.3 It is recommended that initiatives be taken:

- **To acquaint key organisations and individuals in the community of the needs of those who suffer traumatic experiences and of what services are currently available;**
- **To put in place and identify resources who can be contacted by families, employers, clergy and faith leaders, teachers, who are likely to be aware at an early stage of the fact that a person has suffered a traumatic experience or whose needs have given rise to concern (examples of resources are literature, video and named professionals);**
- **To build upon and extend where possible across the Newry and Mourne area community programmes that promote health and address the conditions and causes of traumatic incidences. (Para. 7.2.2; p.36)**

1.4 It is recommended that funders, services and practitioners treating trauma in adults and children in the Newry and Mourne area identify and move to adopt recommended guidelines[1] on the assessment and treatment of trauma related conditions as the basis for service standards.

- **Organisations providing treatments for trauma should audit their practice against recommended guidelines with a view to complying with these guidelines;**
- **Treatments and interventions not specifically addressed by such guidelines should only continue to be used if subject to proper evaluation of treatment outcomes. Treatments and interventions not specifically addressed by the guidelines should only continue to be used following a process of appropriate consultation, supervision and evaluation;**
- **In relation to both adults and children's services, provider organisations and practitioners should make or strive to keep abreast of research with a view to building upon, reviewing and updating their practices. (Para 9.1.5-8; p60)**

1.5 It is recommended that further discussions and planning should be undertaken to determine:

- **How support for primary care services could be developed and provided to assist with the detection of trauma related conditions (and other mental health needs);**
- **The optimum initial responses at primary care levels – in line with other relevant recommendations in this report; and**
- **How best to enable suitable onward referral to appropriate services. (Para. 7.10.2 p.46; and see Recommendation 1.6).**

1.6 It is recommended that GPs and other primary and community care services, including other statutory and non-statutory services working in relevant areas, have the facility to liaise with an identified professional (or professionals), who are competent to advise on the presenting and treatment needs of persons thought to be suffering trauma related conditions. (Para. 7.11.2; p.47; see also Para 7.11.5)

1.7 It is recommended that the NICE (National Institute on Clinical Excellence) Guidance on the treatment and management of post traumatic stress disorder, published in 2005, is used to review

[1] Examples of recommended guidelines provided in references at the end of the document; Appendix 8; p.94

current Trust major incident plans and specifically to assist social services and mental health services to prepare for such events. (Para. 7.14.2; p.53)

1.8 In order to increase awareness about the Troubles related Trauma Counselling Service it is recommended that:

- **Information about criteria for referral, contact details and updates on the Newry and Mourne HSS Trust's Trauma Counselling Service should be circulated to potential referrers on an annual basis.**

- **The service should continue to act as a resource for consultation by the Community Mental Health Teams. In time, as development permits, this facility should be extended to other key organisations within Newry and Mourne. This consultative advisory role should be factored into the Trauma Counsellor's work plan and the time commitment monitored to assess demand and inform future developments. With a development of this service and increased awareness by the public and referrers, demands on the current provision will increase. The demand should be monitored and where indicated the service should be increased as resources become available.**

- **A similar service should be developed within Newry and Mourne to provide trauma-counselling services for people affected by traumatic events not associated with the Troubles. Expanding the existing Trauma Counselling Service or developing a parallel service could achieve this. This innovative service will need to be promoted amongst key professionals and organisations throughout Newry and Mourne. Demand for such a service development is evident.**

- **Consideration should be given to relocating the service from its present location while retaining strong links with the Victim Support organisation.**

- **The Trauma Counsellor establish clinical, referral and support links with other specialist trauma services. (Para 7.11.12; p.49-50)**

1.9 It is recommended that pending the development of regional regulatory arrangements a minimum set of standards is adopted which providers of counselling and related services (such as

befriending, pastoral care, listening ear) should be encouraged to comply with and which in any case, should be required by funders who are part or wholly funding such services. As part of the strategy for improving services, and to assist organisations in meeting the requirements of funders, a programme of support and development should be put in place for community, voluntary, statutory and private organisations involved in responding to trauma related needs. (Para. 9.2.2; p.61)

1.10 It is recommended that a recurrent trauma related training programme is put in place for volunteers, untrained staff and support workers of organisations involved in responding to trauma related needs and for others working in the community to support individuals and families. (Development Programme; Early detection and referral; p.80)

1.11 It is recommended that the SHSSB Trauma Advisory Panel continues to be formally represented in the Newry and Mourne strategic mechanisms that emerge to develop and progress strategic developments in trauma services. (Para. 7.12.1; p.50)

1.12 It is recommended that a directory of trauma related services be developed, published and maintained by a representative partnership of key organisations within the locality. (Para. 9.2.3; p.61-62)

2.0 Introduction

2.1 Being involved in or witnessing terrifying, life threatening or otherwise deeply distressing experiences can lead to the development of short-term periods of distress. Short-term distress can vary from relatively mild upset to the experiencing of a range of very intense symptoms. Such experiences can range from a few days to 4-6 weeks in duration, and often people find that their symptoms and coping improve gradually until they can recall the traumatic event without any undue reaction.

2.2 Consideration of the needs of people who experience acute distress following a traumatic experience, suggests that:

i. Acute distress should not be viewed as an illness; rather as evidence of efforts by the individual to adjust to a distressing experience;
ii. Assistance should have a strong practical and social support focus, and provide sound guidance and information to normalise the reactions, provide reassurance and guidance on how best to manage and minimise the distress, and to monitor (including self-monitoring) one's reactions;
iii. Short-term pharmacological (prescribed drugs) interventions can be helpful to restore sleep and assist with the management of high levels of distress;
iv. Single session one-to-one Critical Incident Stress Debriefing (CISD) is not recommended;
v. Where people present with very high levels of distress, which are indistinguishable from post traumatic stress disorder i.e. within one month of the onset of symptoms, a course of trauma focussed cognitive behavioural therapy should be considered.
vi. A group of people who will not have had any immediate short-term adverse reactions may develop longer-term trauma related problems.

2.3 Beyond such acute responses, a proportion of people will develop more serious post trauma conditions such as post traumatic stress disorder[2] (PTSD) or other conditions or illnesses which can arise following involvement in a traumatic experience. One study[3] (n=211) of admissions to an Accident and Emergency Department showed that, *at 4 months after admission*, 67% did *not* have an illness related to their traumatic

[2] A detailed definition of PTSD is included in Appendix 2

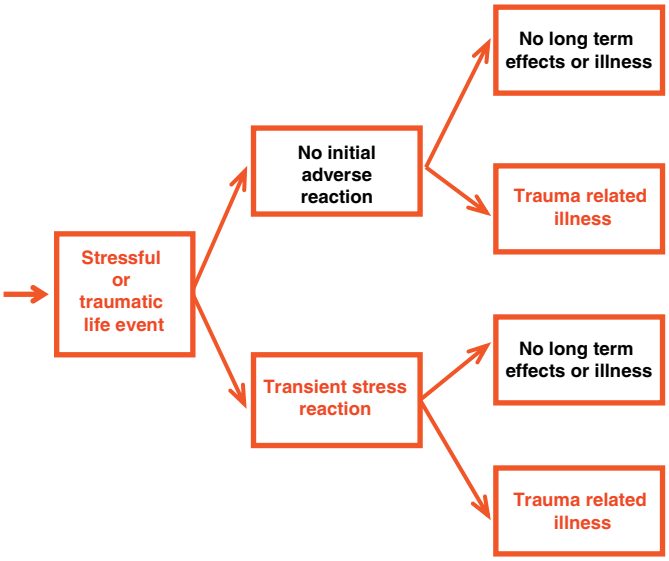
[3] Shalev AY, Yehuda R. Longitudinal Development of Posttraumatic Disorders. In Oldham JM, Riba MB, American Psychiatric Press Review of Psychiatry, Vol. 17, 1988. American Psychiatric Press, Washington, D.C., 1998.

experience (an important point to note). Of those who developed longer term problems, with some over lapping:

- 17.5% developed PTSD;
- 14.7% developed other anxiety disorders; and
- 14.2% developed depression.

2.4 The following chart illustrates the possible outcomes following traumatic experiences.

Chart 1: Outcomes of Traumatic Experiences



The above study[4] found that 17.5% of those who experienced a traumatic event developed post traumatic stress disorder (PTSD) within four months. Other studies[5] found much higher levels of PTSD (as high as 90% in a study of people subjected to rape). For planning purposes we could reasonably conclude that about a quarter of those *directly exposed* to traumatic events will develop PTSD.

2.5 From the sufferer's point of view PTSD and related illnesses are often deeply distressing and result in significant changes in mood, thinking and behaviour (including changes such as withdrawal from relationships and interests, and disengagement from work and other activities). This may lead to daily living problems in social, occupational (work and school) and

[4] Shalev and Yehuda; 1998; op. cit.
[5] See bibliography for some relevant references including Kessler et al 1995.

relationship terms, and the exercising (or omission) of key life choices that have a long-term bearing on the person and his or her family.

2.6 Specifically, the effects of PTSD are felt on the family, school and work. Whitney[6] noted in an overview of research on PTSD, "*the most adverse outcomes are associated with traumas that occurred in childhood, particularly when it is repetitive. In the National Co-morbidity Survey*[7]*, PTSD was associated with:*

- *40% elevated odds of high school and college failure;*
- *150% elevated odds of unemployment during an episode; and*
- *60% elevated odds of marital instability."*

She also notes *"there is an associated mortality with PTSD. PTSD patients are 6 times more likely to attempt suicide compared to controls (i.e. those who did not have PTSD), and PTSD results in more suicide attempts than in all other anxiety disorders*".

2.7 She concluded that in relation to work, the level of productivity loss per employee suffering PTSD was similar to levels found with depression.

2.8 When PTSD symptoms or the causes of related illnesses are not recognised as being related to a traumatic experience, then patients can be misdiagnosed and as a result might not get access to the most appropriate services. Where treatments aimed at managing the symptoms do not actually bring about recovery, they can ease the symptoms, although in such circumstances the need for health and social care services is likely to endure over a lengthy period, until either the person recovers naturally[8] or is provided with an appropriate treatment. Such difficulties are compounded when appropriate services are not readily available, or not available at all.

2.9 It is entirely desirable that people with such conditions are identified and appropriately treated as soon as possible (noting that clinically recommended early intervention services for those with acute distress and recent symptom onset, differ from those aimed at addressing clinically diagnosed PTSD – see 3.2 p.15.

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[6] Whitney; Post Traumatic Stress Disorder; Discussion paper prepared for The Workplace Safety and Insurance Appeals Tribunal; May 2002.

[7] Kessler R.C., Sonnega, A., Bromet E., Nelson C.B. Post traumatic stress disorder in the National Comorbidity Survey. Arch Gen Psychiatry; 52:1048–60; 1995.

[8] Studies show that *a proportion* of people with PTSD will recover without treatments; e.g. Kessler et al 1995.

2.10 There is a key problem for health and social services in planning services for those affected by traumatic experiences, i.e. knowing who will develop PTSD or some other trauma related disorder following traumatic experiences. Studies in PTSD show that whilst trends are observable, the indicators of risk of illness are not sufficiently well known to enable sound judgments to be made about who precisely will be at risk and who should be offered services. The idea of 'watchful waiting' has been used to describe current thinking on how those who have experienced traumatic events could be kept under review (and assisted to monitor their own reactions) with a view to offering (and seeking) appropriate help should a trauma related disorder develop.

2.11 This strategy is based upon a model of care and intervention:

- which provides for pre-trauma and early post trauma preparation, information for the public and key service stakeholders and (first) points of contact for the public;
- which builds upon family and community support, aimed chiefly at detecting distress and providing appropriate supports and responses at that point;
- which supports primary and secondary services being tuned to detect trauma related needs (or being supported to do so) and to provide appropriate responses and services;
- which supports specialist provision for those who have developed trauma related illnesses and in particular for those with complex or chronic trauma related conditions which do not respond to services provided in other parts of the service network;
- which recommends access for self-referring patients[9], and for those who have not recovered from, or are not expected to recover from, interventions provided by community and primary or secondary care services;
- and finally, which incorporates other measures, including family, school and community care and support, much of which are probably largely in place, aimed at reducing isolation, promoting self-esteem, personal growth and development, and which also facilitate the detection of the onset of more serious illnesses, and the seeking of help by those affected by such illnesses.

[9] Open access is recommended as trauma sufferers can be highly avoidant, or may not be accessing other services that might refer them for specialist treatment. In highly avoidant persons, impulsive help seeking is known which can be reversed if the person experiences the onward referral process as a series of obstacles. All possible avenues to provide help should be available.

Much of the above is described in more detail in the strategy and the development programme.

3.0 The Context

3.1 The Newry and Mourne area is served from a health and social services point of view by a range of statutory, voluntary, community and private organisations. The key statutory providers are, the Newry and Mourne Health and Social Services (HSS) Trust, and the public sector funded independent contractors (GPs, pharmacists, dentists and opticians). The Southern Health and Social Services Board (SHSSB) and the Newry and Mourne Local Health and Social Care Group are responsible for the commissioning of health and social care to meet the identified needs of the people of the Newry and Mourne area.

3.2 In relation to the needs of those affected by the Troubles, the Board was responsible for the establishment of the Southern Area Trauma Advisory Panel (TAP) a multi-agency and inter-sectoral working group whose role was defined in the 1998 Social Services Inspectorate (SSI) Report, *Living with the Trauma of the Troubles*. Together, Newry and Mourne HSS Trust, SHSSB and TAP, have initiated a number of steps to develop services for people who have been affected by traumatic events (mainly Troubles related) or to support those services involved in assisting people affected by such events. This includes:

- The establishment of the Specialist Trauma Counselling Service as part of the mental health services in the Newry and Mourne HSS Trust (and the other two Trusts in the SHSSB Area);
- The provision of a number of awareness raising and training programmes including:
  - The SALT (Southern Area Learning as Teams) training for primary care services on the subject of trauma and trauma related services, and
  - A programme of Troubles related awareness raising training for staff working in the health and social services provided by the South and East Belfast HSS Trust's Family Trauma Centre.

3.3 The latter represents progressive developments and strategic use of the Office for the First Minister and Deputy First Minister Strategy Implementation Fund (OFMDFM Strategy – Reshape, Rebuild, Achieve; 2002)

3.4 A number of innovative community based services involving the community, statutory and voluntary sectors have been developed in the area to provide access to services and act as first points of contact and support. Groups such as *REACT* in Kilkeel, the Women and Family

Health Initiative (South Armagh), the Rural Health Partnership, Women's Aid and Victim Support in Newry are examples of efforts to reach out to specific groups or communities which have been exposed to traumatic and distressing experiences, or to offer relevant services to members of the public and their relatives.

3.5 At an inter-personal level and based upon the conversations that have contributed to this strategy, one is left with a striking impression of concern for the community and its vulnerable members, which is coupled with a sense of optimism and achievability. There appears to be considerable energy and potential in local neighbourhood based, and community and voluntary infrastructure to promote the well-being of the community and to contribute to progress. Some contributors drew attention to the link between economic prosperity and social progress on one hand, and well-being and, in the Northern Ireland context, good relations on the other. It was notable that there was a strong impetus for economic and social development in a number of localities, backed up and at times driven by the work of Newry and Mourne Local Strategy Partnership (LSP), Newry and Mourne District Council and Newry and Mourne Enterprise Agency.

