



Health and Social  
Care Board

# **REGIONAL TRAUMA NETWORK**

## **Service Delivery Model and Equality Impact Assessment**

### **REPORT FOR CONSULTATION**

**14<sup>th</sup> June 2019**

## Consultation Announcement

This document is being presented for public consultation. It outlines the proposed service delivery model of the Regional Trauma Network (RTN) and reports the outcome of an Equality Impact Assessment in relation to this conducted by the Health and Social Care Board on the Health and Social Care element of the Regional Trauma Network.

A copy of this document is also available on the Health and Social Care Board website at: <http://www.hscboard.hscni.net/get-involved/consultations/>. Requests for versions of this document in accessible formats will also be considered.

**Consultation will commence on Friday 14<sup>th</sup> June 2019 at 1:00 pm and will end at on Friday 6<sup>th</sup> September 2019 at 1:00 pm.**

We hope that you will find time to comment on this document.

If you would like to submit your comments in writing, you can do so as follows:

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You can also complete the online questionnaire on our website at <http://www.hscboard.hscni.net/get-involved/consultations/>.

If you prefer to meet with us in person, we would be very happy to do so. Please contact us by email, by post, or by phone on: 0300 555 0115.

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## EXECUTIVE SUMMARY

**The Health and Social Care Board is carrying out a public consultation on the proposed service delivery model for the Regional Trauma Network.<sup>1</sup>**

**The Health and Social Care Board proposes to launch the Regional Trauma Network in three phases as follows:**

- **Phase 1: to launch the pathway for victims and survivors of the Conflict/Troubles – Autumn 2019;**
- **Phase 2: full implementation of the Health and Social Care element of the Regional Trauma Network for all children, young people, and adults with significant levels of psychological trauma – April 2020; and**
- **Phase 3: to develop and strengthen the service, pending learning from Phases 1 and 2.**

**This document outlines the Regional Trauma Network service delivery model and describes the rationale for the three phase implementation.**

**It also reports the outcome of an Equality Impact Assessment that has been conducted by the Health and Social Care Board on the Health and Social Care element of the Regional Trauma Network.**

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<sup>1</sup> It is anticipated that the RTN will be delivered in three broad phases: for more detail see Table 1, p.12.

***Our Mission Statement:***

***“We work collaboratively and in partnership with people in our society to improve access to the highest quality psychological trauma care”***

The Health and Social Care element of the Regional Trauma Network aims to improve access to the highest quality trauma services for the population of Northern Ireland by proposing to create a specialised local trauma team in each Health and Social Care Trust. These teams will work closely with other statutory health and social care services and the community and voluntary sector to deliver nationally and internationally recommended evidence-based trauma treatments. They will also develop research, training and education strategies that will inform future national and international practice in relation to addressing the needs of children, young people and adults with clinically significant levels of psychological trauma, including Post Traumatic Stress Disorder (PTSD) and Complex Post Traumatic Stress Disorder (CPTSD).

The Equality Impact Assessment of the Health and Social Care element of the Regional Trauma Network service delivery model has been carried out with reference to the Equality Commission’s ‘Practical Guidance on Equality Impact Assessment’.<sup>2</sup>

## **The Organisation**

The Health and Social Care Board is a statutory organisation. We arrange or ‘commission’ health and social care services for the population of Northern Ireland.

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<sup>2</sup> Available for download at: <https://www.equalityni.org/Employers-Service-Providers/Public-Authorities/Section75/Section-75/What-is-an-EQIA>

## The Regional Trauma Network

As part of the **Stormont House Agreement (2014)**, the Northern Ireland Executive made the following commitment to establish a comprehensive Mental Health Trauma Service:

*The Commission for Victims and Survivors' recommendation for a comprehensive Mental Trauma Service will be implemented. This will operate within the NHS (National Health Service but will work closely with the Victims and Survivors' Service and other organisations and groups who work directly with victims and survivors. (Paragraph 27)*

This commitment was made as part of the Agreement's discussion around dealing with 'the Past'. It refers to recommendations in a *Comprehensive Needs Assessment* published by the Commission for Victims and Survivors in 2012. This research identified mental health as the number one priority for victims and survivors of the Conflict/Troubles and recommended the development of a trauma-focused, co-ordinated network of services led by the Department of Health in partnership with The Executive Office. This network would deliver a comprehensive regional trauma service drawing and building on existing resources and expertise in the statutory and community and voluntary sectors.

The design, development, and implementation of this comprehensive service involve the following key elements:

- **Partnership working** between statutory health services and organisations in the community and voluntary sector;
- **PEACE IV** funding for victims and survivors of the Conflict/Troubles, which resources and links the community and voluntary sector with the five regional Health and Social Care Trusts;
- The **Stepped Care Model**, which underpins the delivery of mental health and well-being services in the region; and
- The specific activity of **the Health and Social Care element of the Regional Trauma Network**, which draws together the



partnership working, PEACE IV-funded activity and Stepped Care Model approach to enhance the existing mental health service provision for children, young people and adults in Northern Ireland.

Below, each of these elements is discussed in more detail.

## **Partnership Working**

In December 2016, a **Partnership Agreement** was established between the Department of Health and The Executive Office (included at **Annex 1**). This outlined how the Victims and Survivors Service would interface with Health and Social Care services to ensure relevant, timely, accessible and comprehensive trauma care for those whose mental health has been impacted by the Troubles/Conflict. This arrangement forms the basis of the phased implementation of the Regional Trauma Network, discussed below. The Partnership Agreement was signed in May 2019. It is important to note that the Partnership Agreement is a binding agreement between the Department of Health and The Executive Office and is not subject to change. It does not form part of this consultation.

The Regional Trauma Network will design, develop and implement a world-leading trauma network for the region. To date, work to design and develop the Regional Trauma Network has been informed by learning from and collaboration with key stakeholders and service delivery partners. Exciting and key elements of this activity include: **strengthening and fostering meaningful partnerships and collaboration with key stakeholders, service-users, carers, and service providers and developing increased and shared learning about the delivery of accessible, acceptable and effective trauma care.**

## PEACE IV

In the period leading up to the Partnership Agreement, the PEACE IV European Union Programme for Peace and Reconciliation<sup>3</sup> named the Victims and Survivors Service as Lead Partner to deliver a *Victims' and Survivors' Programme*. This Programme aims to improve the health and well-being of victims and survivors and to build capacity within the sector to deliver high quality services. It complements existing The Executive Office funding for health and wellbeing services delivered by community and voluntary organisations for victims and survivors across the region.

The Victims and Survivors Service PEACE IV application was approved in November 2016. It secured funding for a network of five Health and Wellbeing Case Managers employed by the Victims and Survivors Service and 25 Health and Wellbeing Caseworkers employed within Victims and Survivors Service-funded community and voluntary organisations across the region, to enhance and support access to services. PEACE IV funding also resources workforce training and development across the Victims and Survivors Service-funded community and voluntary sector, as well as research projects in relation to mental health, trans-generational impact and advocacy support. On this basis, the Victims and Survivors Service-funded community and voluntary sector element of the Regional Trauma Network for victims and survivors was established in April 2017.

**The full implementation of the Health and Social Care element of the Regional Trauma Network, which is for anyone experiencing clinically significant levels of psychological trauma irrespective of the origin of the trauma, is funded by commitments made by Health Ministers in 2015 and 2016. As outlined below, this will be developed and delivered on an incremental basis.**

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<sup>3</sup> For information on the PEACE IV Programme, see: <https://www.seupb.eu/piv-overview> - Citizens' Summary Document available at: <https://seupb.eu/sites/default/files/styles/PEACEIV/PEACE%20IV%20-%20%20Draft%203.pdf>

## Stepped Care Model

The National Institute for Health and Care Excellence (NICE 2018) recommends the **Stepped Care Model** for helping people with psychological trauma needs.<sup>4</sup> Stepped Care is a recovery-focused model that organises the range of services that are required to meet the wide spectrum of people's needs in five broad steps, according to the intensity or specialism of those services. It considers the clinical evidence that for people to recover, they may need a combination of evidence-based social, family, psychological and psychiatric interventions. Delivering this range of interventions and support requires collaborative partnership working across community, voluntary and statutory services.

The Partnership Agreement recognises the value of and integrates the community-based services funded by the Victims and Survivors Service in the provision of support at Steps 1-3, i.e. the services and support delivered on the basis of The Executive Office and PEACE IV funding. It also acknowledges the need to develop a more specialised mental health workforce within Health and Social Care to provide services at Steps 3-5. The Stepped Care Model is illustrated in Diagram 1 below.

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<sup>4</sup> National Institute for Health and Care Excellence (NICE) Clinical Guideline 26 – published December 2018. See: <https://www.nice.org.uk/guidance/ng116>

Diagram 1: Stepped Care Model<sup>5</sup>



<sup>5</sup> Stepped Care Model excerpted from *You in Mind: Regional Mental Health Care Pathway* (Health & Social Care: 2014) (See: [http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you\\_in\\_mind/June-2017-You-In-Mind-Regional-Mental-Health-Care-Pathway.pdf](http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you_in_mind/June-2017-You-In-Mind-Regional-Mental-Health-Care-Pathway.pdf))

## **The Health and Social Care<sup>6</sup> Element of the Regional Trauma Network**

The Health and Social Care element of the Regional Trauma Network is an enhancement of the existing provision of mental health services for children, young people and adults in Northern Ireland. It involves the phased design, co-production and implementation of an integrated service model to respond to the clinical needs of people with significant trauma-related psychological and psychosocial difficulties, irrespective of the origin of the trauma.

This integrated service model will include pathways for individuals to access services across the Stepped Care Model (as illustrated in Diagram 1). Throughout its development, the Health and Social Care element of the Regional Trauma Network will seek to build partnerships with statutory, community and voluntary agencies that represent and support people whose lives have been impacted by trauma. In this way, the Health and Social Care Board will ensure that the Regional Trauma Network becomes a highly *accessible, acceptable, and effective* service (McCusker, 2014)<sup>7</sup> for all those in the Northern Ireland population who need it, irrespective of the origin of their trauma.

### **Phased Implementation**

The Regional Trauma Network will be implemented on an incremental basis. Each phase will involve close collaboration and co-production with existing service providers and professionals across the region and service users and their representatives. This process will enable the Regional Trauma Network to both:

- Develop accessible and acceptable pathways into the enhanced Health and Social Care trauma service for the diverse range of people who require access; and

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<sup>6</sup> See Glossary for definition of 'Health and Social Care' or HSC.

<sup>7</sup> McCusker, C. (2014). *An Outcomes Framework for Psychological Services in Northern Ireland*. Belfast: Health & Social Care Board.

## EXECUTIVE SUMMARY

- Collate evidence and learning at every step, to ensure ongoing improvement and an effective, outcomes-based service for all children, young people and adults in Northern Ireland with clinically significant levels of psychological trauma, regardless of the origin of their trauma.

Table 1 below outlines the phased implementation of the Regional Trauma Network.

