CONSULTATION RESPONSE

"ADDRESSING THE LEGACY OF NORTHERN IRELAND'S PAST"

The need for a victim and survivor centred, trauma-informed approach

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The Research on Trauma and the Troubles

Ulster University research shows that whilst around 71.5% of the population have minimal levels of mental illness, the mental health difficulties of at least half of the remaining 28.5% (approx. 213,000 adults) appear to be directly related to the Troubles. These figures are based on robust data, using strict psychiatric criteria for mental illness, and they illustrate how the conflict was a significant and distinctive stressor in the life of the community in Northern Ireland for over 40 years (McLafferty et al., 2016; O'Neill et al., 2015). This study showed that 39% of the population experienced a traumatic event that was related to the Troubles. Such events included bombings, shootings, and witnessing killings and mutilations. Troubles related trauma was also shown, in these studies, to increase the likelihood of suicidal behaviour (O'Neill et al., 2014) and this fits with theoretical psychological understandings of suicide which demonstrate the impact of violence and habituation to pain and death, on the person's capability to act in response to suicidal thoughts. Sadly, this is also borne out in the population's rates of suicide deaths which, 16 per 100,000 are the highest in the UK. Our male suicide rate is double that of England. The suicide rate has doubled since the Good Friday Agreement, and whilst there are many contributory factors, the fraught nature of the peace process, the legacy of poverty and despair in the areas most affected, has resulted in the most deprived areas having rates that are up to three times those of the last deprived areas (Bunting et al., 2018).

The research demonstrated the depth and scale of the mental health needs of the NI population, however progress on meeting those needs and providing the evidence-based treatments for complex trauma-related illnesses has been slow. In the meantime, the consequences are manifest in the form of social unrest and high rates of prescribed medication (Benson et al., 2018). Mental illness stifles healing and empathy. Psychological therapies can help individuals make meaning from their experiences, which not only reduces their suffering, but also allows them to place the experience in context, to foster recovery. Such processes at both a personal, and community level promote

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peacebuilding, and create the environment for peace. We know, from other research conducted by staff at Ulster University, that for victims and survivors of trauma, the issues of truth, justice, accepting responsibility, compensation and official acknowledgement are part of this "meaning making" and are interwoven with healing (Hamber, 2009). In fact, healing, often promoted by addressing wider victim issues such as truth and justice, in such circumstances may provide the conditions for post traumatic growth (Joseph, 2015). The opposite is also true, that failing to address the wider needs of survivors (such as a desire for justice or truth) can have negative psychological consequences into the long term (Hamber, 2009).

The proposed legacy institutions will therefore have a profound impact on the mental health of the individuals who engage with them, those who for whatever reason choose not to, and those with existing trauma-related conditions and mental illness who either participate, or hear about them from the media and other sources. It is vital that the mental health of those affected is protected through this process.

In this document we base our definitions of trauma and mental illness, and therefore "victimhood", on the psychiatric criteria for mental illness. However, it is important to acknowledge the contested nature of this term and the difficulties associated with the use of narratives of "deserving" and "undeserving" victims, which can in fact, serve to exacerbate suffering and illness among those who have been affected by very real injustices. The term "survivor' may be viewed as more appropriate, and in fact reflects the fact that the majority of those affected by the years of violence have not had significant long-term mental illness. There are numerous examples of post traumatic growth, where people have flourished as a result of their experiences. However significant proportions of those affected by multiple horrors, and adverse childhood experiences will no doubt have serious and chronic mental illness (in NI 4.3% of the population, McLafferty et al., 2016). It is this group that the institutions aim to target and it is incumbent upon them to ensure that the vulnerable people who engage with the institutions have an opportunity to obtain treatments and are not subjected to further harm. In addition, for those without a diagnosed condition, the process will prove extremely stressful and although most have coped over time with what happened, the social and psychological impact of the conflict has been profound (McLafferty et al., 2016; O'Neill et al., 2014).