3.6 The decision by the Local Health and Social Care Group working with the Trauma Steering Group to commission a process that would lead to the development of a strategy for those who experience traumatic events and who subsequently develop psychological consequences is itself a progressive and strategic step. It delivers directly on the intentions of the SHSSB Investing for Health strategy, *Dare to Dream*. This is particularly so when this initiative is viewed against other important developments, including:

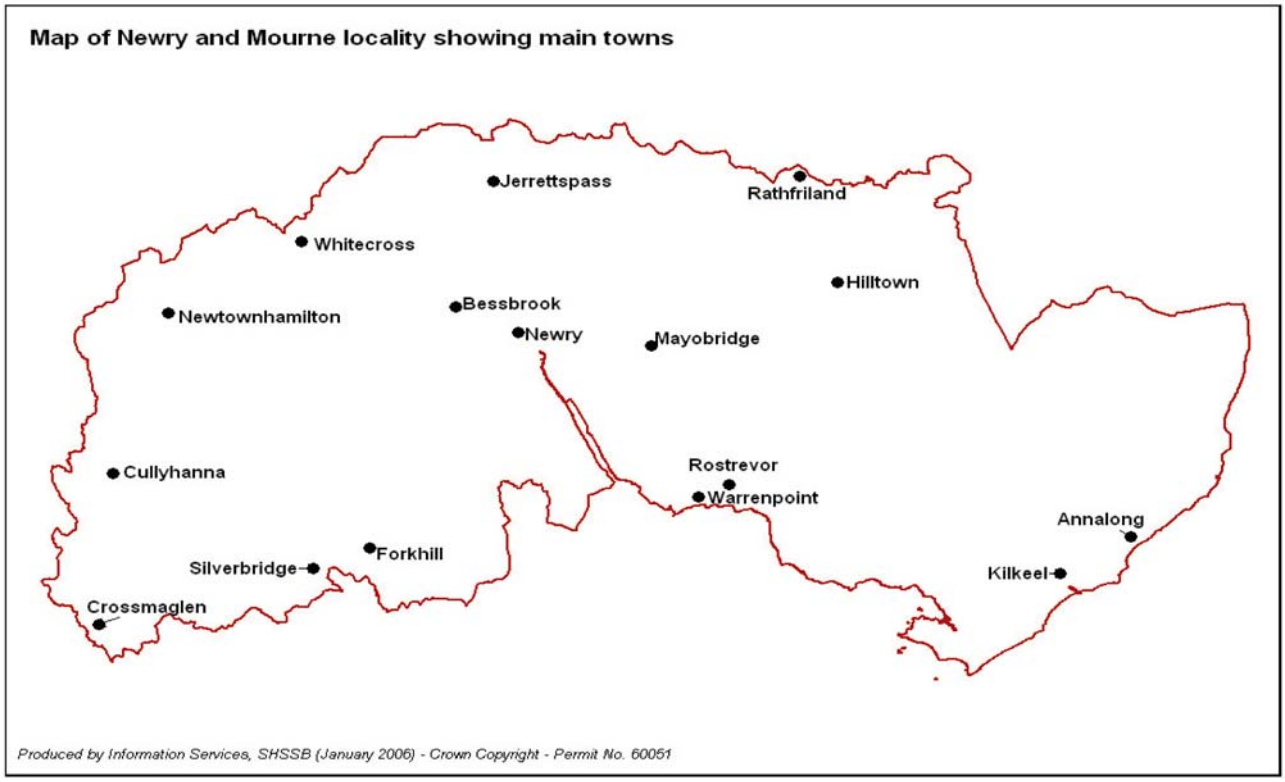
- the emerging knowledge base about trauma and its treatment;
- the development of research based standards for the treatment of trauma;
- the developments in psychotherapeutic services generally;
- the possibilities of strategic and service developments arising from the Northern Ireland Mental Health Review.

4.0 Overview of the Newry and Mourne Area

4.1 The Newry and Mourne Local Strategy Partnership's Integrated Local Strategy *Partnership, People and Places (2002-2006)* provides a comprehensive overview of the Newry and Mourne area along with a summary and assessment of the various governmental and EU policy and funding mechanisms. Key points from the document, which are relevant to the context of developing a trauma strategy, are summarised below.

4.2 Newry and Mourne is an area with a distinctive contemporary and historical identity. The name applies to both the Local District Council, whose headquarters is in Newry, and to two of the health and social services structures, Newry and Mourne HSS Trust, and Newry and Mourne Local Health and Social Care Group. The Local Strategic Partnership is coterminous with the Council and HSS structures.

Chart 2: The Newry and Mourne Area



4.3 The population of the area is approximately 84,500, with Newry City's population estimated at 28,850. The Integrated Local Strategy Report notes that it is the youngest population in Northern Ireland although this is expected to approach regional norms by 2009 as the current relatively high birth rate falls.

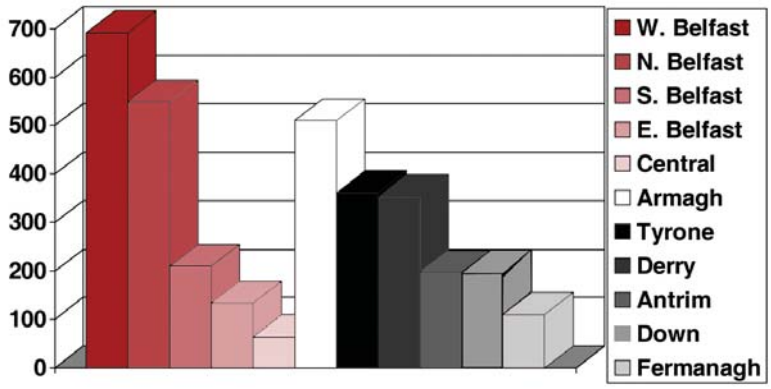
4.4 The report identifies Newry City, South Down and South Armagh as the three key planning areas within Newry and Mourne. These also relate to the distinctive social and cultural contexts of the area, and to a significant extent the distribution and patterns of health and related service provision.

4.5 The economy has developed significantly over the past 10 years, with significant business and retailing investment. Over two thirds of the workforce is employed in the service sector. Agriculture and sea fishing related industries form distinctive and key parts of the economic and social profile.

4.6 The area has been particularly affected by the Troubles. The strategy notes that 13% of all Troubles related fatalities took place in the Newry and Mourne area with the highest concentrations in parts of Newry City and South Armagh. Some housing estates and townlands bore a heavy burden of violence and destruction. Those who live in the areas worst affected continue to live with the legacy of the Troubles and often also endure higher than average levels of socio-economic disadvantage and other problems. Several areas also retain a heavy ongoing military presence, which illustrates the stark nature of the legacy of the Troubles.

4.7 *Lost Lives*, which chronicles Troubles related deaths, was compiled by McKitterick et al (2000) and provides a wider context for the impact of the Troubles. Outside Belfast, Co. Armagh saw the greatest number of deaths, and proportionately to the population of each county, the highest incidence of deaths, associated with the Troubles.

Chart 3: NI Deaths by location 1966-1999



4.8 The nature of the violence had different types of impacts. Deaths of British soldiers from regiments based in Britain impacted on their families living in Britain. Locally recruited army personnel involved both people and families living in the Newry and Mourne area. Deaths of police officers were most often experienced by families living outside the area. Civilian deaths and deaths of members of paramilitary groups affected mostly local families, including families living on the periphery of the area (including the Irish Republic). Deaths are only one measure of impact (although the Cost of the Troubles Study concludes that death rates correlate with intensity of violence). Other impacts are those on people injured in the violence and the impact on witnesses. Wider insidious effects of violence, including fear and general anxiety, though to be expected, was referred to by people and groups consulted in the development of this report, who bore witness to the long-term impact on individuals, families and communities.

4.9 Whilst political change has resulted in actual and perceived reduced levels of organised violence, threats of violence, harassment, surveillance and the memory of violence of recent years is still significantly potent. The years of violence have led to population movements and increased social and geographical segregation. Whilst there is an air of optimism amongst both communities, the sense of, and regret over division and lack of trust was commonly felt. Contributors from both traditions, expressed the desire for progress in relationships, in economic and community development, but to one degree or another had doubts about how quickly this could be achieved.

4.10 Pertinent to this strategy, all contributors who commented on the enduring implications of the Troubles felt there was a largely unexpressed and as yet unknown, but probably substantial long term emotional and psychological legacy from the years of violence.

4.11 Whilst the Troubles constitute a distinctive and significant area of concern in relation to psychological, emotional and mental health related needs, contributors drew attention to the wider context of current need. The Newry and Mourne area experiences the range of events typical of any other modern technologically advanced society. Events giving rise to trauma related needs include: -

- Sudden, accidental and violent deaths and injury due for example to road traffic accidents, assaults, manslaughter and murder, and other accidents (including work related accidents);
- Traumatic grief or trauma arising from sudden death and/or serious illness;
- Grief and adjustment problems arising from stillbirth, miscarriage and peri-natal death, illness or disablement;
- Grief and related problems arising from suicide;
- Other near death or horrific experiences.

4.12 A number of contributors commented with concern on the levels of violence fuelled by youthful passions, alcohol and perhaps illegal drugs. Alcohol consumption was considered to be excessively high by some, and formed one of the ingredients for worrying levels of late night weekend violence on the streets of Newry, for example.

4.13 The Police Service of Northern Ireland expressed concerns about the number of road traffic accidents involving local people which resulted in fatalities and serious injuries.

5.0 Overview of Psychological Trauma

5.1 What is psychological trauma?

5.1.1 It is quite normal and usual to experience very distressing symptoms in the first few weeks after a traumatic event. Usually, these feelings pass after a few days or weeks. Occasionally, people might not have a reaction for months or even years after. If the feelings and reactions last a long time or get worse a person may be said to have Post Traumatic Stress Disorder (PTSD) or some other illness related to the traumatic experience. For some people doing ordinary things like going to work, going to school, being with one's family or going out with friends becomes very difficult. (See Appendix 1, What is Trauma? for more information).

Family, community and professional support for those affected by traumatic events can go some way to alleviating distress. (See Sections 2.1 and 2.2)

5.1.2 Exposure to traumatic experiences can lead to the development of one or more mental health problems including PTSD, depression, specific phobias, personality disorders such as borderline personality disorder and panic disorder[i]. People suffering from PTSD, often have other psychological or mental health conditions such as substance abuse and depression (co-morbidity). Children and young people can suffer PTSD and co-morbid conditions and specifically, can develop trauma related needs directly as a result of their parents, caregivers or other siblings' traumas.

5.1.3 Accidents (including perhaps most strikingly road traffic accidents), assaults (including child abuse and sexual assault) and other traumatic experiences such as those associated with sudden death or serious injury or illnesses are well understood to give rise to risks of post trauma psychological implications for those who experience them. The needs of children (and of adults) who have suffered and continue to suffer psychological and other health related needs arising from childhood traumatic experiences, including abuse, represent a particular professional challenge. In the terms of the Northern Ireland Children Order, children and young people considered to have suffered such experiences, and who as a result have post trauma related problems, could be deemed to be *children in need*.

5.2 Prevalence and recovery

5.2.1 Key to understanding the levels of need arising from psychological trauma is knowledge about:

- The level of exposure to traumatic experiences;
- The incidence of development of psychological trauma following exposure;
- The rate of recovery.

5.2.2 Whilst not everyone who experiences events such as those described above will develop PTSD or a related condition, there is some evidence from specific Northern Ireland studies (in relation to the Troubles) that suggests that a sizable minority of people exposed to traumatic events will develop PTSD.

5.3 The implications

5.3.1 The following key pointers emerge from a consideration of research:

1. Conservatively, approximately 25% of those exposed directly to traumatic experiences will develop PTSD; for some types of traumatic events the risks of developing PTSD seem to be much higher;
2. Certain personal and circumstantial factors are associated with increased levels of trauma related disorders;
3. Some adults experience more than one traumatic event in their lifetimes;
4. In the region of 8% of the young adult population will experience PTSD in their lifetime;
5. One important study suggests that about 40% of those who develop PTSD will recover to (at least) below clinical threshold levels within about 30 months; another study suggests about 58% recover within 9 months;
6. 15% to 35% will have PTSD in the (very) long term.

5.3.2 The fact that so many people do not develop trauma related conditions, or recover relatively quickly without clinical intervention, coupled with the realisation that personal and circumstantial factors seem to matter, points to the potential for prevention and the development of resilience (which some researchers have been exploring).

5.3.3 Clinical experience shows that people with PTSD are sometimes thought to have other conditions and are treated on that basis. This results in long-term treatment programmes, which manage the symptoms rather

than cure the condition. Much trauma and related illnesses therefore, are probably undetected and untreated or inaccurately diagnosed and improperly treated.

5.3.4 Improved arrangements to capitalise on the emerging and rapidly developing knowledge base and treatment skills would represent a significant contribution to addressing this health issue and its social consequences. **A co-ordinated approach, backed up with a managed system that brings into play appropriate contributions at the various levels of services operating in accord with common standards and guidelines would enable progress to be made in this field.** In regard to Troubles related trauma such an approach would facilitate the addressing of the legacy of psychological and related consequences.

5.4 Primary data – potentially traumatic experiences and incidents

5.4.1 In Northern Ireland and specifically Newry and Mourne, there is no central source of data about the levels of trauma related disorders. To get a sense of the level of needs we need to refer to data about the numbers of incidents that might give rise to traumatic reactions on the part of those involved or who witness or have to respond to such incidents. Second, we can refer to international research to get a sense of the prevalence of trauma related disorders that might arise from such incidents (See Appendix 4 for a more detailed discussion on this area). Finally, we can refer to information from local and regional service providers about the demands for and the usage of their services.

An examination of the levels of events in the Newry and Mourne area that could give rise to trauma related disorders should give some insight into the possible levels of need, and if traced over time, give a sense of whether the need is rising, falling or remaining static. The available data relates to:

1. Serious illness;
2. Sudden deaths;
3. Reported crimes;
4. Accidents and road traffic accidents (RTAs) involving injury.

5.5 Trauma outcomes associated with serious illnesses

5.5.1 When people become seriously or suddenly ill, they can suffer psychological reactions to their illnesses. Also, impact can be experienced where body image is altered significantly, through for example scarring or the loss of tissue or a limb. Indirectly, close relatives

(noting in particular the needs of children) can experience traumatic reactions to the sudden illness of patients. The psychological component of the care of patients (and relatives) is an important aspect of care. In the longer-term some people who have had sudden and traumatic experiences of illness will have longer-term problems that can lead to conditions such as post traumatic stress disorder, or other mental health problems.

5.5.2 To get a sense of numbers of people facing serious illnesses, the SHSSB data on cardiovascular disease related admissions to hospital, reveal the level of exposure to traumatic events arising from this type of illness. In the two years 2001/02 and 2002/03, the numbers of Newry and Mourne residents with heart attack and stroke related conditions treated at Daisy Hill and Craigavon Hospitals were as follows:

Table 1: Heart Attack and Stroke Related Hospital Admissions

Primary Diagnosis	2001/02	2002/03
Acute myocardial infarction	118	164
Subsequent myocardial infarction	57	34
Subarachnoid haemorrhage	21	10
Intracerebral haemorrhage	16	10
Other nontraumatic intracranial haemorrhage	9	5
Cerebral infarction	133	104
Stroke, not specified as haemorrhage or infarction	45	51
Other cerebrovascular diseases	15	8
TOTALS	**414**	**386**

Source: SHSSB

Related to this, cardiovascular disease was the most common cause of registered deaths in Newry and Mourne in 2002[10].