**Table 1: Phased Implementation of the Regional Trauma Network<sup>8</sup>**

Phase	Summary information
<p><b>PHASE 1</b></p> <p><i>Autumn 2019 – March 2020</i></p>	<p>As per the reference to victims and survivors in the Stormont House Agreement, a priority in Phase 1 is to <b>work in partnership with the Victims and Survivors Service and its network of funded organisations</b> across the region to establish ready and safe access to trauma services for people affected by Troubles/Conflict-related trauma.</p> <p>Working collaboratively in this way, the Pathway Development Working Group has established a pathway to improve access to community, voluntary and statutory services for individuals (primarily adults) with Conflict/Troubles-related trauma via five Health and Wellbeing <b>Case Managers</b> employed by the Victims and Survivors Service. These Registered Practitioners will work directly with each Health and Social Care Trust.</p> <p><b>During this phase, a Children and Young People’s Pathway Development Working Group will be convened</b> to design and develop a pathway to Regional Trauma Network services for children and young people, in line with the existing Child and Adolescent Mental Health Services (CAMHS) pathway,<sup>9</sup> <b>and a pathway will be developed for individuals with significant trauma symptoms that are not associated with Conflict/Troubles-related incident/s who experience barriers to accessing mental health services.</b></p>

<sup>8</sup> This implementation schedule is subject to ongoing review and adjustment, in line with progress against key deliverables including, for example, successful recruitment of suitably qualified staff across the regional Health and Social Care Trust teams.

<sup>9</sup> For more information, see: <http://www.hscboard.hscni.net/camhs-launch/> - full document available at:

[http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you\\_in\\_mind/21122018-HSCB-CAMHS-Pathway-Document.pdf](http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you_in_mind/21122018-HSCB-CAMHS-Pathway-Document.pdf)

Phase	Summary information
<b>PHASE 2</b>  <i>April 2020</i> – <i>March 2021</i>	Recruitment of full Regional Trauma Network Local Trauma Teams in each of the five Health and Social Care Trusts and <b>implementation of the full stepped care model (see Diagram 1)</b> .  Referral pathways are open to all other relevant statutory and non-statutory referral agents for both child and adult service-users via the General Practitioner (GP) Also continuing to learn from and evaluate Phase 1.
<b>PHASE 3</b>  <i>April 2021</i> – <i>September 2021</i>	Development of <b>future Regional Trauma Network strategy and action planning</b> based on: performance information and learning from Phases 1 and 2; evidence of need, demand, and planning to engage and meet needs of hard to reach groups; and recommendations for future service development and additional resources.

It is important to note that, at the time of this consultation, while the normal provision of Health and Social Care services is in place (in terms of existing psychological therapies, adult trauma services, child services and child trauma services) there are no local Regional Trauma Network trauma teams in operation. **Throughout Phase 1 all members of the Northern Ireland population will continue to have access to existing psychological therapies and trauma services in the Adult and Child Health and Social Care Directorates within Health and Social Care Trusts, via existing pathways, based on their clinical need and irrespective of the origin of their trauma.**

Awareness of the phased implementation of the Regional Trauma Network has been raised over the period 2014 to the present, through an extensive programme of engagement. This has established clear lines of communication with the key stakeholders involved in the Regional Trauma Network (further detail is provided in Section 1 below) (see also **Annex 2**). It has also involved the development of a tailored



service user forum called the **Partnership Alliance for Learning from Lived Experience** (see **Annex 3**), in line with the principles and ethos of the Department of Health *Co-Production Guide* (2018).<sup>10</sup> The Partnership Alliance for Learning from Lived Experience will create equal opportunities for people to influence and shape the design and delivery of the Regional Trauma Network. This means ensuring a representative balance of the people who use mental health/trauma services or who represent those who use or need these services. In line with Section 75 responsibilities, particular attention will be paid to including individuals who experience barriers to accessing mental health services. This process will ensure clear understanding of the pathway and how to engage and safely refer individuals in clinical need to Health and Social Care.

As noted above, at the time of this consultation, there are no local Health and Social Care Regional Trauma Network trauma teams in operation. It is anticipated that capacity for this provision will be in place by Autumn 2019 (subject to the outcomes of this consultation and recruitment). Until then, all stakeholders are working to ensure the demand for and expectations in relation to this service are monitored and mitigated against, since raising such expectations in the absence of confirmed availability of services would potentially have negative impacts on the well-being of individuals and undermine public trust and confidence in the Regional Trauma Network.

## **Clinical Need**

Epidemiological research (CVS, 2011) on the prevalence of trauma in Northern Ireland shows that:

- An estimated 61% of the Northern Ireland adult population have experienced a traumatic event at some point in their lifetime.

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<sup>10</sup> To access the Department of Health *Co-production Guide*, see: <https://www.health-ni.gov.uk/publications/co-production-guide-northern-ireland-connecting-and-realising-value-through-people>

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- An estimated 39% of the population have experienced a Conflict/Troubles-related traumatic event.
- Comparison of the geographical profile of Conflict/Troubles-related deaths (from the Cost of the Troubles study) with the current location of those who experienced a Conflict/Troubles-related trauma, reveals that need is not exclusively located in those areas characterised by intense violence during the Troubles.
- An estimated 8.8% of the Northern Ireland adult population met the criteria for Post Traumatic Stress Disorder at some point in their life while 5.1% met the criteria in the previous 12 months.
- The prevalence of Post Traumatic Stress Disorder in Northern Ireland is the highest of all countries that have produced comparable estimates including the United States, other Western European countries and countries that have experienced civil conflict in their recent history.

The report also highlights that people with Post Traumatic Stress Disorder are more likely to have a range of other mental health disorders, as well as chronic physical conditions. Recognising the biological, psychological and social impact of trauma, the research calls for the provision of evidence based therapies delivered through an integrated service model.

The Regional Trauma Network offers such a model for people experiencing significant psychological and psychosocial distress as a result of both Conflict/Troubles-related incidents and other traumatic events.

The phased implementation of the Regional Trauma Network is founded on the strong Partnership Agreement with shared protocols and robust governance arrangements established between The Department of Health and the Executive Office, with reference to the Victims and Survivors Service and the Commission for Victims and Survivors.

The Health and Social Care element of the Regional Trauma Network is an evidence-based, specialised trauma therapy service that will be delivered by mental health professionals with a high level of skill, training

and experience to support people experiencing clinically significant levels of psychological trauma. A key aim is to ensure people with complex requirements have improved access to a range of the highest quality trauma treatments and support delivered at the right time, in the right place and by the right person. Therapies delivered within the Regional Trauma Network will be outcomes-focused and in line with the best available evidence. All interventions will be monitored, evaluated and supported by clinical research which, as part of the world-leading agenda for the service, will refine and inform future models of psychological trauma care.

The Regional Trauma Network Pathways Development Working Group includes representatives from the Health and Social Care Board, the five Health and Social Care Trusts, the Victims and Survivors Service and people with lived experience of mental health and trauma services. The Working Group has drawn on national and international guidelines, regional audits, research and international diagnostic guidance to develop access criteria to the Health and Social Care element of the Regional Trauma Network in Phase 1. These criteria, which focus solely on adults in Phase 1, have been agreed on the basis of careful analysis of anticipated demand. This analysis is based on information regarding current Health and Social Care psychological therapies services, Victims and Survivors Service data and Regional Trauma Network resource capacity. Experience from Phase 1 will ensure a more robust picture of the level of need for this service.

The Regional Trauma Network clinical needs-based access criteria for **Phase 1** are summarised in Table 2 below.

As shown in Table 1, during Phase 1 a **Children and Young People's Pathway Development Working Group will be convened** to design and develop a pathway to Regional Trauma Network services for children and young people, in line with the existing Child and Adolescent Mental Health Services (CAMHS) pathway.<sup>11</sup>

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<sup>11</sup> For more information, see: <http://www.hscboard.hscni.net/camhs-launch/> - full document available at:  
[http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you\\_in\\_mind/21122018-HSCB-CAMHS-Pathway-Document.pdf](http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you_in_mind/21122018-HSCB-CAMHS-Pathway-Document.pdf)

**Phase 1 also includes engagement to understand how a pathway could be developed for individuals with significant trauma symptoms that are not associated with Conflict/Troubles-related incident/s who experience barriers to accessing mental health services.**

**Table 2: Health and Social Care Regional Trauma Network Service Users: Clinical Needs-Based Access Criteria**

Ref	Detail
1	The service user has experienced one or more traumatic events as defined by established mental health classification systems (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition; International Classification of Diseases 11th Revision).
2	The service user has clinical levels of Post-Traumatic Stress Disorder symptoms and trauma-related psychological difficulties for which they are seeking treatment. This clinical level of severity has been assessed by an appropriately qualified, registered practitioner using a Regional Trauma Network accepted measurement instrument or methodology.
3	The service user has levels of Post Traumatic Stress Disorder and trauma-related psychological difficulties that are moderate-severe in terms of intensity/complexity and cause significant impact on their social, occupational, or overall functioning.
4	The service user is living in the community and can attend regularly and consistently as required for their treatment.
5	The service user is motivated to formulate goals and make active changes to their life to improve their trauma-related psychological difficulties.
6	The service user has the ability to engage in the appropriate therapy for their trauma-related psychological difficulties.

## **Ongoing Monitoring, Evaluation, and Improvement**

The evidence-based measures that will guide the Regional Trauma Network clinical assessment, monitoring and evaluation protocols are included in this document at **Annex 4**. This framework is aligned to the service access criteria described above and, along with those criteria, will be kept under review over the implementation period and adjusted in line with learning and emerging evidence as required.

## **Equality Impact Assessment**

The Equality Impact Assessment concerns the equality implications of the Health and Social Care element of the Regional Trauma Network. It considers the potential impact of the phased implementation process and clinical needs-based access criteria for each of the Section 75 equality categories.

An Equality Impact Assessment is necessary due to the incremental implementation process outlined in Table 1 above. The Phase 1 pathway, which originates in the Stormont House Agreement (2014) and Partnership Agreement (2016) commitments outlined above, involves the development, testing and delivery of a unique pathway into Health and Social Care Regional Trauma Network services for adults with Conflict/Troubles-related trauma. This pathway is enabled via five Health and Wellbeing Case Managers employed by the Victims and Survivors Service, working directly with the Health and Social Care Trusts. Learning from this pathway will inform the full implementation of the Regional Trauma Network in Phases 2 and 3 for children, young people and adults with clinically significant levels of psychological trauma, regardless of the origin of their trauma.

In the meantime, throughout the development and delivery of the Health and Social Care element of Phase 1 of the Regional Trauma Network, the Northern Ireland population continues to have access to existing psychological therapies and trauma services in the Adult and Child

## EXECUTIVE SUMMARY

Health and Social Care Directorates, via existing pathways, based on their clinical need and irrespective of the origin of their trauma.

In conducting this consultation, the following points are noted:

- Phase 1 is the first part of the incremental implementation of the Regional Trauma Network that involves providing enhanced access to services to people with a clinical need (as per Table 2) based on a particular type of trauma.
- Phase 1 is designed to test a concept of enhancing access to Health and Social Care Regional Trauma Network services.
- Phase 1 allows the Health and Social Care Board to understand and subsequently design Regional Trauma Network services that are accessible, acceptable and effective for children, young people and adults, as well as for individuals with significant levels of psychological trauma, irrespective of the origin of the trauma barriers who experience to accessing mental health services.
- The clinical service access criteria 1, 2, 3, and 5 listed in Table 2 above are ascertained on the basis of a comprehensive and collaborative clinical assessment of need.<sup>12</sup> As per all Health and Social Care services, this type of assessment process will apply in every case, including delivery of implementation Phase 1.
- From Phase 2 onwards children, young people and adults with clinically significant levels of psychological trauma, will have access to Health and Social Care Regional Trauma Network services, irrespective of the origin of their trauma.
- Throughout Phase 1 all members of the Northern Ireland population will continue to have access to existing psychological therapies and trauma services in the Adult and Child Health and Social Care Directorates within Health and Social Care Trusts, via existing pathways, based on their clinical need and irrespective of the origin of their trauma.