Among the key goals of the institutions are the promotion of reconciliation and the acknowledgement of the suffering of victims and survivors. However, it is startling in this regard that the needs of survivors, particularly in relation to psychological support, receives scant consideration in the consultation document. In this response we therefore consider the potential impact of the legacy structures and their processes, on the mental health of the people who engage with them, the staff, and on the population in general.

We put forward six key recommendations to mitigate against harm and maximise the potential of the institutions to promote recovery and healing.

Mental health risks of the proposed legacy institutions

The consultation document proposes four new legacy institutions, each addressing the needs of victims and survivors as defined in different ways. Three of the institutions, the Historical Investigations Unit (HIU), the Independent Commission on Information Retrieval (ICIR) and the Oral History Archive (OHA) will deal with the needs of specific groups of victims. There are two challenges with this structure from a mental health perspective, that are not addressed in the current proposals. The first is regarding the differing definitions of victimhood that are implicit within the remit of each of the institutions.

The HIU and ICIR address cases where there has been a death as a result of the Troubles, whereas the OHA takes a broader definition of victimhood, potentially including "anyone who has been touched by the Troubles would be able to share their memories and tell their stories and have these recorded in the Archive. This would include victims and survivors, but also former soldiers and police officers, members of the emergency services, former paramilitaries, and anyone who lived through this difficult period in Northern Ireland's history".

The OHA may be regarded as serving to acknowledge the subjective nature of experiences related to the conflict, and truly "acknowledging the suffering of victims and survivors" as per the goals of the institutions. There is the possibility that the wider definition of the OHA may complement the narrow criteria of the other proposed institutions. However, there will more than likely need to be definitions and boundaries imposed on the OHA and eligibility will need to be established, and even if fairly wide criteria are used in the OHA it will not be able to meet some survivor needs such as justice or truth-recovery. In contrast, the adoption of a narrower definition of eligibility in the HUI and ICIR means that people and families with other types of experiences will be excluded. The result of this for victims, whether established in law or not, could be that losing a relative could be seen as "worthy" of investigation and truth-recovery (with the potential benefits of truth and possibly even justice) in the HIU and ICIR, but being profoundly tortured or disabled by the conflict is only "worthy" of acknowledgement or storytelling in the OHA. The latter of course could in some cases be validating for individuals, but for others it could have a psychological impact in which their subjective suffering is minimised in their eyes by the nature of the institutions. Acknowledgement and validation are important to "meaning making" and will promote recovery, but it has to be noted that the inclusion criteria for the HUI and ICIR has the potential to cause hurt and further harm. We acknowledge that financial and practical limits might be needed to run the different institutions, but the real consequences of including or excluding individuals goes beyond legal and pragmatic questions, and will have mental health consequences thus demanding a duty of care.

The second difficulty with the structures is the possibility that individuals and families may now need to approach one or more institutions, and navigate a system that could turn out to be bureaucratic, complex, mechanistic and "cold". There is little information on how the structures relate to one another and there is the real risk that victims may end up telling their stories to three different bodies, as well as victims having to figure out the role of a new mental health service and Victims and Survivors Support Service at the same time.

There is reference to the fact that support will be provided under each of the institutions (with the exception of the IRG) but this is not discussed in any uniform way in the proposed documents. For example, it is noted that HIU would have "a dedicated family support function to assist families through the process"; ICIR will ensure "families would be supported and the ICIR would keep them informed of progress"; the OHA will make potential contributors aware of "support arrangements available for victims/survivors and appropriate support bodies". In addition to this the "Stormont House Agreement outlined a Commitment from the Northern Ireland Executive to provide access to an advocacy counsellor who would assist victims and survivors to engage with the legacy institutions". In short, there is no standardised approach to support and the broadly autonomous nature of the proposed institutions might result in very different support mechanisms being put in place with different and unequal outcomes. Any support provided needs to meet the needs of victims, many of whom will have had negative experiences in accessing services in the past, which serve to create further pain and distress. In other processes around the world poor administrative treatment of victims and haphazard support has been found to have profoundly negative impacts (Hamber, 2009).