5.5.3 Apart from the physical health related needs and implications of such conditions, the adjustment to such experiences and living in many cases with the risk and fear of further attacks or episodes is a major

[10] Newry and Mourne Local Health and Social Care Group; Primary Care Investment Plan 2004/2005

psychological challenge for most patients. It would be reasonable to assume that some will have adjustment problems and experience trauma or grief type responses to their experiences.

5.6 Sudden deaths

5.6.1 Clearly sudden death brings with it major emotional consequences for family members, neighbours, friends, and colleagues. Especially where the sudden death is accompanied by tragic and horrific circumstances, there can be short and longer-term psychological and perhaps mental ill-health problems. A specific complication of death in traumatic circumstances is traumatic grief. If such grief becomes protracted and unresolved, those providing services need to be mindful of the trauma related needs and the grief related problems.

5.6.2 Indicators of sudden death include stillbirth and sudden infant death, suicide and road traffic accident related deaths. The following Tables summarise the numbers of deaths of people from the Newry and Mourne area[11].

Table 2: Still Births and Infant Deaths

Year	2000-2001	2001-2002	2002-2003
Still birth	8	8	10
Infant death	10	8	6
Total	**18**	**16**	**16**

Source: Registrar General

[11] Note that these figures do not include people who live elsewhere. Also data is based on calendar year (and not fiscal year) hence the apparent discrepancy with other data in this report)

Table 3: Other Sudden Deaths

Year	2000-2001	2001-2002	2002-2003
Suicide/ Self harm	5	10	5
Accidents in the home	1	10	0
Other accidents, assault etc.	14	27	14
	20	**47**	**19**

Source: Registrar General

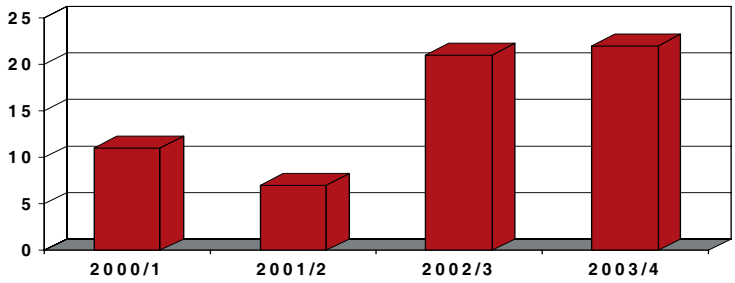
5.6.3 These figures point to members of the public and their families experiencing significant tragic loss. The special needs for support for women, their partners and families following experiences of stillbirth and infant death, are well understood by midwifery and related services. One contributor wished to see clear pathways for the treatment of women (and partners) who develop long-term depression and related illness arising from such experiences. We could add here, the needs of siblings where an expected baby has not come home from the maternity unit, or where a recently born baby brother or sister has died.

5.6.4 As these Tables demonstrate, the numbers of sudden and unexpected deaths (which does not include RTA related deaths) is not insignificant. Bereavements arising from suicide and the traumatic consequences for family and friends were considered to be particularly tragic, resulting in complex and enduring emotions. The role of community support and the rituals of waking and burial for example were all seen to be very important aspects of support by contributors. Church based contributors noted in particular the involvement of chaplaincy and pastoral care services from clergy or church related services at such key points. Beyond that, and as one person put it, "*when the world has moved on*", it is unclear what services are available for people with emerging and enduring trauma related needs. It does depend to some extent on the cause of the death, and the knowledge of professionals and others involved in supporting people through such experiences. Whilst mental health services were considered to be an obvious point of help, there were frustrations with the waiting times for assessment and after assessments have been completed, for any treatment.

5.6.5 For some groups the cause of death means that they might have access to specific support services and networks, such as Compassionate Friends, SANDS and bereavement support services such as CRUSE Bereavement Care. Such services are valued because they can provide good information, are able to authentically acknowledge the experience through the presence and help of trained volunteers can assist with some practical and administrative issues. Similarly, the informal support of neighbours and friends is an essential component especially where it brings sensitive availability and practical help.

5.6.6 Road traffic accident related deaths were a particular area of concern for some contributors. As noted earlier the Newry and Mourne area is intersected by a major route (the A1) linking Belfast and Dublin. In addition to the accidents involving people passing through the area on this major route, concern was expressed about the numbers of accidents involving local people and about the number of accidents on roads other than the A1.

Chart 4: Road Traffic Fatalities in Newry and Mourne



Source: PSNI

Table 4: Deaths of Newry and Mourne residents in transport related accidents (in calendar years)

Year	2001	2002	2003
Total	18	6	10

Source: Registrar General

5.6.7 The Registrar General's publications show that the numbers of road traffic related deaths of people from the Newry and Mourne area are close to the numbers killed in accidents in the area (although direct comparisons are not possible given the use of the fiscal and calendar years respectively).

5.6.8 Taken together, the experience of sudden death from whatever cause, is a significant need in the area. **Success in establishing means by which those bereaved by such experiences could be offered help, from the informal neighbourhood level, to the provision of specialist services for grief and trauma, would represent a significant contribution to service development.**

Table 5: Summary of all sudden deaths

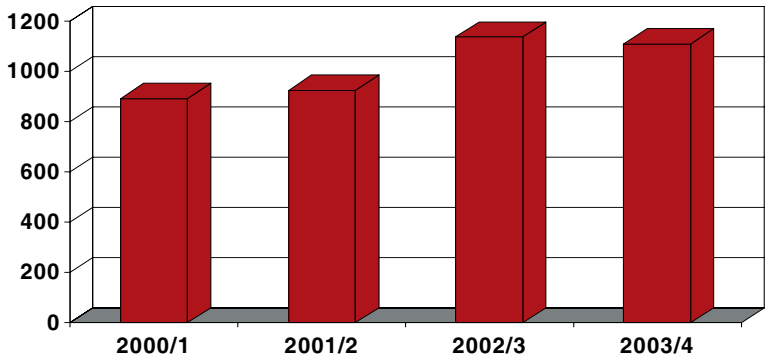
Year	2000-01	2001-02	2002-03
Still birth and Infant death	18	16	16
Accidents, suicides etc.	20	47	19
RTA related deaths	11	7	21
Total	**49**	**70**	**56**

Source: Registrar General and PSNI

5.7 Assaults, accidents etc.

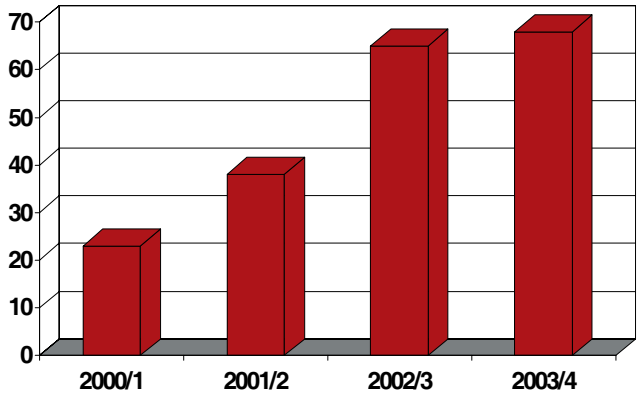
5.7.1 Reported crimes involving violence or traumatic features suggests that there has been an increase over the past 4 years with some levelling off in the most recent year's figures. This pattern is demonstrated in the following charts for reported offences against the person and sexual assaults. A number of respondents noted their observation that some offences seemed to have an increasing level of personal violence associated with them.

Chart 5: Offences Against the Person in Newry and Mourne



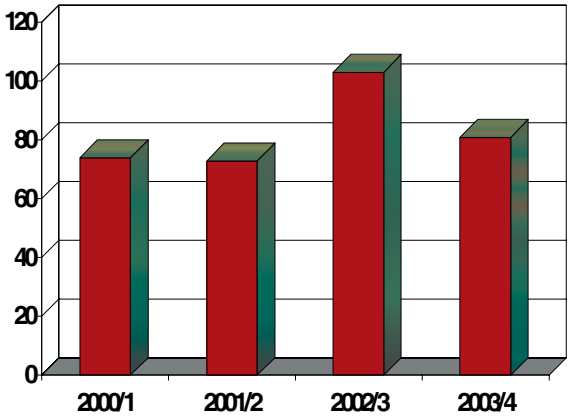
Source PSNI

Chart 6: Sexual Offences in Newry and Mourne



Source PSNI

Chart 7: Road Traffic Serious Casualties in Newry and Mourne



Source PSNI

Table 6 [a], [b] and [c]: Summary of all reported offences involving assault and/or injury; and RTAs involving serious injury

Year	2000-01	2001-02	2002-03	2003-04
Offences against person	892	926	1138	1111
Sexual offences	23	38	65	68
RTA serious injuries	74	73	103	81
Total	**989**	**1037**	**1306**	**1260**

Source: PSNI

5.8 Other observations

5.8.1 This is not an exhaustive list of needs. Rather they are presented as being indicative of the type and scale of need. Other areas highlighted by those who were consulted include, trauma and other mental health related needs arising from domestic violence (95 women and 105 children accommodated in the Newry and Mourne Refuge in 2002-03), the health and social consequences of alcohol and drug abuse (which sometimes have their origins in tragic and unhappy life experiences) and the demands on carers who experience their own distress and sometimes traumas in witnessing and dealing with the suffering and needs of others.

5.8.2 The above data on local levels of need (and see below) raises the questions, *how many of these people suffered traumatic reactions* and *how many developed psychological trauma related needs*? As noted earlier there are no available prevalence studies of the onset of trauma related conditions in relation to the above areas within Newry and Mourne. With reference to international studies we can gain some insight into the possible incidence of illness (and the distress of those who do not actually develop an illness or disorder). It is important to be cautions about drawing direct inferences from this data without further investigation and prevalence studies. However, reference to international research suggests that in relation to some traumatic experiences, 25% or thereabouts of those directly exposed to such experiences went on to develop post traumatic stress disorder (the actual incidence of trauma depending to some degree on the nature of the traumatic event and the individual's experience). It was also noted earlier that some people exposed to traumatic events develop other mental health problems such as depression or other anxiety disorders apart from PTSD.

6.0 Overview of current provision

6.1 Service take-up

6.1.1 The previous section examined some of the evidence for the demand and need in the area. In this section the usage of trauma related services is considered.

6.2 Victim Support

6.2.1 Victim Support is a voluntary organisation funded by grants from Government and charitable donations. It has a branch in Newry and Mourne, located in Newry City with four full-time members of staff. The service works on the basis of selected, trained and supported volunteers contacting Victims of crimes who have been informed about the service and wish to access it. Volunteers provide advice and information, practical and emotional support and access to witness support services. The service also refers clients to other voluntary, statutory or community services e.g. Northern Ireland Housing Executive and Women's Aid. In the period April 2003 to March 2004 the Branch received 1,495 referrals. The breakdown is as follows:

Table 7: Summary of all referrals to Newry and Mourne Victim Support Branch 2003-04

Primary reason for accessing service	Number
Offences against the person	581
Sexual offences	39
Burglary	204
Robbery	60
Theft	276
Fraud and forgery	6
Criminal damage	328
Other offences	1
Total	**1495**

Source: Victim Support

6.3 The Nexus Institute

6.3.1 The Nexus Institute is a regional voluntary organisation that provides support and counselling for adults who have been sexually abused either as children or adults, male or female, and who live in Northern Ireland. It also offers support to partners, family members and parents of children who have been sexually abused. Services are provided after the person makes personal contact with the Institute and arrangements are made for counselling. All counsellors must have a minimum of a Diploma in Counselling and are supervised to BACP (British Association for Counselling and Psychotherapy) standards. The Institute has a centre in Portadown plus outreach centres in Newry and Armagh.

In the past 3 years the Institute's office in Portadown, which includes the outreach services to Newry and Armagh, has provided a service to 662 people. At the time this Report was being prepared 91 people were on a waiting list for its services. The capacity of the organisation through the Portadown office is 1242 client-sessions per year. The Director drew attention to the persistent unmet need generally, and in the Newry and Mourne area in particular.

6.4 The Newry and Mourne HSS Trust Specialist Trauma Counselling Service

6.4.1 The Newry and Mourne Specialist Trauma Counselling Service was established by the Newry and Mourne HSS Trust as a joint initiative with the SHSSB and the two other Trusts in the Board's area. The service is aimed at addressing trauma related need arising from experiences associated with the Troubles. (Other non-Troubles related referrals are made to the mainstream mental health services). A part time counsellor is employed by the Trust providing 20 hours per week. She is trained to masters level in Counselling Psychology and in Eye Movement Desensitisation and Reprocessing (EMDR) and receives regular clinical supervision from a clinical psychologist in the Trust. On average 12-15 people (adults only) are seen by the counsellor each week. Children are referred to the Family Trauma Centre, or to the local Child and Adolescent Psychiatric Team, or the *Just Ask* Team. Referrals come from a range of sources including the Trust Mental Health Services, Victim Support and the Trauma Advisory Panel Coordinator. Some referrals are received from self-help groups and family doctors. The service has been promoted with family doctor services and key local organisations. In the period May 2003 - May 2004, 45 referrals were made to the counselling service. The service is mainly based in Newry (in

the Victim Support Offices) but the counsellor can and does meet clients in other convenient and appropriate locations.

6.4.2 There is currently a waiting time of about one month before the counsellor meets clients. If the service was extended to include non-Troubles related trauma this would clearly impact on the demand and waiting times.

6.4.3 The counsellor uses the CORE system (Clinical Outcomes in Routine Evaluation) to monitor the progress of clients. Professor Michael Barkham of the Psychological Therapies Research Centre, University of Leeds, is currently evaluating the service (along with the services in the other Trusts in the SHHSB area).

6.5 NOVA

6.5.1 NOVA provides support to individuals, families and communities who have been affected by the Troubles. It was established in 1998 by Barnardos and is based in Craigavon. It chiefly serves the population within the SHSSB's area. Through a range of interventions and working collaboratively with individuals and families, the Centre offers personal counselling for trauma related conditions, family work and support for groups endeavouring to address their own and locally identified needs. The range of services includes:

- A community outreach based counselling service;
- Training for self help groups in relation to issues such as anxiety and stress;
- Course in trauma management skills;
- A competent befrienders programme;
- Supervision for volunteers and befrienders.

6.5.2 NOVA's therapeutic approach draws upon the principles of solution-focussed therapy. Therapists also use EMDR[12]. Also, the Centre has recently been developing and evaluating a therapeutic approach known as V*isual Kinaesthetic Dissociation* (VKD). The primary focus is on Troubles related trauma. Referrals, including self-referrals, can be made directly to NOVA. The therapy staff all have a health care or social work background and have additional qualifications in psychotherapy or counselling.

[12] Eye Movement Desensitisation and Reprocessing

6.5.3 NOVA has recently been developing its work on a more formal basis in the Newry and Mourne area, building on earlier more informal developments chiefly through links with self help groups. It plans to provide counselling services mainly through outreach into local areas and by providing therapeutic services in the person's or family's own home. The development of these services is being coordinated by a steering group which includes representatives from adult and children's mental health service, the Trauma Advisory Panel and the SHSSB.

6.5.4 The work of NOVA has shed light on non-Troubles trauma needs and the service is interested in developing services for people with such needs.