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<sup>12</sup> As per National Institute for Health and Care Excellence (NICE) Guidelines NG116 (2018),

## Data Collection

The assessment of the phased implementation of the Health and Social Care element of the Regional Trauma Network and subsequent equality impacts is based on the following:

**Quantitative data** (statistics): to provide a first overview of the characteristics of those people most likely to be affected by the Health and Social Care element of the Regional Trauma Network across the phased implementation period.

Quantitative data was sourced for the Section 75 groups from the Northern Ireland Census 2011,<sup>13</sup> the Victims and Survivors Service and its funded organisations, and the Belfast Health and Social Care Trust Trauma Resource Centre, to identify the key characteristics of actual users of trauma support services, including both victims and survivors of the Conflict/Troubles (per Phase 1) and wider stakeholders and service users. Other population-based data is also used, including: the Northern Ireland Health Survey, the Northern Ireland Life and Times Survey, the Northern Ireland Young Life and Times Survey, and data held by the Northern Ireland Neighbourhood Information Service (NINIS) hosted within the Northern Ireland Statistics and Research Agency (NISRA).

In order to consider the potential impact on Health and Social Care staff assigned to deliver Regional Trauma Network services, the employing Trusts will gather equality monitoring on those staff as they are recruited and come into post during Phases 1, 2, and 3. This data will be considered as part of the ongoing Regional Trauma Network equality impact monitoring as the implementation moves into Phases 2 and 3.

**Qualitative data:** to provide insights into the issues, experiences and needs of those likely to be most affected by the phased implementation of the Regional Trauma Network.

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<sup>13</sup> Northern Ireland Census. (2011). Available at: <http://www.nisra.gov.uk/census.html>

**Secondary sources (including peer reviewed and social policy research):** to provide insights into the needs of Section 75 groups in the context of trauma and mental health and well-being. These are referenced in footnotes throughout this report. The full reference list is included in **Annex 5** to this report.

## Key Findings

The following key findings were made based on all of the information reviewed:

1. An estimated 39% of the population have experienced a Conflict/Troubles-related traumatic event.
2. An estimated 8.8% of the Northern Ireland adult population met the criteria for Post Traumatic Stress Disorder at some point in their life while 5.1% met the criteria in the previous 12 months.
3. The prevalence of Post Traumatic Stress Disorder in Northern Ireland is the highest of all countries that have produced comparable estimates including the United States, other Western European countries and countries that have experienced civil conflict in their recent history.
4. The phased implementation of the Regional Trauma Network, involving collaborative working with partner organisations across the community, voluntary and statutory sectors, is designed to enable a cumulative learning and development process, beginning with the design, testing and implementation of a unique Case Manager pathway for victims and survivors of the Conflict/Troubles.
5. This approach is being tested to inform the design and delivery of accessible, acceptable and effective trauma services for all children, young people and adults in Northern Ireland with clinically significant levels of psychological trauma, irrespective of the origin of their trauma.



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6. Whilst Phase 1 has a focus on providing access to Health and Social Care Regional Trauma Network services via Victims and Survivors Service Case Managers for adults with Post Traumatic Stress Disorder and Complex Post Traumatic Stress Disorder symptoms as a result of the Troubles/Conflict, given the intersectionality of individual identity, this group potentially includes representation from across all Section 75 categories within the population.
7. Access to the Health and Social Care element of the Regional Trauma Network will be based solely on clinical need and not based on any aspect of individual or group identity, whether in terms of gender, age, religion, political opinion, marital status, dependant status, disability, ethnicity, or sexual orientation.
8. During the phased implementation process, 100% of the Northern Ireland population will continue to have access to existing mental health and psychological trauma therapy services via existing pathways.
9. Across all three implementation phases, needs are identified in relation to gender dynamics, those with dependents/carers, older people and those with physical and psychological disabilities. These needs relate to supporting help-seeking behaviour, supporting safety, addressing stigma/perceived stigma associated with mental health needs, responding to communication challenges and enabling access and engagement with therapy. This report details mitigating actions that will be taken to meet these needs and ensure equality of opportunity and access to Regional Trauma Network services during all phases of implementation.
10. From Phase 2 onwards the Health and Social Care element of the Regional Trauma Network will be available to all children, young people and adults in Northern Ireland with clinically significant levels of psychological trauma, irrespective of the origin of their trauma

11. Due to the politically sensitive nature of Troubles/Conflict-related trauma, data on certain Section 75 groupings are not routinely collected among current service user populations, namely: religious and political affiliation. However, population level data and secondary sources indicate that people from all and any political and religious backgrounds and none may have a need for trauma care. Given the broader political and social context of Northern Ireland and the nature of the Conflict/Troubles, particular care will be taken to ensure individual choice and safety are priority concerns at the clinical assessment stage. The report details these and other mitigating actions that will be taken to meet these needs and ensure equality of opportunity and access to Regional Trauma Network services.
  
12. People from Black and Minority Ethnic (BME) and migrant communities are noted to have particular needs associated with the provision of trauma care through the Regional Trauma Network. In general these needs relate to supporting help-seeking behaviour, supporting safety, cultural competence, addressing stigma/perceived stigma associated with mental health needs and enabling access and engagement with therapy. In addition, those who do not speak English as a first language will have communication needs. Phase 1 of the Regional Trauma Network implementation will include a focus on developing a greater understanding of these needs, and on that basis, developing mitigating measures that facilitate and enable access for those who require the service. This report details this approach, as well as ongoing mitigating actions that will be taken to meet the needs of people from black, minority ethnic, and migrant communities, to ensure equality of opportunity and access to Health and Social Care Regional Trauma Network services.
  
13. Data shows that Lesbian, Gay, and Bisexual (LGB) people may have negative experiences of the health sector, associated with fear and stigmatisation and increased levels of need for psychological support. Taking this into account, this report details

mitigating actions that will be taken to meet these needs and ensure equality of opportunity and access to Health and Social Care Regional Trauma Network services throughout all phases of implementation.

14. The design, development and implementation of the Health and Social Care element of the Regional Trauma Network are strongly informed and shaped by extensive stakeholder engagement, service user participation (co-production).

These points of information will be monitored on an ongoing basis throughout the incremental implementation of the Health and Social Care element of the Regional Trauma Network.

The monitoring arrangements will be established in line with current Health and Social Care statistical monitoring approaches and obligations and kept under review through both the operational management and co-production process to ensure their effectiveness.

## **Conclusions**

Based on the information collated, the proposed model of implementing and delivering the Regional Trauma Network constitutes positive action. The phased implementation of the Health and Social Care element of the Regional Trauma Network allows the Health and Social Care Board to understand and subsequently design Regional Trauma Network services that are accessible, acceptable and effective for children, young people and adults and individuals with significant levels of psychological trauma irrespective of the origin of the trauma who experience barriers to accessing mental health services.

Quantitative and qualitative data will be collected and analysed throughout Phases 1, 2, and 3, enabling the Health and Social Care Board to incorporate learning from this model into the business planning for the future design and development of the Regional Trauma Network, maximising the potential for engaging with hard to reach, traumatised

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individuals across different communities, irrespective of the cause or origin of their trauma. Monitoring the uptake of Health and Social Care Regional Trauma Network services of different Section 75 groups, as appropriate, will also help to identify and better understand barriers to access and to develop more effective pathways.

In this way, the Health and Social Care Board aims to reduce barriers to engagement in high quality, evidence-based trauma interventions, ensuring that individuals access both statutory and community-based social and practical supports as necessary, to maximise and sustain their recovery.

Given that an estimated 39% of the population have experienced a Conflict/Troubles-related traumatic event, it is reasonable to anticipate that the Phase 1 enhanced access pathway will include representation from most Section 75 groups within the population, where a clinical need for enhanced trauma services is identified. From Phase 2 onwards all individuals in clinical need of trauma care across all Section 75 groupings will have access to Health and Social Care Regional Trauma Network services.

As noted above, during implementation Phase 1, and across the phased implementation of the full Regional Trauma Network service model, 100% of the Northern Ireland population will continue to have access to existing mental health and psychological trauma therapy services, irrespective of the origin of their trauma.

On the basis of the information discussed in this report, the Health and Social Care Board proposes to proceed with the phased implementation of the Health and Social Care element of the Regional Trauma Network as outlined above. The anticipated launch date of Autumn 2019 for Phase 1 will be kept under review, in line with the outcomes of this consultation process and progress against regional recruitment objectives.

# **1 THE REGIONAL TRAUMA NETWORK SERVICE DELIVERY MODEL**

## **Background to this Report**

**The Health and Social Care Board is carrying out a public consultation on the proposed service delivery model for the Regional Trauma Network.<sup>14</sup>**

**The Health and Social Care Board aims to launch the Regional Trauma Network in three phases as follows:**

- **Phase 1: to launch the pathway for victims and survivors of the Conflict/Troubles – Autumn 2019;**
- **Phase 2: full implementation of the Health and Social Care element of the Regional Trauma Network for all children, young people and adults with significant levels of psychological trauma – April 2020; and**
- **Phase 3: to develop and strengthen the service, pending learning from Phases 1 and 2.**

**This document outlines the Regional Trauma Network service delivery model and describes the rationale for the three phase implementation.**

**It also reports the outcome of an Equality Impact Assessment that has been conducted by the Health and Social Care Board on the Health and Social Care element of the Regional Trauma Network.**

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<sup>14</sup> It is anticipated that the RTN will be delivered in three broad phases: for more detail see Table 1, p.12.

## Organisational Background

The Health and Social Care Board is a statutory organisation that is part of health and social care in Northern Ireland.

The Health and Social Care Board's main roles include:

- Arranging or 'commissioning' a full range of health and social services for the 1.8 million people who live in Northern Ireland.
- Performance management of Health and Social Care Trusts that provide services to the population, and supporting service improvements to ensure optimal quality and value for money, in line with relevant government targets.
- Deploying and managing annual funding from the Northern Ireland Executive – currently around £4.5 billion – to ensure this is targeted according to need, and reflects the aspirations of local communities and their representatives.

The work of the Health and Social Care Board has the potential to reach everyone in Northern Ireland at some point in their lives.

As part of the **Stormont House Agreement (2014)**, the Northern Ireland Executive made the following commitment to establish a comprehensive Mental Health Trauma Service:

*The Commission for Victims and Survivors' recommendation for a comprehensive Mental Trauma Service will be implemented. This will operate within the NHS (National Health Service) but will work closely with the Victims and Survivors Service and other organisations and groups who work directly with victims and survivors. (Paragraph 27)*

This commitment was made as part of the Agreement's discussion around dealing with 'the Past'. It refers to recommendations in a *Comprehensive Needs Assessment* published by the Commission for Victims and Survivors in 2012. This research identified mental health as the number one priority for victims and survivors of the Conflict/Troubles,

and recommended the development of a trauma-focused, co-ordinated service network lead by the Department of Health in partnership with The Executive Office. This network would deliver a comprehensive regional trauma service drawing and building on existing resources and expertise in the statutory, community and voluntary sector.