Currently the mental health support to those who engage with the institutions is likely to come from the Victims and Survivors Service who have in place 23 Advocacy and Support Workers and 25 Mental

Health and Wellbeing case workers. In addition, the institutions plan to work with the Regional Trauma Network to ensure that people who engage with the service receive timely and effective treatments. Participants may also engage wish to engage with the statutory and non-statutory mental health services, including the suicide prevention helpline, Lifeline, as well as wider community-based support and trauma services. But it is not clear how the support spoken about in the consultation document will relate to or interface with these existing supports, or if these will be resourced.

It is therefore important that a process of demand profiling and impact assessment is undertaken prior to the commencement of the work of the institutions so that likely need is established, based on the current research evidence about the numbers affected. The Victims and Survivors Service, Regional Trauma Network and statutory and non-statutory sector need to be adequately resourced to deliver services and treatments on this basis. In addition to this the institutions need to be assessed from the perspective of the survivor navigating through them, and it is to this we now turn.

A victim and survivor centred, trauma-informed approach

The US substance abuse and services administration (SAMSHA, 2018) define a trauma-informed approach as an approach that:

1. *Realizes* the widespread impact of trauma and understands potential paths for recovery;
2. *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system.
3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist *re-traumatization*.

We recommend that the legacy institutions adopt these principles in their engagement with victims and survivors, and the Northern Ireland population as a whole.

Three of the proposed institutions deal with narratives about what happened, which may be described as personal experiences and interpretations, facts, stories, or truths. However, each institution delivers different outcomes, and as such, the structures may be perceived from a psychological level to place a value on the importance of one method (and its attached narrative) over another. Furthermore, although hearing multiple versions of "truth" can be helpful, processes of truth recovery also have the potential for further personal destabilisation (Hamber, 2009). New information and revelations, regardless of which institution they fall under, have the capacity to exacerbate the mental health symptoms associated with trauma exposure and PTSD, and impede healing and recovery. For example, in other processes around the world, truth recovery can often mean previously untold stories emerging (say of betrayal) which can create new dynamics and challenges. To address such complex situations a range of supports will be necessary operating at different levels.

At a practical level, four broad categories or types of interventions that could improve the psychosocial well-being of those in the midst of humanitarian and political emergencies have been identified (IASC, 2007), and we would argue thinking of support in the legacy process could be considered in a similar way (see Figure 1). Needs listed at the bottom of the pyramid require the most intervention, and those identified thereafter need progressively less attention, although all layers are important and require implementation concurrently (IASC, 2007) and are inter-related. Some areas of need might also be acute and demand specific treatments or interventions.
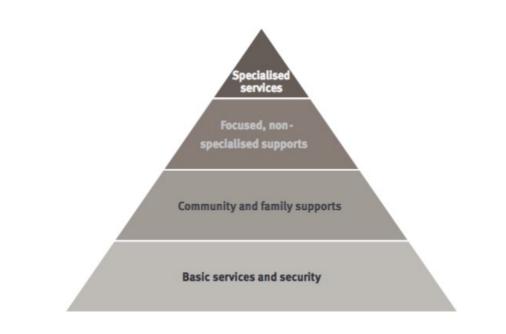
Figure 1 IASC (2007) Intervention pyramid for mental health and psychosocial support, diagram from Hamber (2015)

The most extensive task aimed to ensure psychosocial well-being, according to the IASC Guidelines is to (re)establish security, ensure adequate governance and services that address basic physical needs (food, water, basic health care, control of communicable diseases, etc.). This is beyond the remit of the proposed institutions, although a sensitivity to the fact that mental health is continually impacted upon by social conditions such as living in poverty or areas with serious social problems should underpin any intervention.