6.5.5 The impression conveyed by these and other organisations involved in responding to the impact of traumatic events in people's lives, or trauma related needs is of *busyness*. The primary data above indicates that significant numbers of people in the community experience events that could lead to trauma related reactions and illnesses. The data about the take up of trauma related services suggest that there is a significant demand for locally based services. Also, through the consultation process, concerns were expressed that some of those with needs were not being identified, or were not seeking help, or were not being directed towards the right help and that there were insufficient services in place.

7.0 The wider service context

7.1 The contribution of the community sector

7.1.1 As already noted, the contribution of wider community services and the informal family and neighbourhood-based support systems has a key role to play. Trauma has a social context and part of the response to traumatic events, a key and foundational part, has to be the family, neighbourhood and wider community responses. Key tasks for this sector are:

- Creating a positive and healthy community;
- Creating the context for the building of resilience and coping capacity;
- Playing an active role in promoting health, detecting trauma related distress and illness, promoting help seeking, and providing appropriate support services;
- Supporting families and neighbourhoods in the task of caring for those who have had adverse reactions to traumatic experiences;
- Providing on-going support during the time a person is struggling with trauma related reactions or disorders;
- Enabling bereaved and traumatised people to experience and remain in touch with other, ordinary, parts of their lives.

7.1.2 Examples of this are already happening. For example, the efforts by economic and community development organisations to build the esteem of communities, to facilitate stakeholding, and to promote progress is impressive. The efforts of the Newry and Mourne Enterprise Agency and Kilkeel Development Association are two of a number of such examples. Other organisations have taken a health focus, endeavouring to improve the quality of life for the community by targeting health concerns or providing opportunities for maximising health. One such example is the South Armagh Rural Health Partnership, described in the most benevolent of terms by a contributor not involved directly in its work, as an example of a “low profile – high impact” initiative, making a real difference ‘on the ground’. One of its chief aims is to help people who have health, specifically mental health or learning and other disablement needs, remain integrated into the community. By drawing in appropriate public and other services, and by providing direct care and services, the Partnership supports local people and their families, and adds quality to the life of those with mental health problems, for example. Beyond direct services and service planning for individuals and families, the Partnership is endeavouring to demonstrate models of intervention that are suited to the rural context, to be involved in prevention of ill health and to influence

policy and thinking about services and needs in organisations and other partnerships involved in planning. This approach lends itself to providing effective front line responses and services for those who have experienced traumatic events and developed psychological and health related needs as a result. Acting as a resource for the local community, its members and families, and its public and other organisations involved in addressing the health needs of the community, community based health initiatives can play a key role.

7.2 The role of family and community

7.2.1 At a personal level the concern and support of family, friends, neighbours and colleagues is an important component of coping and recovery from tragic and traumatic experiences. Partly this is to do with acknowledgment and recognition; partly to do with being understood and being given space. It is about practical help at a time when spirits, energy and motivation are low. It is also about knowing we are being understood and cared for (or cared about). Not everyone likes or welcomes the uninvited concern and help of others, and perhaps at different times in our experiences of tragedy, loss or trauma we need and feel like different types of support. It is very much 'Horses for Courses'.

7.2.2 Through the consultation process some contributors who had experienced loss and tragedy bore witness to the help of their family, community and other networks. And there is no doubt about the commonly experienced benefits of the concern and help of others offered and given in sensitive ways. **So any strategy for addressing the impact of traumatic experiences must incorporate the contributions of families, friends and colleagues, neighbours and wider social organisations such as churches and faith based organisations, schools, community groups and sports organisations.** Apart from the supportive role that such parts of our personal and community networks can play, it is often family, friends or colleagues etc. who notice when things are wrong and when help is needed. This front line can be assisted to continue to play its part in helping those who have been through bad times**. It is recommended that initiatives be taken:**

- **To acquaint key organisations and individuals in the community of the needs of those who suffer traumatic experiences and of what services are available;**
- **To put in place and identify resources (e.g. literature, video resources and named professionals) who can be contacted by families, employers, clergy and faith leaders and teachers who**

are likely to be aware at an early stage of the fact that a person has suffered a traumatic experience or whose needs have given rise to concern;

- **To build upon and extend where possible across the Newry and Mourne area community programmes that promote health and address the conditions and causes of traumatic incidences.**

7.3 The contribution of faith communities

7.3.1 Local Christian churches (and increasingly other faith traditions) have traditionally played a pastoral role in the life of their congregations. The role of clergy at key points of crisis in the lives of individuals and families, through parish or chaplaincy ministry is often highly valued, seen as part of a rite of passage, for example, when death occurs, and in relation to which many clergy and pastoral workers have become very skilled.

7.3.2 Consultations with churches suggest that this is still viewed as an important role, but the emphasis varies from place to place, being it seems partly a function of the denomination, the particular view of a clergyman, priest or pastor, the nature of the relationship an individual or family has with their faith community, and the expectations of the congregations.

7.3.3 It would seem important to note that the expectations that church and faith communities have of their role should not be seen as being the same in every place at all times. Also, the degree to which grief and trauma are seen as spiritual rather than psychological issues will influence the view and contribution of faith communities. Nonetheless, for many individuals and families church and other faith communities remain a vital point of contact in times of loss and tragedy, and the churches should be viewed as a significant part of the community infrastructure, being a point of first contact, the avenue through which people might secure further help and a means of ongoing spiritual and social pastoral help and support.

7.3.4 Through the work of local churches and faith communities, and specific pastorally focussed centres such as the Christian Renewal Centre and the Benedictine Monastery, both in Rostrevor, and a number of other mainly Christian related counselling services in the area, there are local resources that can offer support that is particularly related to faith and belief issues, and specifically related to the experience of tragedy and loss in the context of the Troubles.

7.4 Education services, schools and the youth service

7.4.1 Much like the churches, schools play a significant part in the daily life of school age children and their families. Besides the schools themselves, nursery education (and community playgroups), along with the developing services such as after-schools clubs, and the youth services all have unique contact with individuals and families through which problems can be identified and at least in part, addressed. The Education Welfare Services offer support to children and young people, mainly through the schools. Here again the role of first point of contact at times of difficulty is a key role, and all that follows from that.

Having identified a problem, schools etc. can assist in accessing help and services and can continue to offer ongoing support and importantly in the lives of children, through the daily routine, providing stability and maintaining levels of safety and competence. Again, the potential of the schools and education services to play a role probably varies. The opportunity for teachers and youth workers to form relationships with children will vary from context to context. And the knowledge and skills base that individual teachers have in addressing problems likewise can be variable. One important factor raised by one contributor, was the pastoral arrangements within schools, and it does seem to make a difference when there is at least one named individual member of staff, who is interested, has developed a skills and knowledge base about pastoral matters and has responsibility for them.

7.4.2 One innovative pilot pupil-support project, 'Enabling Young Voices', has been initiated by WAVE, Queen's University Belfast and the Southern Education and Library Board (SELB). With funding from the OFMDFM Project Implementation Fund (OFMDFM Strategy - Reshape, Rebuild, Achieve; 2002) this project aims to provide educational support for post primary school children, who have been identified as having been adversely affected by experiences associated with the Troubles. The impetus of the project came from concern about the numbers of school related behavioural problems, school exclusions especially in areas with greater levels of Troubles related problems, Education Welfare Service feedback on the impact of violence and the fear or threats of violence on young people.

7.4.3 The project initiators identified the variable availability of resources to help young people, combined with a lack of awareness about services. Lengthy or even closed waiting lists for young people's mental health services were identified as a particular area of concern. The project aims

to pilot a number of interventions, and through evaluation and research to determine what works best. Thereafter, the project hopes to develop a research-based series of recommendations and initiatives upon which progress can be made. The move to being proactive using practices and interventions that are known to work, is a key part of the programme. By working with young people, teachers and through curriculum development, the project aims to improve services and access to services, increase awareness on trauma, develop core training for teachers, and by developing competency to shift from reactivity to proactivity, from 'being concerned' to taking research based and competent steps to address the needs of children.

7.4.4 This project is in the early stages of development and will be piloted in a number of areas across the SELB**. Key to its success is the establishment of enthusiastic working groups in each school or pilot project**.

7.5 Employers

7.5.1 As noted earlier, trauma related conditions have been shown through research to have a significant impact upon the sufferer's capacity to work and attend work. Employers will have therefore an interest in ensuring that staff suffering from such conditions get access to the most appropriate help and treatment. However, employers and managers are likely to need support in this regard. In large organisations there will probably be support from personnel, staff welfare or an occupational health department. For smaller businesses such support might be limited. There would therefore seem to be benefit in employers securing support in relation to trauma related needs (and indeed other health related needs).

7.5.2 Employers have a key role to play in preventing and addressing trauma related disorders and illness arising from the workplace. This role is a legal responsibility under the Health and Safety at Work Order, and includes the employers' statutory duty of care. Key to this is a comprehensive policy on mental health and well-being which includes a policy in relation to psychological trauma. Policies and their implementation work best if business owners and senior and middle managers are engaged and committed to addressing this issue. Apart from the humanitarian benefits, the prevention and alleviation of mental health and specifically trauma related health needs has strong business benefits.

7.5.3 Strategies and policies also work best when staff are engaged in their development, and feel dis-inhibited in seeking help, for example, have no anxieties about being disadvantaged by expressing their ideas, concerns, vulnerability and need for help.

7.5.4 Key to the success of a policy in relation to mental health and well-being are:

1. Recognition of the duty of care on the part of the organisation in relation to both physical and psychological health (including mental health);

2. The systematic examination of risks to which staff are exposed in the course of their work and clear arrangements in place to address and minimise such risks;

3. Awareness raising and training for staff in relation to personal resilience, stress reduction and positive coping;

4. Competent support and clear avenues for help for staff who have been exposed to traumatic events and feel distressed by them.

Any policy and strategy should be regularly evaluated and account taken of experience and changing circumstances, including changing demands on the organisation and its staff, and changing risks.

7.5.5 Organisations providing counselling and related services to people affected by traumatic experiences should have arrangements in place to ensure that staff are supported both clinically and emotionally. In relation to major or intensely traumatic events, when the demands on organisations are great and the staff and managers are very committed to addressing the needs they are confronted with, pacing and supporting staff involvement will be important, as will the need to rest staff and to avoid unduly long periods on duty.

7.6 Farming and Fishing

7.6.1 The farming and fishing industries play a key and distinctive part in the rural and coastal life of Newry and Mourne. Representatives from both industries contributed to the consultation and both were aware of the specific challenges and needs within their respective sector. The challenges faced by the farming industry are well known. These include the BSE crisis, the Foot and Mouth crisis and the brucellosis problems.

Whilst not aired publicly in the way that BSE and Foot and Mouth made the headlines, the impact of brucellosis on individual farms is every bit as devastating. Currently, herds are being isolated and at times destroyed, and this problem is particularly evident in the Newry and Mourne area. Besides the past and current problems facing farming, the looming reforms of the EU Common Agricultural Policy have posed what the UFU referred to as the challenge of 'change management' for the farming industry and farmers. Likewise fishing is currently facing challenges associated with EU controls and policy. Both industries are also inherently physically risky, and injuries and fatalities occur. The impact on the farming or the fishing communities of such events, particularly at a local level, is well understood by those communities.

7.6.2 The farming industry representatives described how at a regional level, action is being taken to address the challenges facing farming by either representing the interests of farming to government and the EU, or by mobilising and equipping the industry to face and respond to changes. At a local level, local people within each industry either through formal roles or at an informal level respond when for example accidents or deaths occur.

7.6.3 In 2001 the Department of Agriculture and Rural Development funded the Rural Health Partnership to deliver a Rural Support Programme in response to the outbreak of 'Foot and Mouth Disease' in the South Armagh area. The programme was designed to help alleviate stress and reduce isolation by providing information, advice and support to families living in the rural areas. The 'Action for Stress' initiative was later established to assist farmers and their families from the area to cope with increased levels of stress and anxiety. The programme included the provision of three health information seminars and the compilation of an 'Information Directory for Farming Families' to sign-post people to various advice/support organisations in the community, voluntary and statutory sectors.

7.6.4 Another example was the establishment of the Farm Support Helpline during the 'Foot and Mouth' crisis, which was aimed at addressing the practical and emotional and psychological issues faced by families. The Northern Ireland Agricultural Producers' Association's (NIAPA) Farm Crisis Network was established to provide a ready point of access for farmers and a means of offering support and help at times of need. In the fishing industry, the Royal National Sea Fishermen's Mission, based on a pastoral care model, offers assistance directly to seamen and women and

their families including specifically, grief and trauma related support. In relation to trauma, the Mission usually refers individuals for counselling.

7.7 Troubles related needs and concerns: The Self Help sector

7.7.1 A number of groups operate in the area to support specific groups of people and communities, which have been adversely affected by the Troubles. These groups broadly reflect each of the two political identities in Northern Ireland. The groups provide a range of services aimed at supporting members, such as information and advice, form filling, practical help, befriending and what could be called consolation through active membership of the group, and through ceremonial events and processes of acknowledgement. To varying degrees some groups are involved in advocating the interests of their members from political or judicial perspectives. Groups are also engaged to one degree or another in gathering information about the needs of members and wider research as well as facilitating imaginative and creative opportunities for expressions of grief and loss, and remembrance.

7.7.2 The groups have increasingly become an important part of the landscape. They draw most of their funding from the Special European Programmes Body (SEUPB), and longer-term funding is a constant concern. The contribution of volunteers was evident in a number of the consultations, not least in offering support to older members, whose needs were identified by a number of groups as a growing area of concern.

7.7.3 All of the groups consulted are involved in the SHSSB Trauma Advisory Panel and through this mechanism are able to make contact with others who are engaged in similar work, including those who are perceived as being from 'the other community'. The Panel has been instrumental in shaping some of the developments referred to earlier.

7.7.4 Some groups represented concerns about their members' longer-term grief and trauma related needs. As indicated there were specific concerns about older people, who sometimes with growing frailty, feel the loneliness of grief greater. Visiting, practical and befriending services were seen to be particularly relevant to older members. One group felt that alternative therapies had a key part to play in restoring a sense of well-being and building up self esteem.

7.7.5 There were a variety of views on trauma. It tended to be viewed as enduring distress or sadness, and not so much as an illness. There was some thought that actions involving consolation and support, or

acknowledgement or acceptable political progress would contribute to recovery. These views reflect the various dimensions of needs of many who have been adversely affected by the violence associated with the Troubles and suggest that therapeutic services, important though they are, represent one aspect of a wider task of recovery.

7.7.6 Contact with local trauma services was patchy. There was a strong feeling in one group that their members would not feel confident enough and would be fearful to trust services provided from outside the particular self-help group. Trust and confidence were lacking and this contributed to a reluctance to take up services.

7.7.7 Some groups expressed a desire to see services improve and for standards to be raised for people with mental health needs. There was a fairly common view that the needs of members had not been understood and properly responded to in the past, in the period of greater conflict and violence.

7.7.8 It seems that different groups take different approaches to the needs of their members and have different ideas depending on what the specific mission of the group is. Nonetheless efforts to achieve broad agreement about the type and range of services that should be provided for the identified needs of each of the groups would be helpful.

7.7.9 Further discussions could take place between providers of mental health and specialist services and the groups through the TAP, to determine and agree further progress on supporting groups, on one hand in their efforts to address the trauma and grief of members, and on the other in helping members to access trauma services including the specialist trauma service.