The design, development and implementation of this comprehensive service involves the following key elements:

- **Partnership working** between statutory health services and organisations in the community and voluntary sector;
- **PEACE IV** funding for victims and survivors of the Conflict/Troubles, which resources and links the community and voluntary sector with the five regional Health and Social Care Trusts;
- The **Stepped Care Model**, which underpins the delivery of mental health and well-being services in the region; and
- The specific activity of **the Health and Social Care element of the Regional Trauma Network**, which draws together the partnership working, PEACE IV-funded activity and Stepped Care Model approach to enhance the existing mental health service provision for children, young people and adults in Northern Ireland.

Below, each of these elements is discussed in more detail.

## Partnership Working

The National Institute for Health and Care Excellence (NICE) recommends the **Stepped Care Model** for helping people with psychological trauma needs.<sup>15</sup> Stepped Care is a recovery-focused model that organises the range of services that are required to meet the wide spectrum of people's needs in five broad steps, according to the intensity or specialism of those services. It considers the clinical evidence that for people to recover, they may need a combination of

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<sup>15</sup> National Institute for Health and Care Excellence (NICE) NG116.

evidence-based social, family, psychological and psychiatric interventions. Delivering this range of interventions and support requires collaborative partnership working across community, voluntary and statutory services.

The Victims and Survivors Service is an Arms-Length Body of The Executive Office, set up to deliver government funding and support to victims and survivors of the Northern Ireland Conflict/Troubles. In this context, 'victims and survivors' are defined in the Victims and Survivors (Northern Ireland) Order 2006 (section 3) as follows:

*(1) In this Order references to “victim and survivor” are references to an individual appearing to the Commission [for victims and Survivors] to be any of the following—*

*(a) someone who is or has been physically or psychologically injured as a result of or in consequence of a conflict-related incident;*

*(b) someone who provides a substantial amount of care on a regular basis for an individual mentioned in paragraph (a); or*

*(c) someone who has been bereaved as a result of or in consequence of a conflict-related incident.*

*(2) Without prejudice to the generality of paragraph (1), an individual may be psychologically injured as a result of or in consequence of—*

*(a) witnessing a conflict-related incident or the consequences of such an incident; or*

*(b) providing medical or other emergency assistance to an individual in connection with a conflict-related incident.<sup>16</sup>*

In December 2016, a **Partnership Agreement** was established between the Department of Health and The Executive Office (included at **Annex 1**). This outlined how the Victims and Survivors Service would interface

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<sup>16</sup> See: <http://www.legislation.gov.uk/nisi/2006/2953/contents>



with Health and Social Care services to ensure relevant, timely, accessible, and comprehensive trauma care for those whose mental health has been impacted by the Troubles/Conflict. This arrangement forms the basis of the phased implementation of the Regional Trauma Network, discussed below. The Partnership Agreement was signed in May 2019. It is important to note that the Partnership Agreement is a binding agreement between the Department of Health and The Executive Office and is not subject to change. It does not form part of this consultation.

### **PEACE IV**

In the period leading up to the Partnership Agreement, the PEACE IV European Union Programme for Peace and Reconciliation<sup>17</sup> named the Victims and Survivors Service as Lead Partner to deliver a *Victims and Survivors Programme*. This Programme aims to improve the health and well-being of victims and survivors and to build capacity within the sector to deliver high quality services. It complements existing funding from The Executive Office for health and wellbeing services delivered by community and voluntary organisations for victims and survivors across the region.

The Victims and Survivors Service PEACE IV application was approved in November 2016. It secured funding for a network of five Health and Wellbeing Case Managers employed by the Victims and Survivors Service, and 25 Health and Wellbeing Caseworkers employed within Victims and Survivors Service-funded community and voluntary organisations across the region, to enhance and support access to services. PEACE IV funding also resources workforce training and development across the Victims and Survivors Service-funded community and voluntary sector, as well as research projects in relation to mental health, trans-generational impact and advocacy support. On this basis, the Victims and Survivors Service-funded community and

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<sup>17</sup> For information on the PEACE IV Programme, see: <https://www.seupb.eu/piv-overview> - Citizens' Summary Document available at: <https://seupb.eu/sites/default/files/styles/PEACEIV/PEACE%20IV%20-%20%20Draft%203.pdf>

voluntary sector element of the Regional Trauma Network for victims and survivors was established in April 2017.

**The full implementation of the Health and Social Care element of the Regional Trauma Network, which is for anyone experiencing clinically significant levels of psychological trauma irrespective of the origin of the trauma, is funded by commitments made by Health Ministers in 2015 and 2016. As outlined below, this will be developed and delivered on an incremental basis.**

### **Stepped Care Model**

The National Institute for Health and Care Excellence (NICE 2018) recommends the **Stepped Care Model** for helping people with psychological trauma needs.<sup>18</sup> Stepped Care is a recovery-focused model that organises the range of services that are required to meet the wide spectrum of people's needs in five broad steps, according to the intensity or specialism of those services. It considers the clinical evidence that for people to recover, they may need a combination of evidence-based social, family, psychological and psychiatric interventions. Delivering this range of interventions and support requires collaborative partnership working across community, voluntary and statutory services.

The Partnership Agreement recognises the value of and integrates the community-based services funded by the Victims and Survivors Service in the provision of support at Steps 1-3, i.e. the services and support delivered on the basis of The Executive Office and PEACE IV funding. It also acknowledges the need to develop a more specialised mental health workforce within Health and Social Care to provide services at Steps 3-5. The Stepped Care Model is illustrated in Diagram 2 below.

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<sup>18</sup> National Institute for Health and Care Excellence (NICE) Clinical Guideline 26 – published December 2018. See: <https://www.nice.org.uk/guidance/ng116>

Diagram 2: Stepped Care Model<sup>19</sup>



<sup>19</sup> Stepped Care Model excerpted from *You in Mind: Regional Mental Health Care Pathway* (Health & Social Care: 2014) (See: [http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you\\_in\\_mind/June-2017-You-In-Mind-Regional-Mental-Health-Care-Pathway.pdf](http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you_in_mind/June-2017-You-In-Mind-Regional-Mental-Health-Care-Pathway.pdf))

## **The Health and Social Care<sup>20</sup> Element of the Regional Trauma Network**

The Health and Social Care Board is responsible for leading the design, development, and implementation of the Regional Trauma Network.

This involves:

- Developing regionally agreed governance structures and standards.
- Ensuring compliance with relevant statutory duties.
- Monitoring and evaluating delivery progress.
- Engaging relevant representative networks in the co-production process, empowering service users, carers, and staff to take shared ownership for the delivery of positive service outcomes.
- Co-ordinating stakeholder engagement.
- Commissioning services from the five Health and Social Care Trusts to deliver equitable provision across the region of effective, evidence-based trauma-related therapies and support for children, young people and adults with moderate to severe levels of trauma-related psychological difficulties in line with national and international best practice.<sup>21</sup>
- Monitoring and evaluating the delivery and outcomes of services.
- Devising research, training and education strategies to inform future national and international practice in relation to psychological trauma conditions in children, young people and adults, including Post Traumatic Stress Disorder and Complex Post Traumatic Stress Disorder.
- Supporting the Partnership Agreement.
- Engaging and assessing needs of individuals who experience barriers to accessing mental health services.

The Health and Social Care element of the Regional Trauma Network is an enhancement of the existing provision of mental health services for children, young people and adults in Northern Ireland. It involves the

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<sup>20</sup> See Glossary for definition of 'Health and Social Care' or HSC.

<sup>21</sup> As per National Institute for Health and Care Excellence (NICE), International Society for Traumatic Stress Studies (ISTSS), and UK Psychological Trauma Society (UKPTS) guidelines.

phased design, co-production and implementation of an integrated service model to respond to the clinical needs of people with significant trauma-related psychological and psychosocial difficulties, irrespective of the origin of the trauma.

This integrated service model will include pathways for individuals to access services across the Stepped Care Model (as illustrated in Diagram 2). Throughout its development, the Health and Social Care element of the Regional Trauma Network will seek to build partnerships with statutory, community and voluntary agencies that represent people whose lives have been impacted by trauma. In this way, the Health and Social Care Board will ensure that the Regional Trauma Network becomes a highly *accessible, acceptable, and effective* service (McCusker, 2014)<sup>22</sup> for all those in the Northern Ireland population who need it.

### **Phased Implementation**

The Health and Social Care element of the Regional Trauma Network will be implemented on an incremental basis. Each phase will involve close collaboration and co-production with existing service providers and professionals across the region, and service users and their representatives. This process will enable the Regional Trauma Network to both:

- Develop accessible and acceptable pathways into the enhanced Health and Social Care trauma service for the diverse range of people who require access; and
- Collate evidence and learning at every step, to ensure ongoing improvement and an effective, outcomes-based service for all children, young people and adults in Northern Ireland with clinically significant levels of psychological trauma, regardless of the origin of their trauma.

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<sup>22</sup> McCusker, C. (2014). *An Outcomes Framework for Psychological Services in Northern Ireland*. Belfast: Health & Social Care Board.

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Each phase of the process will involve:

- Systematic stakeholder engagement and consultation;
- The development of referral and service-user pathways;
- Continuous learning and analysis of evidence;
- Better understanding of needs; and
- Formulation of recommendations for ongoing service development and improvement.

Table 3 below outlines the phased implementation of the Regional Trauma Network.

**Table 3: Phased Implementation of the Regional Trauma Network<sup>23</sup>**

Phase	Summary information
<p><b>PHASE 1</b></p> <p><i>Autumn 2019 – March 2020</i></p>	<p>As per the reference to victims and survivors in the Stormont House Agreement, a priority in Phase 1 is to <b>work in partnership with the Victims and Survivors Service and its network of funded organisations</b> across the region to establish ready and safe access to trauma services for people affected by Troubles/Conflict-related trauma.</p> <p>Working collaboratively in this way, the Pathway Development Working Group has established a pathway to improve access to community, voluntary and statutory services for individuals (primarily adults) with Conflict/Troubles-related trauma via five Health and Wellbeing <b>Case Managers</b> employed by the Victims and Survivors Service. These Registered Practitioners will work directly with each Health and Social Care Trust.</p> <p><b>During this phase, a Children and Young People’s Pathway Development Working Group will be convened</b> to design and develop a pathway to Regional Trauma Network services for children and young people, in line with the existing Child and Adolescent Mental Health Services (CAMHS) pathway,<sup>24</sup> <b>and a pathway will be developed for individuals with significant trauma symptoms that are not associated with Conflict/Troubles-related incident/s who experience barriers to accessing mental health services.</b></p>

<sup>23</sup> This implementation schedule is subject to ongoing review and adjustment, in line with progress against key deliverables including, for example, successful recruitment of suitably qualified staff across the regional Health and Social Care Trust teams.