Secondly, it should be recognized that for many victims (and the population at large) key community and family support is essential to well-being, and often the first port of call in times of distress.

Thirdly, non-specialised supports (these can include emotional and livelihood support) for the still smaller number of people who additionally require more focused individual, family or group interventions by trained and supervised workers should be ensured.

There are many different types of intervention implicit in the community, support and non-specialised levels outlined above. Less clinical and community-driven approaches include activities such as group sharing of problems, befriending, community dialogue, healing rituals, art projects, theatre initiatives, interpersonal skills development, training on issues such as legal support, advocacy and mediation. Many community groups, and local structures, in Northern Ireland have provided these supports over the years. They should continue to be resourced to offer these supports throughout the legacy process and to complement specialized services.

Finally, the specialised services of psychologists, psychiatrists or other trained individuals should be offered to people with severe mental disorders whenever their needs exceed the capacities of existing primary/general health services (IASC, 2007).

In terms of specialised services it is important to consider the mental health impact of trauma, and the features of post-traumatic stress disorder (PTSD) in particular. This understanding is critical to a trauma-informed approach. Exposure to types of traumas associated with the Northern Ireland Troubles can lead to specific clusters of mental health symptoms, and PTSD. The effects of trauma

exposure are not only borne by those who have experienced the trauma, but also by those who work with them and witness their testimonies.

PTSD is characterised by three clusters of symptoms:

- Horrifying flashbacks and nightmares of a particular event, where it is as if that person was re-experiencing the event;
- Avoidance and numbing, where the person suppresses even positive emotional responses, to avoid any reminder of the event and to avoid "triggering" a flashback or intrusive memory;
- Hypervigilance; a heightened stress reactivity that impedes day to day functioning.

In the Northern Ireland study of health and stress we found that in 2008 8.8% of the population had met the criteria for PTSD (Bunting et al., 2013). PTSD is treatable, but this requires specialist "trauma-informed" therapies, which serve to "re-programme" the interactions between the person's memories of the event and their stress response systems (NICE recommends trauma focused Cognitive Behavioural Therapy, NICE, 2018). In addition to PTSD, trauma exposure was associated with a wide range of other mental illnesses many of which were also severe and enduring. In 2008 only one in five had received treatment that they perceived to be effective (Bunting et al., 2015). There is therefore huge concern about the level and impact of this unmet need, and the institutions need to consider this when implementing the proposals.

Many people with trauma related mental illnesses avoid reminders of the events that led to their illness. This is particularly the case for people with PTSD, as any reminder may trigger flashbacks, and in effect consolidate the illness. People who share their experiences and who receive inappropriate responses, or who ask for help and do not receive treatment that is effective, frequently report a worsening of symptoms. Worryingly, inappropriate responses to requests for help for mental illness can worsen the sense of hopelessness and despair that is associated with suicidal thoughts. One of the main goals of the legacy institutions is to encourage disclosure, therefore the implications for mental health and trauma need to be carefully considered and the effects mitigated against. A deliberate trauma-informed approach that offers support throughout and after the process is necessary.

But any direct traumatic responses cannot be addressed completely outside the wider social and political context. The legacy institutions will generate "new" information, as disclosed to the institutions of the legacy, or available as a result of the oral history archive. Perceptions about the value placed on that information, in terms of the extent of suffering and the need for compensation can impact upon the "meaning making" that fosters recovery. However, equally whilst truth can be powerful and transformative, it can also exacerbate pain and suffering, and prompt further unhelpful rumination. Truth, justice, and recovery processes can serve to validate and prioritise some perspectives over others. The processes must therefore be delivered cautiously and monitored carefully. When people share testimonies that even their nearest and dearest may be unaware of they can become vulnerable. The testimonials are precious and the ways in which they can be made public and used, or in fact exploited by others needs to be managed carefully. The same can be said of testimonies collected in the OHA. We note with deep concern that "there would be a procedure for the disposal of records where the Deputy Keeper has decided collected records should not form or should cease to form part of the OHA". In terms of testimony destroying a victim's testimony, no matter the reason, could have very deep and lasting impact for the individual. Again, any such process of record destruction from a psychological perspective needs to be deeply considered, if not removed from the remit of the OHA.