7.8 Ex-prisoners and their families

7.8.1 A number of people who were consulted drew attention to the needs of those affected by their experiences of imprisonment, in the context of the Troubles, and their families. A number of distinctive needs were identified which broadly speaking relate to the challenge of adjustment. First, there are the challenges associated with imprisonment and processes of prosecution and trial. Second, on release, is the challenge of adjusting to 'ordinary' life, including the adjustment to picking up on family roles and responsibilities, engagement in ordinary life and work, and maintaining links with the ex-prisoner community with which there are strong and valued attachments whilst endeavouring to resume an independent life.

For many, imprisonment has led to missed opportunities in terms of relationships and work in particular, some of which may not be recoverable. The enduring sense of obligation to the organisations and ideological goals with which many if not most former prisoners have been associated is another distinctive factor.

7.8.2 Whilst contributors noted that many former prisoners have made positive adjustments and have actively and positively re-integrated, this is not always so. In some cases former prisoners have suffered mental health problems, directly as a longer-term reaction to release, sometimes with alcohol or drug dependency. The Report, *No Sense of an Ending* (2002) which reported on a detailed study of 25 former prisoners and their families noted that, "The results from … diagnostic assessment instruments suggest that most of the men are likely to have been suffering from significant symptoms of depression, and up to four (i.e. out of 25) of the men may have had significant symptoms of post-traumatic stress disorder, at the time of the interviews". The Report and other contributors drew attention to the needs of former prisoners' families who also have adjustments to make and sometimes find it hard to understand or relate to the former prisoner. Access to services and treatment for those affected by mental health and trauma related needs, which take account of the context of the ex-prisoners pre-imprisonment, imprisonment and post-imprisonment circumstances and personal and psychological challenges, is a distinctive requirement of this group. Also, it was clear from the consultations that efforts to address the mental health and trauma related needs of ex-prisoners, requires associated services to help and support families.

7.9 Statutory mental health services

7.9.1 The Newry and Mourne HSS Trust's mental health services are based around a department for adults and another for children and young people. Over and above those structures, there are some specialist and support services (such as the Specialist Counsellor for Troubles Related Trauma) and either contractual or informal links with other providers, mainly in the voluntary sector. The waiting time for urgent referrals and others with clinical priority is five working days; for non-urgent referrals, three months[13]. However, reflecting the pressures on mental health services found more widely in Northern Ireland, the demands on mental health services outweighs to one degree of another, the resources available to respond. For those with non-urgent or no apparent clinical priority the result is waiting lists for both initial assessment (where people's needs are assessed and a determination made as to what is the

[13] Source: Mental Health Department at Daisy Hill Hospital, Newry

best way to treat or respond to their condition) and for treatment itself. The demands on child and adolescent services was noted by a number of contributors, along with the problems in some cases accessing and providing services at all. In some cases the waiting time to be seen for assessment is eight months.

7.9.2 The problems faced by mental health services have a number of causes. Demand being greater than resources is clearly one. This pressure is being recognised regionally in the NI Mental Health Review and in the fullness of time with further investment, this particular pressure may be eased. The pressure is replicated in other services where demand is up to capacity and in some areas there are lengthy waiting lists, for example, for the Nexus Institute. With the expansion of services the opportunity should be created to provide different configurations of services and to increase the emphasis on new and emerging therapeutic interventions.

7.9.3 Another pressure is the demand being made on services by people with serious or enduring mental health illnesses. In these circumstances understandably, the focus of staff and services is always drawn to those who present with the greatest need, or greatest risk. Whilst this is substantially a function of demand outstripping resources, it is also related to the difficulty of the service to set aside some resources to respond as quickly as possible to early or developing mental health problems before they become more serious (and before they make greater demands on resources). Trauma related disorders are such an example. Clinical experience shows that those who have recently experienced a trauma and have developed illnesses as a result, are more likely to recover more quickly if they receive a service as soon as possible following the onset of a trauma related condition. Further, as our knowledge grows, it will hopefully become increasingly possible to determine what could be done to prevent the onset of illness, during that period immediately following exposure to a traumatic event.

7.10 Primary care services

7.10.1 Meanwhile, further back along the referral chain family doctors see people usually long after problems arising from traumatic events have developed. (Additionally, some patients with trauma related conditions do not contact primary care services at all). Spotting trauma related disorders, which have symptoms quite like other mental health needs and illnesses, is not easy (even with very detailed clinical assessments). So in some cases the capacity of the family doctor service to detect trauma is restricted. Consultations revealed that if a GP identifies that a trauma might lie at the

basis of presenting symptoms he or she is more likely than not to begin initial primary care treatment, and to refer to a psychiatrist. This will happen especially where the GP is concerned about other potentially serious mental health problems. GPs are not inclined to refer people with, what appear to be primary mental health needs, to anyone other than the statutory mental health services. Partly this is related to the concerns about the severity of need, but it also relates to the GP service's lack of information on the availability and on the competence of for example, voluntary based services. Where however, a relationship and confidence with a non-statutory service develops, GPs are more likely to refer to such services, though this seemed to be the exception rather than the rule.

7.10.2 Whilst GPs recognised the value of psychological therapies there was a feeling that the statutory sector services were overloaded, and private services were too expensive for most patients. **The case for providing further support for primary care services became apparent through the consultation process with the goal of detecting trauma related conditions (and other mental health needs), of determining and providing the optimum initial response and of enabling appropriate onward referral**. One GP contributor argued strongly for such support to be located within the primary care team, on a collegiate basis with other primary and community care services. **It is therefore recommended that further discussions and planning should be undertaken to determine:**

- **how support for primary care services could be developed and provided to assist with the detection of trauma related conditions (and other mental health needs);**
- **the optimum initial responses at primary care levels – in line with other relevant recommendations in this report; and**
- **how best to enable appropriate onward referral to appropriate services.**

7.11 Further discussion of statutory services

7.11.1 It is apparent from the consultation process that many organisations and professionals are concerned to be able to help those who are suffering from trauma related conditions. However, in the context of trying to properly and accurately identify the needs of people presenting with a whole range of needs, primary and community care services (chiefly but not exclusively within the statutory sector) need recourse to sound guidance and advice. It is not possible as already indicated for all GPs and others involved in primary care and front line services to be

sufficiently expert in trauma related needs (and indeed a wide range of other conditions and needs), especially when the presentation of anxiety and depression so common with trauma related conditions, can be associated with other conditions.

7.11.2 In view of this **it is recommended that GPs and other primary and community care services, including other statutory and non-statutory services working in relevant areas, have the facility to liase with an identified professional (or professionals), who are competent to advise on the presenting need's of persons thought to be suffering trauma related conditions**. Two participants likened such a facility to *triage*[14] (and that the facility might extend to a range of anxiety and depression related disorders). Such a support for primary care could be provided through community mental health teams although the precise arrangements should be the subject of further consideration between mental health services and GPs, other primary and community care services, and identified voluntary and other statutory organisations. (In Armagh and Dungannon a pilot in placing cognitive behavioural therapists with GPs is currently underway and offers a model for consideration). Local circumstances and possibilities should determine the optimum arrangements. Such a service (triage) would aim to:

1. Advise enquirers what the presenting need's of a person seeking assistance might suggest;
2. Advise what further assessments could be carried out at primary/community care levels;
3. Advise what initial and further responses could be made at primary/community levels; and
4. Advise when, where and how to refer to assessment, treatment or other supportive services.

7.11.3 If these arrangements were in place they would assist the earliest identification of needs, and the accessing of (including onward referral to) appropriate service.. It should lead to a reduction in waiting times for assessments, especially by mental health teams (and reduce void referrals where the referred person is eventually seen and determined not to have needs relevant to the service to which they have been referred or where they do not turn up for assessment).

[14] the task of prioritising who should receive aid or services on the basis of urgency of need and the likely benefit to be derived from access to services.

7.11.4 Such a development is in line with the thinking emerging through the Northern Ireland Mental Health Review, which recommends specific developments and increases in community mental health services, and advocates the support of primary and community care services.

7.11.5 Another contributor described something similar to that described above, i.e. a single point of contact for professionals AND members of the public which could be called, for example*, Trauma Link*, to give it a distinctive name that describes its purpose. This additional dimension to a primary and community services trauma resource could be a further development, to build upon the experience in supporting primary and community care services, as soon as resources become available to do so.

7.11.6 On the basis of consultations the current locality based configuration of mental health services in Newry and Mourne HSS Trust would seem to be well placed to support GPs to begin with. Further developments beyond that to support other community and primary care services, and other identified statutory and non-statutory organisations should be developed as opportunity permits (and certainly as developments take place on foot of the Mental Health Review). Developments in primary care over and above development in secondary mental health services should be considered as a further development, when resources and opportunities permit.

7.11.7 Whilst the difficulties and needs identified above were highlighted during consultations chiefly in relation to the needs of adults, several contributors were anxious to see similar provision in place or developed as soon as practicable in respect of children and young people, with strong links to the child and adolescent psychiatric services.

7.11.8 Beyond the immediate provision offered by community mental health teams particular attention is drawn to the specialist provision within Newry and Mourne for people suffering from Troubles related trauma (see 7.1.11 below).

7.11.9 Together this layered approach would offer substantial support to local primary and community care services in Newry and Mourne.

7.11.10 Finally in relation to this issue, some of those consulted, expressed concerns about people with trauma related needs not being referred sufficiently early for assessment and treatment, an observation which underpins the need for earlier intervention and service (i.e. both clinical and quality) standards.

7.11.11 The Newry and Mourne specialist Troubles related Trauma Counselling Service is provided by the Newry and Mourne HSS Trust (based at the Victim Support premises in Newry). This has been a progressive and valuable initiative, the availability of which has been widely communicated within the Newry and Mourne area. Highlighting the need for on-going publicity and information about this important service, a small number of key contributors, who could identify people who would benefit from referral to this service, had either vague knowledge of it, or did not know about it at all.

7.11.12 Having considered a number of issues relating to this service the following recommendations are made.

In order to increase awareness about the Troubles related Trauma Counselling Service it is recommended that: -

- **Information about criteria for referral, contact details and updates on the Newry and Mourne HSS Trust's Trauma Counselling Service should be circulated to potential referrers on an annual basis.**

- **The service should continue to act as a resource for consultation by the Community Mental Health Teams. In time, as development permits, this facility should be extended to other key organisations within Newry and Mourne. This consultative, advisory role should be factored into the Trauma Counsellor's work plan and the time commitment monitored to assess demand and inform future developments. With a development of this service and increased awareness by the public and referrers, demands on the current provision will increase. The demand should be monitored and where indicated the service should be increased as resources become available (but see the next part of this recommendation).**

- **A similar service should be developed within Newry and Mourne to provide trauma-counselling services for people affected by traumatic events not associated with the Troubles. Expanding the existing Trauma Counselling Service or developing a parallel service could achieve this. This innovative service will need to be promoted amongst key professionals and organisations throughout Newry and Mourne. Demand for such a service development is evident.**

- **The specialist worker(s) establish clinical, referral and support links with other specialist trauma services.**

7.12 The Trauma Advisory Panel

7.12.1 The Trauma Advisory Panel of the SHSSB was established following the Social Services Inspectorate Report of 1998, *Living with the Trauma of the Troubles.* It represents a significant constellation of services and interests, although its primary focus is on the impact of the Troubles. The Panel is a Board-wide body (one of four in Northern Ireland) and so its work relates to the wider Southern Board area of which Newry and Mourne is a part. To sustain and build upon the important liaisons and processes that connect the Panel and the Newry and Mourne initiatives, **it is recommended that the Trauma Advisory Panel continues to be formally represented in the Newry and Mourne strategic mechanisms to develop and progress strategic developments in trauma services.**

7.13 Other related matters

7.13.1 A number of specific issues were highlighted during the consultations, which are noted here as of particular importance and value. First, the support to mothers, fathers and children following miscarriage and stillbirth (and other early infant deaths) is effectively integrated with the midwifery service based at Daisy Hill Hospital. This seamless approach, supported by the midwifery service managers, is a particularly elegant example of how statutory and voluntary sector organisations can work together and represents a model of good practice.

7.13.2 Discussions with the local Director of the Samaritans, which is primarily a confidential listening ear service, highlighted the particular needs of those who have been affected by traumatic events and who carry an associated burden of guilt or shame about their involvement. An example of this is where somebody has to one degree or another played a part in the death or injury of another. Such circumstances pose additional burdens on the person and they might feel that they cannot forgive themselves, or do not warrant services that could bring them ease. There are particular challenges in reaching out to persons in this position, and additional challenges providing therapeutic and other support and mental health services.

7.13.3 Discussions with Women's Aid and others involved in supporting those who experience domestic conflict and violence pointed to the particular problems in helping victims of abuse and assault whilst the conditions for on-going abuse prevail. Some contributors thought such circumstances posed ethical problems for counselling services, i.e. how can a service treat somebody for psychological and mental health problems whilst

abuse or the threat of violence is on-going? This is an ethical and safety issue and in such circumstances it might be that support services are required to help the victim of abuse cope and make key decisions, before any treatment would commence; or that treatment would have limited goals and could continue once the abuse had ceased. Approaching each person and their circumstances as an individual would seem to be a key factor in determining the most appropriate service responses. This scenario highlighted the value of additional social and other supports in and around counselling and other therapeutic interventions. Also, the work of Women's Aid and other organisations working in similar situations highlighted the value of post-abuse or post-trauma personal development programmes that build upon the recovery and re-establishment of self-worth, and that assist recovering people to reclaim and re-engage with parts of their lives that had been forgotten, or set aside, or in some cases to find fulfillment in new directions.

7.13.4 Women's Aid provides an interesting example of an integrated approach to a social problem, in this case a social problem with traumatic dimensions to the experiences of those who suffer abuse. With strong policy, educational and service strands, the organisation working regionally and locally, seeks to heighten awareness about domestic violence, address its causes, achieve prevention through education, provide support and refuge, enable victims of violence to explore choices and act upon them, provide counselling and other therapeutic services, liaises with other relevant services and as noted above, promotes and enables personal development beyond the experience of abuse. Reference to this approach casts light on how an integrated approach might work, including approaches that involve a number of agencies.

7.13.5 Several contributors drew attention to the need for support for people before, during and after treatment for trauma related conditions, and from the above examples the role of support services has been demonstrated. The Suicide Bereaved Support Group is an example of how professional and voluntary services, working with families, can support individuals. In complex situations where trauma is chronic, where families need support or guidance, or where there are risks of self harm or harm to others, multi-agency and multidisciplinary working is essential.

7.13.6 The traumatic component of the experiences of children and young people who have been subjected to abuse by carers and others is an area in which social work and other professions, and a wide range of public and voluntary organisations have been working for many years. Consultations revealed that whilst there has been for some time an

awareness of the emotional, behavioural and other impacts of abuse, there is a growing awareness of practitioners and service providers of the importance of focusing on understanding and addressing post traumatic distress and disorders in children and young people. This is undoubtedly an important component of care, and a distinctive development beyond the essential tasks of protecting and supporting children.

7.13.7 One area mentioned by a number of contributors was the needs of adult survivors of childhood experiences of sexual abuse. This group of service users (or potential service users) were considered to have enduring and complex problems, including emotional and relationship difficulties, psychological difficulties and recurrent or chronic mental health disorders. These have to one degree or another, implications for personal and family life, wider social relationships, and economic and social functioning. Improvements in services were suggested including improved access, improved skills and specialisation, and an increase in the amount of services available. A 1999 Report by The Western Interagency Group[15] looked at this area of need in great detail. It concluded that there should be progress in the following key areas:

- Access to appropriate services;
- Greater clarity about how and where to access services;
- Increasing the level of services available for the current demand;
- Greater service coordination;
- Increase in the number of specialist staff;
- Improvements in information for clients and for staff;
- Improvements in staff training, support and supervision;
- A comprehensive strategy that would address these issues.