<sup>24</sup> For more information, see: <http://www.hscboard.hscni.net/camhs-launch/> - full document available at: [http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you\\_in\\_mind/21122018-HSCB-CAMHS-Pathway-Document.pdf](http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you_in_mind/21122018-HSCB-CAMHS-Pathway-Document.pdf)

Phase	Summary information
<b>PHASE 2</b>  <b>April 2020</b> – <b>March 2021</b>	Recruitment of full Regional Trauma Network Local Trauma Teams in each of the five Health and Social Care Trusts and <b>implementation of the full stepped care model (see Diagram 1)</b> .  Referral pathways are open to all other relevant statutory and non-statutory referral agents for both child and adult service-users via the General Practitioner (GP) Also continuing to learn from and evaluate Phase 1.
<b>PHASE 3</b>  <b>April 2021</b> – <b>September 2021</b>	Development of <b>future Regional Trauma Network strategy and action planning</b> based on: performance information and learning from Phases 1 and 2; evidence of need, demand, and planning to engage and meet needs of hard to reach groups; and recommendations for future service development and additional resources.

As shown above, during Phase 1 a **Children & Young People’s Pathway Development Working Group will be convened** to design and develop a pathway to Regional Trauma Network services for children and young people, in line with the existing Child and Adolescent Mental Health Services (CAMHS) pathway.<sup>25</sup> **Phase 1 also includes engagement to understand how a pathway may be developed for individuals with significant trauma symptoms that are not associated with Conflict/Troubles-related incident/s who experience barriers to accessing mental health services.**

The rationale for the Regional Trauma Network phased service delivery model is underpinned by the developments outlined above, namely:

<sup>25</sup> For more information, see: <http://www.hscboard.hscni.net/camhs-launch/> - full document available at:  
[http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you\\_in\\_mind/21122018-HSCB-CAMHS-Pathway-Document.pdf](http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you_in_mind/21122018-HSCB-CAMHS-Pathway-Document.pdf)



- The political commitments made in the Stormont House Agreement (2014);
- Subsequent strategic developments, including the cross-departmental Partnership Agreement (2016) and investment of The Executive Office and PEACE IV European Union Programme for Peace and Reconciliation<sup>26</sup> in the community and voluntary sector via the Victims and Survivors Service; and
- Incremental resource and capacity building with Health and Social Care Trusts. Throughout the phased implementation the Regional Trauma Network is committed to making the best use of existing resources to deliver trauma care of the highest quality and will seek additional resources to address gaps in service provision.

It is important to note that, at the time of this consultation, while the normal provision of Health and Social Care services is in place (in terms of existing psychological therapies, adult trauma services, child services and child trauma services) there are no local Regional Trauma Network trauma teams in operation.

**Throughout Phase 1 all members of the Northern Ireland population will continue to have access to existing psychological therapies and trauma services in the Adult and Child Health and Social Care Directorates within Health and Social Care Trusts, via existing pathways, based on their clinical need and irrespective of the origin of their trauma.**

### **The Victims and Survivors Service Case Manager Pathway**

Working in partnership with the Victims and Survivors Service and its funded organisations, the Regional Trauma Network Pathways Development Working Group have established a pathway to enhance access to community, voluntary and statutory services for individuals

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<sup>26</sup> For information on the PEACE IV Programme, see: <https://www.seupb.eu/piv-overview> - Citizens' Summary Document available at: <https://seupb.eu/sites/default/files/styles/PEACEIV/PEACE%20IV%20-%20%20Draft%203.pdf>

with Conflict/Troubles-related Post Traumatic Stress Disorder and Complex Post Traumatic Stress Disorder. This pathway operates via the five Health and Wellbeing Case Managers employed by the Victims and Survivors Service. These Registered Practitioners will work directly with each Health and Social Care Trust. This pathway will be implemented, monitored, and evaluated in Phase 1.

The need for this unique pathway into mental health services for victims and survivors has its origin in recommendations made by the Commission for Victims and Survivors which was based on research and evidence published by them subsequent to the original *Comprehensive Needs Assessment* in 2012. The Commission's report *Towards a Better Future: The Trans-generational Impact of the Troubles on Mental Health* (2015) is a relevant example: this research is based on robust, internationally comparable data, adopting the same criteria for mental disorders that are used by psychiatrists. It points to the Conflict/Troubles as a significant and distinctive stressor in the life of the Northern Ireland population. It highlights that 28.5% of the population, or around 213,000 people, have suffered serious mental health issues, and estimates that mental health issues experienced by "at least" half of that number were directly linked to the Conflict/Troubles (CVS, 2015: 8).

## **Pre-Consultation Stakeholder Engagement**

Stakeholder and wider public awareness of all Phases of the Regional Trauma Network has been raised prior to this Consultation over the period 2014 to the present, through the following key actions:

1. The Stormont House Agreement (2014) (see above).
2. On 10 September 2015 the Health Minister announced the establishment of the new 'Regional Trauma Mental Health Network.'<sup>27</sup>

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<sup>27</sup> See: <https://www.health-ni.gov.uk/news/health-minister-moves-transform-major-trauma-services>

3. In September 2016 the Health Minister re-affirmed commitment to the development of the network and pledged a further non-recurrent £180K to enable its design, development and implementation.<sup>28</sup>
4. In November 2015 the European Union Programme for Peace and Reconciliation (PEACE IV)<sup>29</sup> named the Victims and Survivors Service as the Lead Partner delivering a *Provision of Services for Victims and Survivors Programme*, with a specific focus on improving the health and wellbeing of victims and survivors of the Conflict/Troubles and building capacity within the sector to deliver high quality services.
5. The Victims and Survivors Service application for PEACE IV funding was approved in November 2016, securing funding for five Health and Wellbeing Case Managers (Registered Practitioners), 25 Health and Wellbeing Caseworkers and significant resources to increase training and build capacity and expertise within the sector. On this basis, the community and voluntary sector element of the Regional Trauma Network for victims and survivors was established in April 2017.
6. In December 2016 a Partnership Agreement was drawn up between the Department of Health and the Executive Office, which set out the mechanisms via which the Victims and Survivors Service would interface with Health and Social Care to ensure relevant, timely, accessible, and comprehensive trauma care for those whose mental health has been impacted by the Troubles/Conflict.
7. The Health Minister committed recurrent funding of £0.175M in 2016/2017 to establish the Health and Social Care element of the Regional Trauma Network.

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<sup>28</sup> See: <https://www.health-ni.gov.uk/news/hamilton-announces-start-funding-new-world-leading-mental-trauma-service>

<sup>29</sup> For information on the PEACE IV Programme, see: <https://www.seupb.eu/piv-overview> - Citizens' Summary Document available at: <https://seupb.eu/sites/default/files/styles/PEACEIV/PEACE%20IV%20-%20%20Draft%203.pdf>

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8. In 2016/2017 the Regional Trauma Network Implementation Team and Partnership Board were established with representatives from Health and Social Care Board, Victims and Survivors Service, Health and Social Care Trusts, Commission for Victims and Survivors, Department of Health, The Executive Office, and service users.
9. A further £0.720M was committed to the Health and Social Care element of the Regional Trauma Network by the Department of Health in 2017/2018.
10. From 2017/2018 and 2018/2019 a total of £0.560M has been allocated to Trusts.
11. In September 2018 a Regional Trauma Network Manager was appointed to the Health and Social Care Board.
12. Engagement with the All Party Group on Suicide Prevention (October 2018).
13. Active involvement with the Northern Ireland Adverse Childhood Experiences (ACEs) Reference Forum.
14. Active involvement with the Safeguarding Board Northern Ireland.
15. Ongoing engagement with the Rural Community Network.
16. The Department of Health allocated a further £0.500M to the Health and Social Care element of the Regional Trauma Network in 2018/2019.
17. Ongoing engagement with the Victims and Survivors Practitioners' Working Groups, the key platform for Victims and Survivors Service-funded community and voluntary organisations.

18. Ongoing engagement with the Victims and Survivors Service, the Commission for Victims and Survivors, and the Forum for Victims and Survivors.
19. Ongoing engagement with the Health and Social Care Trusts.
20. In January 2019, the Regional Trauma Network established a bespoke Co-production forum, in line with the Health and Social Care Co-production principles and ethos.<sup>30</sup> This forum is known as the Partnership Alliance for Learning from Lived Experience (see **Annex 3**).
21. Stakeholder engagement events lead by the Health and Social Care Board in February 2018 and February 2019, enabling communication with wider stakeholders. This included, for example, representatives from organisations that deliver services and support to Black and Minority Ethnic (BME) communities, Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) individuals and groups, refugees and asylum seekers, veterans, police and prison personnel, children and young people, families, and people living with Human Immunodeficiency Virus (HIV). Follow-up engagement is ongoing.
22. December 2018 onwards presentations in relation to the development of the Regional Trauma Network have been delivered to:
  - Royal College of Psychiatrists International Congress, London.
  - British Association of Counselling and Psychotherapy (BACP) Annual Conference, Belfast.
  - Northern Ireland Eye Movement Desensitization and Reprocessing (EMDR) Annual Conference, Belfast.

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<sup>30</sup> To access the Department of Health (DoH) *Co-production Guide*, see: <https://www.health-ni.gov.uk/publications/co-production-guide-northern-ireland-connecting-and-realising-value-through-people>

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- Royal College of Psychiatrists Northern Ireland Spring Conference, Belfast.
- 'Five Nations' Adverse Childhood Experiences Forum, London (including members from Health, Education, Police and Justice).
- Queens University Medical Students in partnership with WAVE Trauma Centre.
- Health and Social Care Trust staff across the region.
- National Health Service Confederation.
- Queens University Belfast Trauma-Focused Cognitive Behavioural Therapy Master students.
- Northern Ireland British Psychological Society (BPS) Annual Conference, Antrim.

This extensive programme of engagement has established communication with the Regional Trauma Network's key stakeholders, ensuring clear understanding of:

- The background to the initial pathway to be tested in Phase 1, which aims to improve access to community, voluntary and statutory services for individuals with Conflict/Troubles-related trauma via five Health and Wellbeing Case Managers employed by the Victims and Survivors Service.
- The collaborative work that will be undertaken in Phase 1 to design and develop a pathway to Regional Trauma Network services for children and young people, in line with the existing Child and Adolescent Mental Health Services (CAMHS) pathway, and for individuals with significant trauma symptoms that are not associated with Conflict/Troubles-related incident/s who experience barriers to accessing mental health services.
- The process of ongoing learning and development, which will ensure that lessons and research accumulated in Phase 1 inform and shape continuous improvement in Phases 2 and 3.
- How to engage and safely refer individuals in clinical need to Health and Social Care, throughout the phased implementation period.

## **Continued and Current Provision of Existing Mental Health Services**

At the time of this consultation, there are no local Health and Social Care Regional Trauma Network trauma teams in operation. It is anticipated that capacity for Phase 1 provision will be in place by Autumn 2019; recruitment to ensure capacity for implementing Phases 2 and 3 is required by April 2020. These dates will be kept under review in line with the outcome of this public consultation, budget allocation to the Health and Social Care element of the Regional Trauma Network and progress against recruitment, and all partners will be kept updated.

Until then, all stakeholders across the network are working to ensure the demand for and expectations in relation to this service are monitored and mitigated against, since raising such expectations in the absence of confirmed availability of services would potentially have negative impacts on the well-being of individuals, and undermine public trust and confidence in the Regional Trauma Network.