By defining the boundaries of victimhood in terms of who can speak to what institution, or deeming certain information irrelevant, may be perceived to be making judgements about a person's suffering, that is at best insensitive and at worst, itself traumatizing. By diminishing the very real suffering caused by the trauma of physical injury, witnessing death or serious injury (all of which are included in psychiatric definitions of trauma) we risk causing additional harm. Such harm needs to be mitigated at the top of the pyramid outlined above by offering adequate and professional support through, and at the other levels ensuring that social, legal, welfare and community support is also forthcoming and resourced, most likely through assessing needs and making appropriate referrals.

We make six specific recommendations:

1. The institutions should **adopt a victim and survivor-centred perspective**. This means that the process should be scrutinised from the perspective of the victim, and their journey through engagement with one of more of the structures. The impact on the individual and their family should be charted. We advise that clear guidelines are set in place regarding how to contact the institutions, and that all those who engage with them are guided and supported through the whole process and afterwards. Demanding a victim re-tell their story in multiple ways to different individuals and bodies needs to be avoided, and synergy between the institutions at this level needs to be ensured. We understand the need to create a legal framework for the legacy institutions, but from a mental health perspective victims' engagement with such processes, and setting them up from their perspective is vital. The current legislative process runs the risk of being overly focused on the procedural at the expense of how victims subjectively experience engagement with the institutions.

2. **Support for victims through the process should be standardised and offered on an equal basis to all survivors across the legacy institutions**. As noted above, the various institutions seem to talk about family and victim support in different ways in the consultation document, and it is not clear how the process outlined interfaces with the Stormont House Agreement proposals for Advocacy Counsellors. A standardized support process, with varying and individually appropriate referral strategies, for family and individual support needs to run across all the legacy institutions. There should not be different support mechanisms in different institutions. This links to the point above 1. In so far as the entire journey through the process for a victim should be considered holistically not just in an individual institutional lens (e.g. ICIR, HIU, OHA).

3. It is important that **a process of demand profiling and impact assessment is undertaken prior to the commencement of the work of the institutions** so that need is established, based on the current research evidence about the numbers affected. The Victims and Survivors Service, Regional Trauma Network and statutory and non-statutory sector need to be adequately resourced to deliver services and treatments on this basis. The balance between offering support and appropriate referral at different levels (e.g. specialized and non-specialized support) needs to be struck. In other words, adequate social and community support (offered by many community groups already) for anyone engaging in the process needs to be ensured through adequately resourced referral networks and awareness, along with specialized support services.

4. At the specialized level, the institutions should **adopt a trauma-informed approach**. We need to ensure that the legacy structures and processes screen people for mental illness and trauma-related conditions and facilitate people with mental illnesses and symptoms of trauma and PTSD in receiving treatment. This would ensure that the structures and processes operate in a manner that is cognisant of the need to avoid causing further hurt for those with diagnosable conditions, and does not impede the process of recovery and healing of victims who have trauma-related mental illness.

5. We recommend that **a Mental Health Advisory Group** is convened to oversee and monitor the implementation of the institutions, working across all four of the institutions. The role of this group would be to ensure that the institutions and those who work with people who engage with them adopt a compassionate, trauma-informed approach, screening for suicidality and trauma-related mental illnesses and referring where appropriate. The Mental Health Advisory Group should also advise on, as well as assess, how all supports at different levels will interface with existing structures in the statutory and non-statutory sectors, an issue that is not clear in the consultation document. This group would also monitor how the institutions manage the expectations of the general public and publicise the work, so as to ensure that the potential for re-traumatisation and the exacerbation of existing psychological conditions is minimized. The Mental Health Advisory Group should also continually take stock, and make recommendations, on how to ensure the institutions run in a victim-centered way and the experiences of victims are holistically taken into account in terms of how they are dealt with throughout the process from the administrative level, to making referrals through to meeting specialized mental health needs.