This series of recommendations has a wider application to the development of services for those affected by traumatic events.

7.14 Disaster planning and disaster related services

7.14.1 People involved in major traumatic events such as disasters, are likely to be exposed to extraordinary events which will place them at risk of developing post trauma related disorders. Such events will require a specific interagency response, which addresses the range of practical and mental health needs. Responsibility for providing a post major incident response which addresses both welfare and psychological needs is placed, by the Department of Health, Social Services and Public Safety,

[15] Ginnety, Pauline: The Heather Report; A Report on the Service Needs of Adult Survivors of Sexual Abuse; June 1999

on health and social services Trusts and Boards. Also, public and media interest will give rise to expectations of a response.

7.14.2 Guidance on the treatment of post traumatic stress disorder from the National Institute for Clinical Excellence (NICE – England and Wales; 2005) contains a number of recommendations, which are discussed and summarised here as a basis for providing a local response. **It is recommended that the NICE Guidance on the treatment and management of post traumatic stress disorder, published in 2005, is used to review current Trust major incident plans and specifically to assist social services and mental health services to prepare for such events.**

7.14.3 The NICE Guidance recommends that a multi-agency social and psychological care steering group should be part of the wider emergency planning arrangements. This should include representatives from primary care, adult mental health services, child and adolescent mental health services, social services, non-statutory organisations and should meet regularly to develop and maintain a psychosocial care-plan and have authority to decide on provision. The steering group should plan responses that are evidence-based and delivered in a pre-planned, coordinated manner that is integrated into the central disaster plan.

7.14.4 Services to meet social and psychological care in the immediate to longer-term should be planned and provided including immediate comfort and practical help through to longer-term psychological support that may need to be provided for 18 to 24 months, or even longer. Services should be designed to complement and mobilise the excellent support many people will receive from their family and friends.

7.14.5 To enable psychosocial care services to be delivered, staff involved need to be trained, coordinated, supervised and cared for, in undertaking their work. Plans should be flexible enough to incorporate unplanned but important contributions, from for example, community leaders, faith leaders, and others. Such groups should be supported in their response to the incident.

7.14.6 The initial focus is likely to be on immediate practical matters and dealing with concerns about missing or ill relatives, friends etc. Information about the availability of help should be widely circulated. Early interventions should be provided in an empathic manner and will have an emphasis on good information about the impact of traumatic events, how to deal with

problems arising from the disaster and when and where to seek help. Formal counselling or psychological intervention is usually inappropriate at this time. The creation of an emotional support telephone helpline should be considered along with arrangements for the identification of those at highest risk and the assessment of their need for more formal intervention. Typically, mental health services will only become directly involved with members of the public in the initial phase if individuals develop extreme responses.

Evidence-based interventions should be offered to those with specific needs through adequately trained and supervised counsellors/clinicians. With a view to offering support and services, it is important to record personal details and create a database of individuals involved (including health and social care staff, emergency services and volunteers as well as lay victim of the disaster).

7.14.7 Additional support may be required for any legal proceedings, inquiries and inquests. Mutual support groups and self-help work can be facilitated to aide recovery.

8.0 Key points emerging from the consultation

In summary, the consultation revealed:

1. Imaginative examples of community based practice aimed at promoting community involvement and addressing the conditions that lead to conflict or illness;
2. Concern across a number of sectors about the levels of alcohol and youth related violence;
3. Concern about the long term effects on individuals and families of the violence and conflict associated with the Troubles;
4. The development of strategies incorporating highly relevant principles in the SHSSB Investing for Health strategy;
5. Specific services to address the needs of those affected by suicide, crime, sexual assault, miscarriage and stillbirth;
6. Specialist trauma treatment services for those affected by the Troubles;
7. Some degree of awareness and ability to respond to trauma related needs amongst front line (statutory and non-statutory) services;
8. A potentially significant pilot in supporting pupils by the SELB with WAVE and QUB;
9. Finally the existence of the Trauma Steering Group, initiatives taken by the SHSSB and the TAP, and this initiative by the LHSCG are themselves evidence of imaginative responses to needs and a desire to get to grips with these issues and to see development and progress.

8.1 Areas for development

The current development of trauma related services could be described as 'work in progress'. Much has already been done in relation to Troubles related needs for example through the imaginative use of the OFMDFM Strategy Implementation Fund by both the health and social services, and the education sectors. Further progress can be made by:

Further integration and coordination of existing services and arrangements:

a. Put in place arrangements to maximise the coordination and standardisation of services across statutory, voluntary, community and industry based sectors. This could take the form of the development of a trauma focussed managed service network which will identify the contribution of each level and connect them together into a coherent service network, governed by common principles and standards;
b. Improve cross referral to the most appropriate services based on increased information and quality of information about the available

services and their roles, improved communication and guidance about good practice.

The development of standards:

a. Develop or adopt standards for services that treat trauma related disorders;
b. Develop and maintain a directory of services that meet identified standards to promote knowledge and confidence in services, and to aid appropriate referral.

Further training and awareness raising:

a. Improve public knowledge about trauma;
b. Minimise stigma about help seeking, and in relation to mental health needs, distressing and the negative feelings sometimes associated with 'not coping';
c. Improve knowledge and information in relation to trauma related conditions and services, held by first point of contact organisations (e.g., GPs, key community based organisation, employment sector bodies etc);
d. Improve skills and knowledge about the detection of trauma related needs, prevention and early interventions.

Further development and expansion of services:

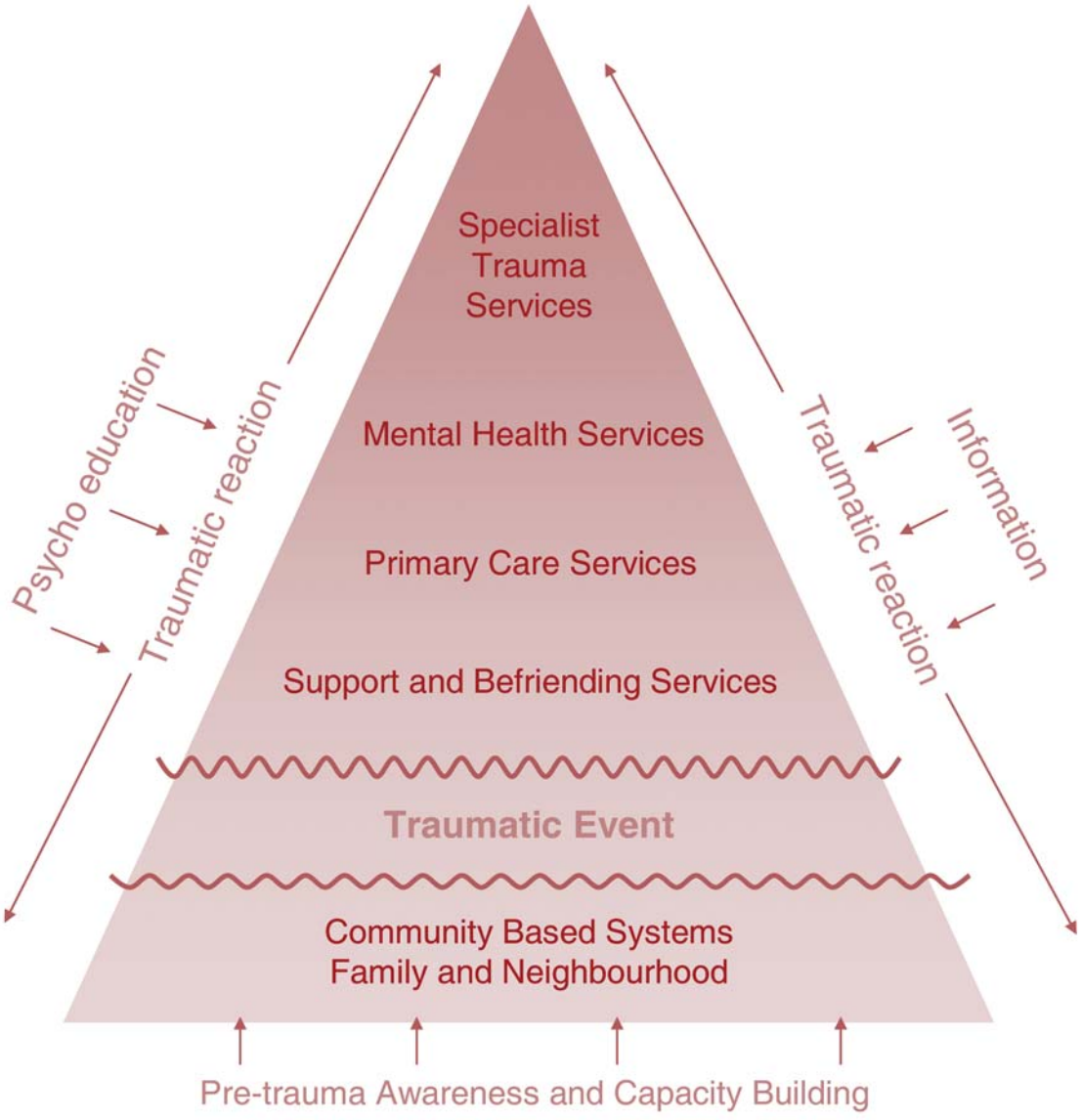
a. Develop a plan for the measured expansion of specialist services (to build upon recommendations arising from the NI Mental Health Review);
b. Developing support for primary care services (in line with the recommendations emerging through this report);
c. Promote and develop community health education initiatives by for example replicating good practice already demonstrated in the area.

8.2 Making the connections

8.3 Key to progress is the integration of current and future services and seeing the various contributions and possible contributions as an integrated whole. Clearly some services will be core to this integration. Others will play their part from time to time as needs and issues arise which require to be addressed. The Trauma Steering Group is in place to form the nucleus of an integrating mechanism. A useful model is that referred to in the health and social services as *managed clinical networks*. This approach could be adopted to integrate all levels of services, including those that are occasionally engaged and those that are centrally involved on a regular or continually basis in responding to traumatic events or post trauma distress or illness. To be successful, the corporate support and engagement of key organisations and sectors will be necessary.

The chart below illustrates some of the key relationships and processes described in this report.

Chart 8: Trauma Pyramid



The pyramid illustrates access to the tiers of services. It acknowledges the continuum of need and of service provision required.

8.3 Cost effectiveness and value for money

There are a number of elements to these themes. First, our increasing knowledge about the levels of trauma related disorders, the hidden trauma behind many mental and physical health problems, along with our growing knowledge about how best to prevent, detect and treat trauma related conditions, points clearly in the direction of taking measures which will be more cost effective. This will be so for a number of reasons. First, minimizing illness and the effects upon the individuals and the family; second, promoting health and well-being, based upon our developing knowledge; and third, reducing demands upon and the costs of providing health care services.

A key element involves making current services work better, through improvement and coordination. By ensuring people have access to them at the most appropriate time, ensuring better integration across services (enabling members of the public to be referred as quickly as possible to the most appropriate service) and by continuing to increase knowledge and skill (including clinical knowledge and skills), we can see advances in services without much additional financial investment. Skills development, improved information and developing clinical practices will all make their contribution. Service expansion will also be necessary, although this could involve in part, a re-focusing of existing resources. The strategy and the associated draft development programme contained in this Report, provides a means of taking these matters forward.

It has not been possible to include in this Report an evaluation of the value for money of the current arrangements. The variety of approaches, the differing focuses of different organisations, and the lack of information about outcomes (as opposed to outputs – e.g. the number of people passing through an organisation) made this impossible. In the event of common standards being developed, and practices converging in line with the developing knowledge about what works in prevention, detection and treating trauma related conditions, then we would be in a better position to make an assessment of the value of the impact of trauma related services. Pending such developments, a health economics view gives us some grasp of the potential of developing the right configuration of services.

9.0 Principles and Standards: Doing the right things and doing them well

9.1 Evidence based services

9.1.1 Knowledge about the specific psychological and mental health related implications of post traumatic stress disorder and related conditions has developed rapidly over recent years. The effects of life threatening and oppressive experiences on some people have been known for many, many years with the concept of shell shock from the First World War being one presentation of the condition. What has not been so well understood until quite recently have been the psychological, neurological, biochemical and physiological effects, about which knowledge is expanding at a considerable rate.

9.1.2 The knowledge base however, is not yet complete by any means and much remains to be understood. Nonetheless, research and clinical practice is reinforcing the perception of PTSD and such conditions as serious illnesses with potentially serious health and life consequences. The attention of researchers is beginning to differentiate the active psychological components of the traumatic reaction and treatments based on this type of analysis are being developed and producing impressive results (for example, Ehlers and Clark 2000).

9.1.3 Research is also casting doubt on the efficacy of some interventions for trauma that have been recommended and used up until now. For example, a major debate has been raging for a number of years on the pros and cons of using CISD (Critical Incidence Stress Debriefing) a particular approach which aims to reduce the onset of PTSD by providing a short group based intervention within 48 hours of exposure to a traumatic event. A strong movement that developed and advocates the use of this approach, is matched by a formidable sceptical movement that questions its efficacy. Of concern however, is the view that CISD might inhibit natural (i.e. spontaneous) recovery. Whilst the approach is being questioned (and some caution on the use of CISD has been included in the 2003 DHSSPS CREST Guidance on the treatment of PTSD in adults and the 2005 NICE Guidance), a recent major review of the literature concludes that it is not clear what, if any, early interventions would be helpful[16].

9.1.4 Some advocates for treatments and other interventions not included in the authoritative guidance are concerned that the interventions they advocate

[16] McNally, R.J., Bryant, R.A., and Ehlers, A.; Does Early Intervention Promote Recovery from Posttraumatic Stress? 2003; see bibliography.

are not included and believe that they have something to offer. This poses a dilemma for funders and referrers. How do they determine if a treatment or intervention, not included in authoritative guidance, is safe and effective? In the context of clinical and social care governance within the Health and Social Services, and the responsibilities of funders to minimise risks etc. these are serious considerations. To address this dilemma and the wider issues, the following approach is recommended.

9.1.5 It is recommended that funders, services and practitioners treating trauma in adults and children in the Newry and Mourne area identify and move to adopt recommended guidelines[17] on the assessment and treatment of trauma related conditions as the basis for service standards.

9.1.6 Organisations providing treatments for trauma should audit their practice against recommended guidelines with a view to complying with these guidelines.

9.1.7 Treatments and interventions not specifically addressed by such guidelines should only continue to be used if subject to proper evaluation of treatment outcomes. Treatments and interventions not specifically addressed by the guidelines should only continue to be used following a process of appropriate consultation, supervision and evaluation.

9.1.8 In relation to both adults and children's services, provider organisations and practitioners should make or strive to keep abreast of research with a view to building upon, reviewing and updating their practices.

9.2 Service standards and user confidence

9.2.1 As noted earlier in the section on primary care services, a number of those participating in the consultation, and in particular those who felt responsible for referring persons to appropriate services, expressed concerns or queries about their responsibilities. These concerns are summarised in the following questions:

- Where do I get advice and guidance to help and support someone who has been exposed to a traumatic event?

[17] Examples of recommended guidelines provided in references at the end of the document; Appendix 8; p.106

- To what services do I refer someone who is (or who I think might be) suffering from a trauma related condition?

- How can I be sure that such services are operating in accord with reasonable standards?