In the meantime, throughout the incremental development and delivery of the Health and Social Care element of the Regional Trauma Network, the Northern Ireland population continues to have access to existing psychological therapies and trauma services in the Adult and Child Directorates within Health and Social Care Trusts, via existing pathways, based on their clinical need and irrespective of the origin of their trauma.

### **Clinical Need**

Epidemiological research (CVS, 2011) on the prevalence of trauma in Northern Ireland shows that:

- An estimated 61% of the Northern Ireland adult population have experienced a traumatic event at some point in their lifetime.
- An estimated 39% of the population have experienced a conflict-related traumatic event.

## 1: THE SERVICE DELIVERY MODEL

- An estimated 8.8% of the Northern Ireland adult population met the criteria for Post Traumatic Stress Disorder at some point in their life while 5.1% met the criteria in the previous 12 months.
- The prevalence of Post Traumatic Stress Disorder in Northern Ireland is the highest of all countries that have produced comparable estimates including the United States, other Western European countries and countries that have experienced civil conflict in their recent history.

The Health and Social Care element of the Regional Trauma Network is an evidence-based, specialised trauma therapy service that will be delivered by mental health professionals with a high level of skill, training and experience to support people experiencing clinically significant levels of psychological trauma. A key aim is to ensure people with complex requirements have improved access to a range of the highest quality trauma treatments and support delivered at the right time, in the right place and by the right person.

The Regional Trauma Network Pathways Development Working Group includes representatives from the Health and Social Care Board, the five Health and Social Care Trusts, the Victims and Survivors Service and people with lived experience of mental health and trauma services. The Working Group has drawn on national and international guidelines, regional audits, research and international diagnostic guidance to develop access criteria to the Health and Social Care element of the Regional Trauma Network in Phase 1. These criteria, which focus solely on adults in Phase 1, have been agreed on the basis of careful analysis of anticipated need based on current Health and Social Care psychological therapies service and Victims and Survivors Service data versus Regional Trauma Network resource capacity.

The Health and Social Care Regional Trauma Network clinical needs-based access criteria for service users in Phase 1, which are aligned to these evidence-based measures, are summarised in Table 4 below.



**Table 4: Clinical Needs-Based Access Criteria (Phase 1)**

Ref	Detail
1	The service user has experienced one or more traumatic events as defined by established mental health classification systems (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition; International Classification of Diseases 11th Revision).
2	The service user has clinical levels of Post-Traumatic Stress Disorder symptoms and trauma-related psychological difficulties for which they are seeking treatment. This clinical level of severity has been assessed by an appropriately qualified, registered practitioner using a Regional Trauma Network accepted measurement instrument or methodology.
3	The service user has levels of Post Traumatic Stress Disorder and trauma-related psychological difficulties that are moderate-severe in terms of intensity/complexity and cause significant impact on their social, occupational, or overall functioning.
4	The service user is living in the community and can attend regularly and consistently as required for their treatment.
5	The service user is motivated to formulate goals and make active changes to their life to improve their trauma-related psychological difficulties.
6	The service user has the ability to engage in the appropriate therapy for their trauma-related psychological difficulties.

### Ongoing Monitoring, Evaluation, and Improvement

The evidence-based measures that will guide the Regional Trauma Network assessment, monitoring, and evaluation protocols are included in this document at **Annex 4**. This framework is aligned to the service access criteria described above, and, along with those criteria, will be kept under review over the implementation period and adjusted in line with learning and emerging evidence as required.

## 2 GUIDING PRINCIPLES & CLINICAL GUIDELINES

**The guiding principles and clinical guidelines outlined in this section pertain to the Health and Social Care element of the Regional Trauma Network.**

The most authoritative international guidelines on the effective management of trauma that will inform practice within the Health and Social Care trauma teams are provided by the International Society for Traumatic Stress Studies (ISTSS), the National Institute for Health and Care Excellence Guideline (NG 116) and the United Kingdom Psychological Trauma Society Guidelines (UKPTS). On this basis, therapies provided will be either:

- Based on and informed by appropriate clinical evidence as agreed by Department of Health e.g. high intensity Trauma-Focussed Cognitive Behavioural Therapy (TF-CBT), Prolonged Exposure Therapy (PE), Family/Couples Therapy, Eye-Movement Desensitisation and Reprogramming Therapy (EMDR) and Dialectical Behaviour Therapy (DBT); or
- Part of an emerging evidence base, which in the opinion of the Department of Health is appropriate for use e.g. in more complex cases, integrative, combinatory and phased approaches incorporating evidence-based practice and multiple intervention elements (e.g. stabilisation, psychiatric care) may be required.

Table 5 below provides an overview of these guidelines.

**Table 5: Overview of Key Clinical Guidelines**

CLINICAL GUIDELINE	RECOMMENDATIONS
<p><b>National Institute for Health and Care Excellence (NICE) Guideline for Post Traumatic Stress Disorder (PTSD) Clinical Guideline (NG) 116</b></p>	<p>This guideline has been developed to advise on the treatment and management of Post Traumatic Stress Disorder. The guideline recommendations have been developed by a multidisciplinary team of healthcare professionals, Post-Traumatic Stress Disorder sufferers and guideline methodologists after careful consideration of the best available evidence.</p> <p>National Institute for Health and Care Excellence Guidelines recommend that people with Post Traumatic Stress Disorder should be offered a course of trauma-focused psychological treatment. Based on current best available evidence, the most effective treatments are trauma-focused cognitive-behavioural therapy (CBT) or eye movement desensitisation and reprocessing (EMDR). The guideline also recognises the contribution of the non-statutory sector that is increasingly providing a range of psychological interventions with a stronger evidence base for the treatment of Post Traumatic Stress Disorder alongside providing practical, social, and emotional support, and advocacy and self-help or support groups, which can play a vital part in overcoming the impact of severe trauma. The guideline therefore recommends an integrated approach to the care of Post Traumatic Stress Disorder sufferers.</p> <p>The full National Institute for Health and Care Excellence Guideline can be found at the following link:  <a href="https://www.nice.org.uk/guidance/ng116">https://www.nice.org.uk/guidance/ng116</a></p>

CLINICAL GUIDELINE	RECOMMENDATIONS
<p><b>United Kingdom Psychological Trauma Society (UKPTS) Complex Post Traumatic Stress Disorder Guideline (2017)</b></p>	<p>The 11th revision to the World Health Organization's International Classification of Diseases (ICD-11) proposes two distinct sibling conditions: Post Traumatic Stress Disorder (PTSD) and Complex Post Traumatic Stress Disorder (CPTSD). The United Kingdom Psychological Trauma Society guideline was developed as a pre-emptive measure to this. In summary it cites the growing awareness that Complex Post Traumatic Stress Disorder may develop in adults exposed to extreme circumstances such as combat, torture, domestic violence, or dangerous political unrest. Dissociation, somatisation, and disturbances of affect regulation and interpersonal functioning, and changes in beliefs about the self and the world have been identified in such groups, in addition to high rates of Post Traumatic Stress Disorder.</p> <p>Several studies and models suggest that a phased approach to treatment is likely to be of benefit to individuals presenting with such difficulties. Phases will overlap and may also be cyclical, with the individual needing to return to earlier phases as therapy progresses:</p> <ul style="list-style-type: none"> <li>• <i>Phase one:</i> Stabilisation (symptom management, increasing emotion regulation skills and addressing current stressors).</li> <li>• <i>Phase two:</i> Trauma processing (focused processing of traumatic memories).</li> <li>• <i>Phase three:</i> Reintegration (re-establishing social and cultural connections and addressing personal quality of life).</li> </ul>

CLINICAL GUIDELINE	RECOMMENDATIONS
	<p>Evidence indicates that psychological therapies can be highly effective for Complex Post Traumatic Stress Disorder. There is currently insufficient evidence to recommend any single intervention in particular, as the most effective trauma-focused therapy for the treatment of Complex Post Traumatic Stress Disorder is unknown, but in accordance with the general literature on the impact of post-traumatic stress, it is generally agreed that treatment needs to address three domains: cognitive, affective and sensorimotor.</p> <p>The full United Kingdom Psychological Trauma Society Complex Post Traumatic Stress Disorder Guideline can be found at the following link:  <a href="http://www.ukpts.co.uk/links_6_2920929231.pdf">http://www.ukpts.co.uk/links_6_2920929231.pdf</a>  <a href="http://www.ukpts.co.uk/guidance.html">http://www.ukpts.co.uk/guidance.html</a>)</p>
<p><b>International Society for Traumatic Stress Society (ISTSS) Guidelines for Post Traumatic Stress Disorder (PTSD) and Complex Post Traumatic Stress Disorder (CPTSD)</b></p>	<p>The International Society for Traumatic Stress Society developed guidelines for the treatment of Post Traumatic Stress Disorder in 2002 that were subsequently amended in 2008 and are currently undergoing further revision.</p> <p>The International Society for Traumatic Stress Society assert that current Post Traumatic Stress Disorder frameworks do not give adequate consideration to the more complicated symptom profile and integrative treatment methods required for individuals exposed to prolonged and repeated trauma, referred to as Complex Post Traumatic Stress Disorder. In 2012, they published treatment guidelines for Complex Post Traumatic Stress</p>

CLINICAL GUIDELINE	RECOMMENDATIONS
	<p>Disorder in adults based on expert consensus of high-profile clinicians/researchers in the field. The majority endorsed a phase-oriented approach as a first-line treatment approach for Complex Post Traumatic Stress Disorder and, in acknowledging the gap between the available evidence and expert opinion in relation to Complex Post Traumatic Stress Disorder, they make the following specific research recommendations:</p> <ul style="list-style-type: none"> <li>• The development, empirical evaluation, and routine use of reliable measures for Post Traumatic Stress Disorder and Complex Post Traumatic Stress Disorder in clinical practice;</li> <li>• Evaluation of single-stage trauma-focused therapies versus sequential therapies for different symptom sets and populations; and</li> <li>• Sustained monitoring of symptoms during treatment and extended follow-up.</li> </ul> <p>Further information on International Society for Traumatic Stress Society Guidelines can be found at the following link: <a href="https://www.istss.org/">https://www.istss.org/</a></p>

The current PEACE IV funding creates the opportunity to engage with those whose mental health has been impacted by the Troubles/Conflict and to remove barriers to their accessing timely, effective and integrated support from the community, voluntary and statutory services as needs identified dictate, and in line with the Stepped Care Model in Phase 1 of the Regional Trauma Network implementation.

Relationships and partnerships will be developed with health and well-being services across the community and voluntary sector that deliver

Step 1 and Step 2 interventions, either to the general population or to specific populations (e.g. Armed Forces and Veterans, Black and Minority Ethnic community, Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) individuals and groups, the Homeless, etc.), to ensure this model meets the needs of anyone in the population experiencing trauma-related difficulties.

The Regional Trauma Network will provide trauma interventions across the lifespan. This encompasses child, young person, adult and older adult service provision.

The Regional Trauma Network will not provide urgent or crisis management interventions. Service-users attending community and voluntary sector services who are deemed to be at risk should be referred immediately to the General Practitioner (GP) who will assess their mental state and recommend the appropriate level of response from the Health and Social Care Trust. Those already attending the Regional Trauma Network local trauma team will have access to statutory services that can provide this form of support (e.g. Crisis Response and Home Treatment Teams).