6. We need to **protect the mental wellbeing of those who work within the legacy institutions** particularly those who witness the testimonies of the victims and survivors and those tasked with delivering justice and establishing level of need. This area is often ignored but all those interfacing with victims, from senior staff to those taking testimony, should be trained with regards to understanding the psychological impact of historical trauma on victims. Research in other contexts has shown that failing to pay attention to the mental health needs of staff in commission-related processes can have a range of psychological consequences for individuals, as well as undermining the efficacy of institutions and impacting negativity on the victims experiences of the process (Hamber, 2009). In short, all staff should be trained to know how to interact with survivors but also have access to support services themselves if necessary.

References

Benson, T., Corry, C., O'Neill, S., Murphy, S., Bunting, B. (2018). Use of prescription medication by individuals who died by suicide in Northern Ireland. *Arch Suicide Res,* 22, 1, 139-152. https://doi.org/10.1080/13811118.2017.1289870

Bunting, B.P., Ferry, F.R., Murphy, S.D., O'Neill, S.M., Bolton, D. (2013). Trauma associated with civil conflict and posttraumatic stress disorder: evidence from the Northern Ireland study of health and stress. *J Trauma Stress,* 26, 134–141. https://doi.org/10.1002/jts.21766

Bunting, B., Corry, C., O'Neill, S., Moore, A. (2018). Death by suicide at the Ward level in Northern Ireland. *Psychol Med,* 48(8), 1375-1380. https://doi.org/10.1017/S0033291717003026

Hamber, B. (2009). *Transforming Societies After Political Violence: Truth, Reconciliation and Mental Health*. New York: Springer.

Hamber, B. (2015). Dealing with Painful Memories and Violent Pasts: Towards a Framework for Contextual Understanding. In B. Austin & M. Fischer (Eds.), Berghof Dialogue Series 11. Berlin: Berghof Centre. Retrieved from: http://image.berghof-foundation.org/fileadmin/redaktion/Publications/Handbook/Dialogue_Chapters/dialogue11_hamber_lead.pdf

Inter-Agency Standing Committee (IASC). (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Retrieved from:

http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

Joseph, S. (2015). A person-centred perspective on working with people who have experienced psychological trauma and helping them move forward toward posttraumatic growth. *Person-Centered and Experiential Psychotherapies*, 14(3), 178-190

McLafferty, M., Armour, C., O'Neill, S., Murphy, S., Ferry, F., Bunting B. (2016). Suicidality and profiles of childhood adversities, conflict related trauma and psychopathology in the Northern Ireland population. J Affect Disor*d,* 200, 97-102. https://doi.org/10.1016/j.jad.2016.04.031

NICE (2018). Guidance: the treatment of PTSD. Retrieved from: https://www.nice.org.uk/guidance/cg26/chapter/1-Guidance#the-treatment-of-ptsd

O'Neill, S., Ferry, F., Murphy, S.D., et al. (2014). Patterns of suicidal ideation and behaviour in Northern Ireland and associations with conflict related trauma. *PLoSOne,* https://doi.org/10.1371/journal.pone.0091532

O'Neill, S., Armour, C., Bolton, B. et al., (2015). *Towards a Better Future: The Transgenerational Impact of the Troubles on Mental Health*. Belfast, CVSNI. Retrieved from: https://www.cvsni.org/media/1171/towards-a-better-future-march-2015.pdf

SAMHSA (2018). Trauma-Informed Approach and Trauma-Specific Interventions. Retrieved from:

https://www.samhsa.gov/nctic/trauma-interventions