- How can I be sure that such services are providing an appropriate response (treatment) for trauma related disorders?

- Can I be sure that the service will re-refer if necessary to a more appropriate service?

9.2.2 Agencies providing therapy and counselling services (and others involved in related activities such as advice and guidance, pastoral care, befriending and listening ear services), should be working to standards that are deemed to reflect good practice. The key difficulty here is that there is no central standards body nor no central agreed set of standards. Progress has been made in this area by the Social Services Inspectorate of Northern Ireland, which, in its 2003 Report, *Counselling in Northern Ireland,* identified the current deficits (some of which have serious implications) and made clear recommendations about how further progress should be made in this area. However, the development of central standards and a body for registering therapists, counsellors etc. and provider organisations, is still awaited and it is likely to be at least 2007 before such is in place. Pending the development of such arrangements **is recommended that pending the development of regional regulatory arrangements a minimum set of standards is adopted which providers of counselling and related services (such as befriending, pastoral care, listening ear) should be encouraged to comply with and which in any case, should be required by funders who are part or wholly funding such services. As part of the strategy for improving services, and to assist organisations in meeting the requirements of funders, a programme of support and development should be put in place for community, voluntary, statutory and private organisations involved in responding to trauma related needs**. This might require phasing in, the operational arrangements for which will be a matter for any body implementing the recommendations in this report.

9.2.3 To assist key first points of contact in determining which services to refer people suspected or identified as suffering from trauma related disorders (including PTSD) **it is recommended that a directory of trauma related services be developed, published and maintained by a**

representative partnership of key organisations within the locality. Besides the basic information about the name, location, purpose, and the contact and referral arrangements for services included in the directory it will be helpful to key referrers if clear information about the standards and, where appropriate treatment guidelines, is also provided.

The directory[18] should form the first step in moving the counselling and therapy services towards compliance with best standards, which are likely, with the follow up to the *Counselling in Northern Ireland* Report (SSI, 2003), to become mandatory to one degree or another. In this way the development of standards, and requirements to comply with treatment guidelines, with a degree of realism about where services are at present and where we need to move to, will assist with the general raising of standards, and should also assist providers in reaching minimum requirements if and when they are legally required. The accuracy of the directory should be kept under review and revisions or new directories published when necessary. A website which could readily reflect the most recent changes would reduce the need for frequent updates until such times as a major revision was required.

9.2.4 In addition to having regard to evidence based information (*what should be done*) there is benefit to be derived from taking account of practice based evidence which helps service providers and practitioners reflect on whether *the right things have been done* and *have they been done right*. Audit, service improvement, benchmarking, and outcomes monitoring are important elements of considering the effectiveness and delivery of services, and are likely to be helpful in a situation where knowledge is growing fast, such as in the area of trauma related needs and illnesses.

[18] The SHSSB Trauma Advisory Panel published a Directory in 2003. This has a Troubles focus but contains very useful information relevant to a broader range of needs; see Appendix 8 for reference

10.0 A programme for progressing an integrated trauma service

The proposed programme is built around a public health approach to psychological trauma. The benefits of a public health approach are summarised below.

10.1 A public health and well-being approach

It is recommended that a strategy for addressing the causes and consequences of trauma related needs is developed through a public health and well-being initiative. This is recommended on the basis that it:

- Allows a joined up strategy and service portfolio to be developed which incorporates and addresses the full range of public health practice from:
    - Prevention;
    - Health promotion (building resilience and coping mechanism) and engagement of wider support networks';
    - Identification and early intervention (screening, identification, early service responses etc.);
    - Appropriate and effective service interventions at primary and secondary care levels;
    - Access to specialist provision.

- Brings to bear the analytical and service development skills and practice that have been well developed and tested in other areas of public health:
    - Health promotion (building resilience and coping mechanism) and engagement of wider support networks.

- Facilitates the deployment and contributions of family, community, voluntary, statutory (and where appropriate private) sectors i.e. multi-sectoral involvement in addressing the problems and consequences of violence, accidents etc.

- In the context of the Troubles, addresses the health consequences of the violence not as a partisan matter but as a major health (and therefore mainstream political) issue pertinent to the well-being of the whole community (and future generations);

10.2 Approaches such as this are increasingly being adopted or promoted, to address health and social matters of public concern. The approach developed in relation to domestic violence in Northern Ireland (referred to above) is a particularly good example. Similarly, a recent report by the World Health Organisation (WHO) identifies violence and its consequences as a major health concern and advocates a public health approach. In the context of trauma etc. it is not a huge leap to include in such an approach, trauma related concerns and needs arising from causes other than violence.

10.3 The aim of an integrated trauma strategy should be to:

Promote health and well-being[19] through:

- **Prevention;**
  - **by reducing traumatic incidents,**
  - **by promoting resilience, coping, information sharing and help seeking,**
- **Early detection and referral; and**
- **Providing appropriate treatments and support services.**

In more detail, these aims will be achieved through:

Prevention

- Preventing traumatic experiences;
- Promoting resilience;
- Promoting coping;
- Promoting information sharing;
- Promoting help seeking.

Early detection and referral

- Equipping service gatekeepers to detect, to respond appropriately and refer;
- Raising the skills and knowledge of key organisations and their staff;
- Alleviating distress;
- Promoting help seeking;
- Providing appropriate information, support and treatment services;
- Clear referral arrangements and standards.

[19] This could also be stated in terms of reducing the demands on health and social services and other social consequences, a focus that would be particularly relevant in responding to major traumatic incidents and disasters.

Appropriate treatments and service responses

- The provision of appropriate services for early intervention;
- The provision of appropriate primary, secondary and specialist services;
- The provision of supportive services.

See Appendix 6 for a draft programme associated with this strategy.

10.4 The strategy requires services to be coordinated. So **it is recommended that arrangements be put in place to coordinate the unfolding and operationalisation of this strategy and to provide a mechanism for ensuring key stakeholders are involved** building upon what is already in place in the Newry and Mourne HSS Trust area.

10.5 This strategy is elaborated further in a draft development plan, set out in Appendix 6.

11.0 Appendices

Appendix 1: What is Trauma?

Appendix 2: DSM (IV) definition of post traumatic stress disorder.

Appendix 3: List of organisations and persons consulted.

Appendix 4: Overview of research.

Appendix 5: Digest of organisations providing services in the Newry and Mourne area.

Appendix 6: A programme for delivering the trauma strategy.

Appendix 7: Background to the brief.

Appendix 8: References and resources.

Appendix 1

What is Trauma?

Traumatic events

What is traumatic for one person might not be so, for another. However, generally speaking when a person is involved in or witnesses an event that is deeply shocking, life threatening or where they have a deep feeling of helplessness then such an event has been, for them, a traumatic experience. Examples of events or experiences that could be traumatic include road traffic accidents, assaults including abuse or rape, other serious accidents, serious and sudden illness. Incidents associated with the civil conflict in Northern Ireland (assaults, riots, shootings, bombings etc.) represent a particular range of traumatic events.

Some people, often as a consequence of their jobs, are frequently exposed to traumatic events. Others, whilst they might not be able to identify a particular event might have experienced an enduring traumatic experience, for example, living in constant fear, or in a particularly abusive relationship.

Early reactions to traumatic experiences

Following a distressing, frightening or life-threatening event many people will experience a short and possibly intense reaction, that usually settles after a few days or weeks. During this period a person can have one or more symptoms such as sleep disturbance, vivid and disturbing recall of the event, bad dreams or nightmares, anxiousness, sadness, a feeling of numbness or 'disconnection', loss of appetite, loss of concentration, or memory problems.

Typically, most people who have these experiences recover in a few days or weeks, and will benefit from reassurance, informed advice on how best to deal with the distress, taking steps to minimise problems caused by loss of concentration or memory problems, and in some cases a short course of medication prescribed by a doctor to ease the more uncomfortable symptoms. The support of family, friends and colleagues can be particularly helpful during this period.

Longer term reactions to traumatic experiences

In some circumstances the initial distress does not ease and the symptoms can persist or intensify. Also, some people who had no reaction to begin with, can later (sometimes much later) develop distressing symptoms such as those described above.

It is this continuing or late onset distress that is known as psychological trauma. One group of symptoms is known as post traumatic stress disorder (PTSD). Many people will recover without treatment from such conditions over several months with support. However, as it is difficult to know in advance who will and who will not recover, and because it is important that people suffering these distressing conditions are relieved of their symptoms as soon as possible, early referral for appropriate treatment is recommended. Left untreated, a significant number of people will go on to suffer psychological trauma related problems or illness for many years and in some cases for the rest of their lives.

Not surprisingly, distress or a illness linked to the traumatic experience, along with concerns about the distress or illness, can have a significant impact on the person's relationships, faith and beliefs, schoolwork, occupation and other aspects of his or her life. Also, people with psychological trauma can develop a range of secondary conditions or needs, such as other mental health problems, dependence on alcohol or drugs, other physical health problems or social problems.

Treating Trauma

In recent years new and effective treatments have been developed for trauma. In most circumstances such treatments will totally or substantially relieve symptoms and sufferers can go on to experience a real sense of recovery and personal growth.

For those who have developed other physical or mental health problems following a traumatic experience, they will usually find such conditions improve when the psychological trauma problems are treated although additional treatments might also be required for such conditions.

Trauma is a serious condition and sufferers can sometimes experience a sense of hopelessness or become worn down by the ongoing or recurring symptoms. So it is important that their needs are identified and understood as trauma related and that they have access to effective treatments. It is also important that they are reassured and supported. Also, as much as possible, the person should make efforts themselves to recognise their needs, to seek help and follow through with treatment, and take positive choices about lifestyle that will ease the symptoms and aid recovery.

Nonetheless it is not uncommon for people to experience some of the symptoms described earlier, but not to make the link with the traumatic experience. Even when the link is recognised it can be difficult to think about the event, and some will try to avoid reminders of it. As thinking about the

event can give rise to distress or a fear of losing control or even of dying, some sufferers conclude that it is better not to think or talk about the event. The experience of therapists, and of sufferers who have recovered with the help of therapy, shows that traumatic experiences can be talked about and worked through safely and that people make good recoveries.

The Northern Ireland Centre for Trauma & Transformation

Appendix 2

DSM-IV DEFINITION OF POST TRAUMATIC STRESS DISORDER
Extract from CREST Guidelines

In Northern Ireland clinical practice, the International Classification of Diseases, 10th revision (ICD10) is used for clinical coding purposes. With regard to PTSD, it is widely acknowledged that the diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) (12) are much superior to ICD10. Both clinicians and researchers working in the field tend to use DSM-IV in preference almost exclusively and this is the rationale behind the use of the DSM-IV criteria in this guideline.

A: The person has been exposed to a traumatic event in which both of the following were present:

1: The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others;
2: The person's response involved intense fear, helplessness or horror.

B: The traumatic event is persistently re-experienced in one (or more) of the following ways:

1: Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions;
2: Recurrent distressing dreams of the event;
3: Acting or feeling as if the traumatic event was recurring (includes a sense of reliving the experience, illusions, hallucinations and disassociative flashback episodes, including those that occur on awakening or when intoxicated);
4: Intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event;
5: Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C: Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1: Efforts to avoid thoughts, feelings or conversations associated with the trauma;
2: Efforts to avoid activities, places, or people that arouse recollections of the trauma;
3: Inability to recall an important aspect of the trauma;
4: Markedly diminished interest or participation in significant activities;
5: Feeling of detachment or estrangement from others;
6: Restricted range of affect (e.g. unable to have loving feelings);
7: A sense of a foreshortened future (e.g. does not expect to have a career, marriage, children or a normal life span).

D: Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1: Difficulty falling or staying asleep;
2: Irritability or outbursts of anger;
3: Difficulty concentrating;
4: Hyper-vigilance;
5: Exaggerated startle response.

E: Duration of the disturbance (symptoms in criteria B, C and D) is more than one month.

F: The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Appendix 3

The following includes key organisations, interests and persons who were consulted during the fieldwork

Organisation
Barnardos Newry Family Resource Centre
Benedictine Monastery
British Association of Social Workers
Christian Renewal Centre
Church representatives - various
Combat Stress
Community Development and Health Network
The Crossfire Trust
CRUSE
EXPAC
FAIR
Family Trauma Centre
General Practitioners (6)
Health and Safety Executive
Independent Christian Counselling organisation
Just Ask
Kilkeel Development Association
Newry and Kilkeel Institute
Newry and Mourne Enterprise Agency
Newry and Mourne LHSCG
Newry and Mourne Trust Business Support
Newry and Mourne Trust Maternity Services Manager
Newry and Mourne Local Strategy Partnership
Newry and Mourne Trust Mental Health Services
Newry and Mourne Trust Director of Administration
Newry and Mourne Trust Specialist Trauma Counsellor
Nexus
NIAMH
Northern Ireland Agricultural Producers Association
NOVA
Person affected by Troubles related violence/TAP
Police Service of Northern Ireland, Newry
REACT, Kilkeel
Relate
Relatives for Justice
Royal College of Psychiatrists

Royal College of Nursing
Royal National Mission to Sea Fishermen
Rural Health Partnership
The Samaritans
Saver/Naver
SDLP
Social Services Inspectorate
Southern Education and Library Board, Youth Service
Southern Health and Social Services Board, PGC
Southern Investing for Health Partnership, '*Dare to Dream*'
Southern Health and Social Services Board Planning Department
Southern Health and Social Services Board, Senior Health Promotion Officer for Mental Health
Trauma Advisory Panel, SHSSB
Ulster Farmers Union
Victim Support
WAVE
Women's Aid, Newry
South Armagh Women and Family Health Initiative

Appendix 4

Overview of research

Kessler and colleagues reported upon a major study into the prevalence of PTSD in 1995 and concluded, "PTSD is a highly prevalent lifetime disorder that often persists for years. The qualifying events for PTSD are also common, with many respondents reporting the occurrence of quite a few such events during their lifetimes." Among a randomly sampled group of adult Americans aged 15 to 54 years the estimated lifetime prevalence of PTSD is 7.8%, with women (10.4%) twice as likely as men (5%) to have PTSD at some point in their lives. A number of other studies have reported on epidemiological studies. Helzer and colleagues and Davidson and colleagues found 1% and 3% respectively, although these results might be the result of the inclusion of a wider range of eligible life experiences. Results in line with Kessler and colleagues were found by Breslau and colleagues, that is, 9.2% overall, 6% of men; 11.3% of women and Resnick and colleagues, that is, 12.3% of women.

Kessler and colleagues found that the most frequently experienced traumas were:

- Witnessing someone being badly injured or killed;
- Being involved in a fire, flood, or natural disaster;
- Being involved in a life-threatening accident;
- Combat exposure.

In the study 60.7% of men and 51.2% of women reported at least one traumatic event. The majority of the people experienced two or more types of trauma. More than 10% of men and 6% of women reported four or more types of trauma during their lifetimes. The survey identified types of traumatic experience that were more likely to be associated with PTSD but none of these events invariably produced PTSD in those exposed to it, and a particular type of traumatic event did not necessarily affect different sectors of the population in the same way.

Other studies have reported on the incidence of development of PTSD after exposure to traumatic events. Green reported an overall incidence of 25% of individuals exposed to traumatic events. In relation to rape, Figley reported between 35% and a striking 92%. Norris found an incidence of 69% in a sample of 1000 people exposed to traumatic events. Breslau and colleagues found that the rate of PTSD in those who were exposed was 23.6%. The variation across studies might, in part at least, be due to the changing definitions of PTSD in the 1980's and 1990's and the severity of exposure in

some of the studies. Nonetheless the findings point to significant consequences.