### 3 STRATEGIC CONTEXT

The strategic direction of the Regional Trauma Network is informed by a range of key policies and strategies, including:

- The draft Programme for Government (2016-2021)<sup>31</sup>
- The Executive Office Outcomes Delivery Plan<sup>32</sup>
- The Department of Health Departmental Business Plan<sup>33</sup>
- Victims and Survivors Service Corporate Plan<sup>34</sup>
- Strategy for Victims and Survivors (2009-2019)<sup>35</sup>
- PEACE IV Programme (2014-2020)<sup>36</sup>
- The Stormont House Agreement (2014)<sup>37</sup> and A Fresh Start: The Stormont House Agreement Implementation Plan (2015)<sup>38</sup>
- Transforming Your Care (2011)<sup>39</sup>
- Making Life Better (2013)<sup>40</sup>
- Health and Wellbeing 2026, Delivering Together (2016)<sup>41</sup>
- Service Framework for Mental Health and Wellbeing (2012)<sup>42</sup>

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<sup>31</sup> Available at: <https://www.northernireland.gov.uk/consultations/programme-government-consultation>

<sup>32</sup> The Executive Office – Outcomes Delivery Plan 2018-19 is available at: <https://www.executiveoffice-ni.gov.uk/sites/default/files/publications/execoffice/outcomes-delivery-plan-2018-19.PDF>

<sup>33</sup> Available at: <https://www.health-ni.gov.uk/publications/department-health-business-plan-201819>

<sup>34</sup> Available at: <http://www.victimsservice.org/about-us/publications-and-corporate-documents/>

<sup>35</sup> Available at: <https://www.executiveoffice-ni.gov.uk/publications/strategy-victims-and-survivors-2009>

<sup>36</sup> For information on the PEACE IV Programme, see: <https://www.seupb.eu/piv-overview> - Citizens' Summary Document available at:

<https://seupb.eu/sites/default/files/styles/PEACEIV/PEACE%20IV%20-%20%20Draft%203.pdf>

<sup>37</sup> Available at: <https://www.gov.uk/government/publications/the-stormont-house-agreement>

<sup>38</sup> Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/479116/A\\_Fresh\\_Start\\_-\\_The\\_Stormont\\_Agreement\\_and\\_Implementation\\_Plan\\_-\\_Final\\_Version\\_20\\_Nov\\_2015\\_for\\_PDF.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/479116/A_Fresh_Start_-_The_Stormont_Agreement_and_Implementation_Plan_-_Final_Version_20_Nov_2015_for_PDF.pdf)

<sup>39</sup> Available at: <https://www.health-ni.gov.uk/topics/health-policy/transforming-your-care>

<sup>40</sup> Available at: <https://www.health-ni.gov.uk/topics/health-policy/making-life-better>

<sup>41</sup> Available at: <https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together>

<sup>42</sup> Available at: <https://www.health-ni.gov.uk/publications/mental-health-and-well-being-service-framework-documents> (information about the revised framework and 2018 public consultation around that document is available at: <https://www.health-ni.gov.uk/consultations/revised-service-framework-mental-health-and-wellbeing-2018-2021>)



The design, development and implementation of the Regional Trauma Network will evolve in line with the outworking of these strategies. These transcend a number of government departments including the Victims and Survivors Service, The Executive Office, and Department of Health, in addition to a number of additional key stakeholders including the Commission for Victims and Survivors, the Northern Ireland Commissioner for Children and Young People, and the Commissioner for Older People for Northern Ireland.

#### **The draft Programme for Government (2016-2021)<sup>43</sup>**

The design, development and implementation of the Regional Trauma Network align to the draft Programme for Government, with primary links to the following outcomes:

- Outcome 4: We enjoy long, healthy, active lives;
- Outcome 8: We care for others and we help those in need; and
- Outcome 14: We give our children and young people the best start in life.

For each of these outcomes, the Regional Trauma Network Delivery Plan will set out targets/outcomes that will contribute to the achievement of indicators that have been set at a population level. The Regional Trauma Network Management Team will monitor and report to the Department of Health / The Executive Office inter-departmental group on performance against these indicators within its service-user population on a quarterly basis.

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<sup>43</sup> Available at: <https://www.northernireland.gov.uk/consultations/programme-government-consultation>

**The Executive Office,<sup>44</sup> Department of Health,<sup>45</sup> Health and Social Care Board,<sup>46</sup> and Victims and Survivors Service<sup>47</sup> Corporate, Outcomes Delivery, and Business Plans**

The Regional Trauma Network Outcomes Delivery Plan is directly linked to the Corporate Plans of the Department of Health, The Executive Office, Health and Social Care Board and Victims and Survivors Service.

**Strategy for Victims and Survivors (2009-2019)<sup>48</sup>**

The Strategy for Victims and Survivors is structured around three key themes: *Dealing with The Past*; *Improving Services*; and *Building for the Future*. These themes, in turn, are underpinned by 11 overarching principles:

1. Be victim and survivor centred and driven;
2. Address the practical and other needs of victims and survivors in a co-ordinated manner;
3. Ensure the services for victims and survivors are provided in response to assessed need, adhere to published standards and are designed to have clear outcomes;
4. Establish arrangements to ensure, through the work of the Commission and the Victims and Survivors Forum that the practical and other needs of victims and survivors are kept under review and that services are responsive to changing needs;

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<sup>44</sup> The Executive Office – Outcomes Delivery Plan 2018-19 is available at:

<https://www.executiveoffice-ni.gov.uk/sites/default/files/publications/execoffice/outcomes-delivery-plan-2018-19.PDF>

<sup>45</sup> Available at: <https://www.health-ni.gov.uk/publications/department-health-business-plan-201819>

<sup>46</sup> Available at:

[http://www.hscboard.hscni.net/download/PUBLICATIONS/CORPORATE%20AND%20FINANCIAL/corporate\\_plan/Corporate-Plan-2017-2018.pdf](http://www.hscboard.hscni.net/download/PUBLICATIONS/CORPORATE%20AND%20FINANCIAL/corporate_plan/Corporate-Plan-2017-2018.pdf)

<sup>47</sup> Available at: <http://www.victimsservice.org/about-us/publications-and-corporate-documents/>

<sup>48</sup> Available at: <https://www.executiveoffice-ni.gov.uk/publications/strategy-victims-and-survivors-2009>

### 3: STRATEGIC CONTEXT

5. Promote collaborative working between statutory and voluntary organisations, community groups and others, where practicable;
6. Reduce the level of trauma for victims and survivors;
7. Build the trust and confidence of victims and survivors and assist them where this is consistent with their wishes and well-being, to participate on a sustained basis in the building of a shared and better future;
8. Ensure that while recognising their particular needs, victims and survivors work does not become isolated and that people should not be defined solely as a victim and survivor but as people with the same needs and aspirations as the wider population;
9. Ensure, so far as is practicable, that victims and survivors work is integrated with and can influence other government policies and initiatives;
10. Ensure that victims and survivors play an active role in the development of ways to deal with the past and other transitional mechanisms affecting their journey towards recovery and well-being; and
11. Assist victims and survivors, where this is consistent with their wishes and wellbeing, to participate as part of wider society in addressing the legacy of the past.

#### **PEACE IV Programme (2014-2020)<sup>49</sup>**

The PEACE IV Programme aims to promote social and economic stability in the region, notably through actions designed to promote cohesion between communities.

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<sup>49</sup> For information on the PEACE IV Programme, see: <https://www.seupb.eu/piv-overview> - Citizens' Summary Document available at: <https://seupb.eu/sites/default/files/styles/PEACEIV/PEACE%20IV%20-%20%20Draft%203.pdf>

### 3: STRATEGIC CONTEXT

In recognition of the needs among those who have suffered trauma as a result of the Troubles/Conflict, the Programme, under its *Shared Space and Services* theme, will develop capacity for services to meet the needs of victims and survivors. To ensure co-ordination of these services for victims and survivors, the Victims and Survivors Service is the single Lead Partner for this part of the Programme.

PEACE IV-funded actions delivered by the Victims and Survivors Service will focus on the following:

- *Advocacy support*: practical support for victims and survivors engaging with institutions, historical process and enquiries;
- The development of *qualified assessors and health and well-being case workers* to identify and address the needs of victims and survivors;
- *A resilience programme* to address the individual needs of victims and survivors, including Level 1 and Level 2 mental health interventions; and
- The development of the capacity of the sector through *training and development (to meet national and regional standards), research and improved regulation*.

#### **The Stormont House Agreement (2014)<sup>50</sup>**

As part of the Stormont House Agreement, the Northern Ireland Executive made the following commitment to establish a comprehensive Mental Health Trauma Service:

*The Commission for Victims and Survivors' recommendation for a comprehensive Mental Trauma Service will be implemented. This will operate within the NHS (National Health Service) but will work closely with the Victims and Survivors Service and other organisations and groups who work directly with victims and survivors.*

*(Stormont House Agreement, 2014 – paragraph 27)*

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<sup>50</sup> Available at: <https://www.gov.uk/government/publications/the-stormont-house-agreement>

This commitment, made in the context of the Agreement's discussion around dealing with 'The Past', refers to recommendations informed by a *Comprehensive Needs Assessment*<sup>51</sup> published by the Commission for Victims and Survivors in 2012. On that basis, it signals the Executive's intention to prioritise the mental health needs of victims and survivors, and enable access for all individuals in need to high quality services.

The Government remains committed to the provisions of the Stormont House Agreement in relation to providing better outcomes for victims and survivors.

#### **A Fresh Start: The Stormont House Agreement Implementation Plan (2015)**<sup>52</sup>

This implementation plan details the delivery of the Stormont House Agreement commitments.

#### **Transforming Your Care (2011)**<sup>53</sup>

The current direction of healthcare service reform originates in the 'Transforming Your Care' review of Health and Social Care services announced in 2011 by the then Minister for Health, Edwin Poots MLA.

Transforming Your Care proposed: a new integrated model of health and social care; population-based planning of services; care to be provided as close to home as practical; and a shift of resource from hospitals to community health and social care services. Crucially, TYC advocates the stepped care model outlined in **Figure 1** above.

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<sup>51</sup> Available at: <https://www.cvsni.org/media/1434/comprehensive-needs-assessment-february-2012.pdf>

<sup>52</sup> Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/479116/A\\_Fresh\\_Start\\_-\\_The\\_Stormont\\_Agreement\\_and\\_Implementation\\_Plan\\_-\\_Final\\_Version\\_20\\_Nov\\_2015\\_for\\_PDF.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/479116/A_Fresh_Start_-_The_Stormont_Agreement_and_Implementation_Plan_-_Final_Version_20_Nov_2015_for_PDF.pdf)

<sup>53</sup> Available at: <https://www.health-ni.gov.uk/topics/health-policy/transforming-your-care>

### **Making Life Better (2013)<sup>54</sup>**

*Making Life Better 2013–2023* is the ten-year public health strategic framework for Northern Ireland. It builds on the Investing for Health strategy (2002–2012). A key long-term objective is “Improved Mental Health and Wellbeing, Reduction in Self Harm and Suicide”.

Key actions for delivery in the early years of the strategy include:

- Development of new policy to promote positive mental health, reduce self-harm and suicide;
- Increase resilience and improve mental well-being in children and young people through initiatives including Family Support, Roots of Empathy and iMatter (pupil’s emotional health and well-being programme);
- Reduce levels of self-harm through implementation of evaluated approaches; and
- As part of the joint healthcare and criminal justice strategy, work to identify and support people with mental ill-health or other vulnerabilities who have offended.