Kessler's work is also important as it endeavours to describe the recovery rate from PTSD. In short, 40% of sufferers recover (without treatment) by about 30 months after onset of symptoms. At the other extreme, 35% suffer enduring (and what could be taken to be lifetime) PTSD. The prospect of one third of those who develop PTSD having it in the very long term (and as noted above the real possibility of also having other mental health related problems) is particularly relevant to our understanding for the long-term impact of the Troubles.

PTSD risk factors

As noted already, not everyone exposed to traumatic events develops a post traumatic illness. Various studies have drawn attention to the personal and circumstantial factors, which seem to be linked to an increased likelihood of developing the condition. For example, in a meta analysis by Brewin, Andrews and Valentine three risk factors for PTSD were identified consistently across all studies namely, psychiatric history, history of childhood trauma and family history of psychiatric disorders. Specific studies point to other pre-existing personal and social circumstances, and post trauma appraisals and coping as also being related to the development or presence of PTSD. This developing area of knowledge has implications for identifying those at most risk, for screening, assessment and interventions.

The impact of the troubles

In a secondary analysis of a nationally representative population survey conducted in 1997, O'Reilly and Stevenson concluded that "The Troubles are a separate and additional [public health] burden and therefore contributes significantly to the higher psychological morbidity in Northern Ireland", and "It is probable that mental health has been significantly affected by the Troubles."

In The Cost of the Troubles Study, the researchers concluded that about 30% of those who participated in the study and who had been exposed to violence associated with the Troubles had needs approximating to PTSD. This finding seems high and might be associated with the methodology used in the study. Cairns and colleagues found that the mean GHQ scores of a sample of 1000 adults from across Northern Ireland was 10.05, which was in line with the findings of an earlier study carried out in Derry/Londonderry. That study had detected similar or higher rates of psychiatric disorder in Derry/Londonderry to that found in inner city London. Cairns and colleagues concluded, "The

ceasefires have not led to any notable change in overall levels of psychological well-being in the Northern Irish population".

One particular incident associated with the Troubles as which was the subject of three major needs assessment casts some light on the impact of a single incident. The Omagh bombing of August 1998 killed 29 people and two unborn children. Over 400 were injured, of whom 135 were seriously injured. In the course of the three and a half years following the bombing, over 670 people were seen by the Omagh Trauma and Recovery Team, which was established in the wake of the bombing by the local health and social services provider, the Sperrin Lakeland HSS Trust. In addition, an unknown, but probably very large, number of people were provided with support from a range of primary care, mental health, voluntary and occupational health related services.

A major community study (a needs assessment) commissioned by the Sperrin Lakeland HSS Trust (unpublished) suggests that 55% of those who were in the immediate vicinity of the Omagh explosion had PTSD at the time the study was undertaken i.e. 8-10 months after the explosion. The Sperrin Lakeland HSS Staff Study (a needs assessment) revealed that of those staff who were exposed to work associated with the response to the bombing, 38% of staff had developed PTSD in the period 4-17 months after the bombing.

Appendix 5

Digest of organisations providing services in the Newry and Mourne area

Relationships

Accord
Cana House
Trevor Hill
Newry
Co Down
(028) 3026 3577

Relate
28 Corn Market
Newry
Co Down
BT35 8BG
(028) 3025 2636

Drugs and Alcohol

Alcoholics Anonymous
11c Trevor Hill
Newry
Co Down
(028) 3026 5406

Don't Blow it
REACT
2 Bridge Street
Kilkeel
Co Down BT34 4AD
(028) 4176 9344

Cuan Mhuire
132 Armagh Road
Newry
Co Down
(028) 3026 2429

Specific Illness and Carers

Alzheimers Society
Ballybot House
28 Cornmarket
Newry
Co Down
(028) 3025 6057

Children and Young People

Barnardo's Newry Adolescent Partnersip
14a The Mall
Newry
Co Down
(028) 3025 1115

Barnardo's Newry Family Resource Centre
Lisdrum House
Chequer Hill
Newry
Co Down
(028) 3026 0668

You First
REACT
2 Bridge Street
Kilkeel
Co. Down BT34 4AD
(028) 4176 9912

Local Troubles related services and Self-help groups

Newry and Mourne Trust Specialist Trauma Counselling Service Newry and Mourne Mental Health Service 3-5 Railway Ave Newry Co Down BT35 6BA (028) 3083 5725 or (028) 9032 5623	NOVA Child and Family Centre Bocombra Lodge 2 Old Lurgan Road Portadown BT63 5SG 028 38 335173
The SHSSB Trauma Advisory Panel Coordinator, SHSSB Ballybot House Newry BT35 8BG (028) 3083 3074 0r 3083 3076	WAVE 9 Dobbin Street Armagh BT61 7QQ (028) 3751 1599
South Down Action for Healing Wounds SDAHW 16 Downpatrick Street Rathfriland Co. Down BT34 5DG (028) 4063 1259 Fax: (028) 4063 1269	SAVER/NAVER Bingham House 43 main street Markethill BT60 1PH (028) 3755 2808
MAST Reivers House 10 Newcastle Street Kilkeel BT34 4HT (028) 4176 3280	SAOL 39 Slatequarry Road Cullyhanna Newry BT35 0PX (00353) 861739722
FAIR Mount Pleasant House 18 Mowhan Road Markethill Co. Armagh BT60 1PH (028) 3755 2619 Fax: (028) 3755 2719 Email: info@victims.org.uk	Crossfire Trust Darkley Co. Armagh BT60 3AY (028) 3753 1636

Ex-prisoners support organisations

Cumann na Meirleach 10 Newry Street Crossmaglen BT35 9JH Co. Armagh (028) 3086 0017	Expac 59 Glaslough Street Monaghan RoI (00353) 4772182

See also the SHSSB Trauma Advisory Panel Information Directory for People Affected by the Troubles; SHSSB 2003.

Community

Community Development and
Health Network
30a Mill Street
Newry
Co Down
(028) 3026 4606

Rural Health Partnership
The Wald Centre
Tullynavall Road
Cullyhanna, Co. Armagh
BT35 0PZ
(028) 3086 1220

Women and Family Health Initiative
Mullaghbawn Community
Tullymacrieve Road
Mullaghbawn
Co Armagh
BT35 9RD
(028) 3088 9073

Bereavement, suicide, still birth etc.

Cruse Breavement Care
5 Edward Street
Newry
Co Down
BT35 6AN
(028) 3025 2322

SANDS
Stillbirth and Neonatal Death Society
Local Contact Point
Daisy Hill Hospital
(028) 3026 1414

Counselling and support organisations

Newry Women's Aid
7 Downshire Place
Newry
Co Down
(028) 3025 0765
(028) 9033 1818 (Helpline)

The Nexus Institute
119 University Street
BELFAST
BT7 1HP
(028) 9032 6803

The Samaritans
19 St Colman's Park,
NEWRY
Co. Down,
(028) 3026 6366

Victim Support
3-5 Railway Avenue
Newry
Co Down
(028) 3025 1321

NIAMH
Beacon Centre
17 Abbey Street
Armagh
Co Armagh
(028) 3750 8771

'Just Ask' Counselling Service
Newry and Mourne Trust
John Mitchell Place
Newry
Co Down BT34 2BL
(028) 3083 4200

Appendix 6

A PROGRAMME FOR DELIVERING THE TRAUMA STRATEGY

Promote health and well-being[20]

- **By reducing traumatic incidents:**
- **By promoting resilience, coping, information sharing and help seeking;**
- **By early detection and referral; and**
- **By providing appropriate treatments and support services.**

Promote health and well-being through:-

- **Prevention**
  - **by reducing traumatic incidents;**
  - **by promoting resilience, coping; information sharing and help seeking;**
- **Early detection and referral; and**
- **Providing appropriate treatments and support services.**

This will be achieved through:-

Prevention

- Preventing traumatic experiences;
- Promoting resilience;
- Promoting coping;
- Promoting information sharing;
- Promoting help seeking.

Early detection and referral

- Equipping service gatekeepers to detect, to respond appropriately and refer;
- Raising the skills and knowledge of key organisations and their staff;
- Alleviating distress;
- Promoting help seeking;
- Providing appropriate information, support and treatment services;
- Clear referral arrangements and standards.

Appropriate treatments and service responses

[20] This could also be stated in terms of reducing the demands on health and social services and other social consequences, a focus that would be particularly relevant in responding to major traumatic incidents and disasters.

- The provision of appropriate services for early intervention;
- The provision of appropriate primary, secondary and specialist services;
- The provision of supportive services.

Newry and Mourne Draft Strategy template

Aim	Objectives	Desired outcomes	Possible actions	Possible Key players
Prevention	**Preventing traumatic experiences**	Reduction in incidence of: - Violence - RTAs - Other accidents - Reckless and dangerous behaviours Reduction in incidence of acute distress Reduction in longer-term trauma related disorders	Build on current programmes Parental advice and support programmes 'Alternatives to violence' and safety programme for younger children Violence reduction programme with young people Personal safety programmes	Family focussed organisations Community and voluntary organisations Key statutory agencies Education services and schools Church and faith communities Cultural organisations Sports organisation

Aim	Objectives	Desired outcomes	Possible actions	Possible Key players
Prevention	**Promoting resilience** **and** **Promoting coping**	Maximising personal and family strengths and competence Maximising personal and family coping	Development and provision of personal resilience programme Pre-stress coping programmes for high risk groups Early intervention programme focusing on coping successfully Leaflets for key persons and organisations to give to those recently exposed to distressing events	Family focussed organisations Community and voluntary organisations Primary and Community services Education services and schools Church and faith communities Cultural organisations Sports organisation Interagency Disaster Planning Group

Prevention	**Promoting information sharing**	Clear and accessible information for service users, families, those acting to support persons affected by traumatic events etc.	A range of communication initiatives aimed at different sections of the community, groups, professional personnel, community, voluntary, private and statutory organisations etc.	LHSCG Trauma Steering Group Newry and Mourne HSS Trust GP Services/FPSU Peer groups Membership (self-help) organisations A & E Primary and Community Care services TAP Education Services Employers Church and faith groups Interagency Disaster Planning Group

Aim	Objectives	Desired outcomes	Possible actions	Possible Key players
Prevention	**Promoting help seeking**	Minimising delays in seeking treatment Minimising chronic illness Enabling access to services De-stigmatising services and help seeking	Attractive and informative public communication on coping with a distressing experience Clear and widely available advice on how to access help after a distressing experience Awareness raising programmes for key persons and organisations on identifying distress, appropriate interventions and assisting onward referral Initiatives to enhance responses to early distress by key service providers and gatekeepers	Community based organisations Peer groups Membership (self-help) organisations A & E Primary and Community Care services Employers Church and faith groups Cultural groups Sports groups Secondary care services Interagency Disaster Planning Group

Aim	Objectives	Desired outcomes	Possible actions	Possible Key players
Early detection and referral	**Equipping community based organisations and service gatekeepers to detect, to respond appropriately and refer**	Confident and competent community based services	Awareness raising programmes for families and communities Awareness raising programmes for community based, voluntary and statutory services	Community based organisations Membership (self-help) organisations A & E TAP Primary and Community Care services Secondary care services Employers Church and faith groups Cultural groups Sports groups Interagency Disaster Planning Group
	Raising the skills and knowledge of key organisations and their staff	Equipping current services	Awareness raising and basic skills programmes for community based, voluntary and statutory services	as above
	Alleviating distress	Optimum responses for those in distress	'Competent Helper' type programmes with an emphasis on distress and trauma Distress and trauma focussed knowledge and skills programmes	as above

Aim	Objectives	Desired outcomes	Possible actions	Possible Key players
Early detection and referral	**Promoting help seeking**	Enabling access to services De-stigmatising services and help seeking	Public communication on coping with a distressing experience Advice on how to access help after a distressing experience Awareness raising programmes on identifying distress, appropriate interventions and assisting onward referral Initiatives to enhance responses to distress and trauma by key service providers and gatekeepers	Community based organisations Peer groups Membership (self-help) organisations A & E TAP Primary and Community Care services Secondary care services Employers Church and faith groups Cultural groups Sports groups Interagency Disaster Planning Group

Aim	Objectives	Desired outcomes	Possible actions	Possible Key players
Early detection and referral	**Providing appropriate information, support and treatment services**	Clear and accessible information for service users, families etc.	A range of communication initiatives aimed at different groups etc.	LHSCG Trauma Steering Group Newry and Mourne HSS Trust GP Services/FPSU TAP Interagency Disaster Planning Group
	Clear referral arrangements and standards	Clear and accessible referral processes Trust wide referral standards Basis for evaluating services	Agreement amongst key agencies on referral arrangements and protocols Open access referrals for families and individuals Fast track for urgent cases Inter-professional links and co-working arrangements	LHSCG Trauma Steering Group Newry and Mourne HSS Trust GP services/FPSU Voluntary and Community sector TAP Interagency Disaster Planning Group

Aim	Objectives	Desired outcomes	Possible actions	Possible Key players
Appropriate treatments and service responses	**The provision of appropriate services for early intervention**	Promote coping Monitoring progress Treat as soon as indicated (in accord with best practice)	Design Trust wide optimum service profile Build on current strengths Plan for further development Build services through Mental Health Review	**Possible providers**: Community based organisations Voluntary providers Statutory services Employment based services Interagency Disaster Planning Group
	The provision of appropriate primary, secondary and specialist services	Optimum response for user at each service level Access to more specialist treatment services	As above	Primary care and community services Community Mental Health Teams Voluntary mental health providers Specialist trauma services Interagency Disaster Planning Group
	The provision of supportive services	Practical and befriending services to support person during treatment	Audit current provision Agree standards	Trauma Steering Group Mental health services Voluntary and Community sector TAP Befriending services Membership (self help) groups Personal development programme providers Interagency Disaster Planning Group

Aim	Objectives	Desired outcomes	Possible actions	Possible Key players
Coordination	**To coordinate roll out of strategy** **To coordinate future developments and build on future opportunities** **To monitor strategy and its implementation**	Coordinated development Coordinated and joined up integrated strategy Evaluation	Development of service standards Development of investment and development plans Prioritisation of future investment Determine training priorities Evaluation of initiatives and programmes	Trauma strategy coordinating group with broad representation and Interagency Disaster Planning Group

Appendix 7

The Brief

The brief required an outcome that would identify the most appropriate model of service having taken account of: -

- Clarity on the identification of trauma rather than distress or mental ill health;
- Identifying the continuance of the experience of trauma and providing guidance on how best to optimise timing and the level of intervention along that continuum;
- The requirement to identify, build upon and maximise existing community and family support systems, including proposals to strengthen and develop such systems;
- Current statutory, voluntary, community and private service provision – what trauma support services are currently provided in the area? Who provides these services? How are they provided? How are they accessed? What links are there between services?
- Demand for trauma support services in Newry and Mourne – met, current and perceived need;
- Characteristics of the Newry and Mourne – geography, demography, sub-localities, deprivation, settlement pattern, disadvantaged groups and areas;
- Evidence –based best practice;
- Cost effectiveness and affordability;
- Accessibility for potential service users;
- Equity of provision across the locality.

Appendix 8

References and Resources

Recommended Guidance for the treatment and management of PTSD

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   http://www.crestni.org.uk/publications/post_traumatic_stress_disorder.pdf

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