### **Health and Wellbeing 2026, Delivering Together (2016)<sup>55</sup>**

In early 2016, the then Health Minister, Simon Hamilton MLA, appointed an expert, clinically-led panel, chaired by Raphael Bengoa, to consider and lead debate on the best configuration of health care services for Northern Ireland. The subsequent Health Minister, Michelle O’Neill MLA, published the Expert Panel’s report on 25 October 2016, alongside the Department’s document *Health and Wellbeing 2026, Delivering Together* (which detailed the outworking of the Expert Panel’s recommendations).

This paper highlights mental health as a priority area of focus and specifically cites expansion of services in the community and services to

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<sup>54</sup> Available at: <https://www.health-ni.gov.uk/topics/health-policy/making-life-better>

<sup>55</sup> Available at: <https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together>

deal with trauma associated with the Conflict and the past in Northern Ireland.

Crucially, this paper advocates the *co-production* model, meaning that patients, service users, and staff will be empowered to: design the system as a whole, with a focus on prevention; work together to develop pathways of care and Health and Social Care services; and be partners in the care they receive with increased self-management and choice.

#### **Service Framework for Mental Health and Wellbeing (2012)<sup>56</sup>**

This Framework is underpinned by the ethos of ‘recovery’, and includes 58 standards for mental health and well-being.

Like all Service Frameworks for health services, this document sets out the standards of care that patients, service-users, their carers and wider family can expect to receive in order to help people to:

- Prevent disease or harm;
- Manage their own health and well-being including the causes of ill health and its effective management;
- Be aware of what types of treatment and care are available; and
- Be clear about the standards of treatment and care they can expect to receive.

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<sup>56</sup> Available at: <https://www.health-ni.gov.uk/publications/mental-health-and-well-being-service-framework-documents> (information about the revised framework and 2018 public consultation around that document is available at: <https://www.health-ni.gov.uk/consultations/revised-service-framework-mental-health-and-wellbeing-2018-2021>)

## 4 OUTCOMES BASED ACCOUNTABILITY

The achievement of the Regional Trauma Network mission to work collaboratively and in partnership with people in our society to improve access to the highest quality psychological care is set within the context of Outcomes Based Accountability (OBA).

Outcomes Based Accountability provides the Regional Trauma Network with an important model for understanding the performance of service provision by asking three broad questions:

- How much did we do?
- How well did we do it?
- Is anyone better off?

### Four Strategic Outcomes for the Regional Trauma Network

As per the Partnership Agreement, all services provided within the Regional Trauma Network will focus on improving people's psychological, social and economic outcomes in line with the Programme for Government, namely:

- Outcome 4: We enjoy long, healthy, active lives;
- Outcome 8: We care for others and we help those in need; and
- Outcome 14: We give our children and young people the best start in life.

These outcomes are also aligned to the 'three pillars' approach to clinical outcomes in mental health (McCusker, 2014)<sup>57</sup>, a protocol that provides guidance on how to design a feasible, sustainable, high quality outcomes framework as part of routine care. The three pillars are:

- Access
- Acceptability
- Effectiveness

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<sup>57</sup> McCusker, C. (2014). *An Outcomes Framework for Psychological Services in Northern Ireland*. Belfast: HSC Board.



#### 4: OUTCOMES BASED ACCOUNTABILITY

In November 2017, the Regional Trauma Network Implementation Team proposed the following 4 strategic outcomes for the new service which will underpin the work of all that we do going forward as follows:

- *Strategic Outcome 1:* People have improved access to quality trauma care. (ACCESS)
- *Strategic Outcome 2:* Improved partnership working with the people of Northern Ireland to deliver highest quality trauma care. (ACCEPTABILITY)
- *Strategic Outcome 3:* People receive world leading, effective, and evidence-based trauma care. (EFFECTIVENESS)
- *Strategic Outcome 4:* An international centre of excellence for training, research and trauma is developed. (LEARNING AND GROWTH)

**Diagram 3: Regional Trauma Network Strategic Outcomes**



## 5 EQUALITY IMPACT ASSESSMENT

### Background

Section 75 of the Northern Ireland Act 1998 has placed the following statutory requirements on each public authority.

1. *A public authority shall in carrying out its functions relating to Northern Ireland have due regard to the need to promote equality of opportunity –*
  - (a) *Between persons of different religious belief, political opinion, racial groups, age, marital status or sexual orientation;*
  - (b) *Between men and women generally;*
  - (c) *Between persons with a disability and persons without;*  
*and*
  - (d) *Between persons with dependants and persons without.*
  
2. *Without prejudice to its obligations under subsection (1), a public authority shall in carrying out its functions relating to Northern Ireland have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.*

A key practical element of the statutory equality duties is that public bodies should assess the impact of their policies and procedures on the promotion of equality of opportunity and good relations. This is practically carried out by initially assessing the equality implications of a policy or procedure, called screening. Those policies assessed as having major equality implications should then be considered for an equality impact assessment.

An Equality Impact Assessment is a thorough and systematic analysis (see **Annex 6**) of a policy to determine whether or not that

policy has a negative impact on groups or individuals in relation to one or more of the nine equality categories. It also aims to identify further opportunities for promoting equality of the accessibility and acceptability of services.

### **Scope of this Equality Impact Assessment**

This Equality Impact Assessment concerns the equality implications of the Health and Social Care element of the Regional Trauma Network. It considers the potential impact of the phased implementation process and clinical needs-based access criteria for each of the Section 75 equality categories.

### **Equality Screening Rationale**

The Equality Commission for Northern Ireland notes that policies that are likely to have an impact on equality of opportunity should be screened and, if necessary, assessed in terms of their potential impacts for each of the Section 75 equality categories. The Commission defines a ‘policy’ as ‘denoting any strategy, policy (proposed/amended/existing) or practice and/or decision, whether written or unwritten’ and that a policy is therefore “wide ranging and may include such matters as planning decisions, corporate strategies, ‘temporary’ policies and service changes.”<sup>58</sup>

In line with the guidance provided by the Equality Commission, the Health and Social Care Board considers the Regional Trauma Network to constitute a ‘temporary policy’ which focuses on a particular section of the population of Northern Ireland, i.e. adults with psychological trauma symptoms in keeping with Post Traumatic Stress Disorder and Complex Post Traumatic Stress Disorder.

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<sup>58</sup> As per the guidance provided by the Equality Commission:  
<https://www.equalityni.org/Employers-Service-Providers/Public-Authorities/Section75/Section-75/Screening>

An Equality Impact Assessment is necessary due to the incremental implementation process outlined in Table 1 above. The Phase 1 pathway, which originates in the Stormont House Agreement (2014) and Partnership Agreement (2016) commitments outlined above involves the development, testing and delivery of a unique pathway into Health and Social Care Regional Trauma Network services for adults with Conflict/Troubles-related trauma. This pathway is enabled via five Health and Wellbeing Case Managers employed by the Victims and Survivors Service, working directly with the Health and Social Care Trusts. Learning from this pathway will inform the full implementation of the Regional Trauma Network in Phases 2 and 3 for children, young people and adults with clinically significant levels of psychological trauma, regardless of the origin of their trauma.

In conducting this Equality Impact Assessment, the following points are noted:

- Phase 1 is the first part of the incremental implementation of the Regional Trauma Network that involves providing enhanced access to services to people with a clinical need (as per Table 2) based on a particular type of trauma.
- Phase 1 is designed to test a concept of enhancing access to Health and Social Care Regional Trauma Network services.
- Phase 1 allows the Health and Social Care Board to understand and subsequently design Regional Trauma services that are accessible, acceptable, and effective for children, young people and adults, as well as for individuals with significant levels of psychological trauma, irrespective of the origin of the trauma who experience barriers to accessing mental health services.
- The clinical service access criteria 1, 2, 3, and 5 listed in Table 2 above are ascertained on the basis of a comprehensive and collaborative clinical assessment of

need<sup>59</sup> rather than on any aspect of an individual's identity in terms of Section 75 groups. As per all Health and Social Care services, this type of assessment process will apply in every case, including delivery of implementation Phase 1.

- From Phase 2 onwards children, young people and adults with clinically significant levels of psychological trauma, will have access to Regional Trauma Network services, irrespective of the origin of their trauma.
- Throughout Phase 1 all members of the Northern Ireland population will continue to have access to existing psychological therapies and trauma services in the Adult and Child Health and Social Care Directorates, via existing pathways, based on their clinical need and irrespective of the origin of their trauma.

The Health and Social Care Board notes the Equality Commission's *Section 75 of the Northern Ireland Act 1998: Practical Guidance on Equality Impact Assessment*, which states "Where one or more public authorities share responsibility for policy setting and implementation, the necessary arrangements for assessment and monitoring should be put in place and public authorities should cooperate fully in carrying out an Equality Impact Assessment" (p.8). In line with this guidance, the Health and Social Care Board has notified its partner organisations of the current Equality Impact Assessment, demonstrating the need for them to take the necessary steps in line with their respective statutory duties, where applicable.

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<sup>59</sup> As per National Institute for Health and Care Excellence (NICE) Guidelines NG116 (2018).

## 6 EQUALITY IMPACT ASSESSMENT DATA COLLECTION

Any assessment of the equality impacts of a policy should be based on two types of data:

- **Quantitative data** (statistics), which would provide a first overview of the characteristics of those people most likely to be affected by the policy; and
- **Qualitative data**, which would provide some insights into perceptions held by those who are likely to be most affected by the policy as well as suggestions for improvement.

Noting the Equality Commission's guidance in relation to the types and sources of data that should inform an assessment,<sup>60</sup> the Health and Social Care Board has established that **secondary sources**, i.e. information that has been collected and produced by other authorities, provides sufficient evidence to inform this Equality Impact Assessment.

Key sources referred to throughout this assessment are listed below. Each of these documents has been identified for its relevance to the phased implementation of the Regional Trauma Network and incorporates a combination of qualitative and quantitative data.

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<sup>60</sup> As per the guidance provided by the Equality Commission:  
<https://www.equalityni.org/Employers-Service-Providers/Public-Authorities/Section75/Section-75/Screening>

## Key Sources

The sources outlined below are not listed in any specific order.

1. **Census 2011:**<sup>61</sup> Northern Ireland population statistics draw on Census 2011 figures, which estimate the Northern Ireland population to be 1,810,863 people.
2. **Northern Ireland Health Survey (2019):**<sup>62</sup> This is a Department of Health survey that runs every year on a continuous basis. The survey covers a range of health topics that are important to the lives of people in Northern Ireland today.
3. ***Mental Health in Northern Ireland: Fundamental Facts 2016 (Mental Health Foundation, 2016):***<sup>63</sup> This report is an accessible summary of statutory, evidence-based, and peer-reviewed mental health research that provides key facts and figures, covering all key areas of mental health in Northern Ireland, incorporating considerations of the Section 75 Equality categories.
4. ***Troubled consequences: A report on the mental health impact of the civil conflict in Northern Ireland (CVS, 2011):***<sup>64</sup> This report, published by the Commission for Victims and Survivors (CVS), provides critical insight into the prevalence and impact of Conflict/Troubles-related trauma on the Northern Ireland population. It is a particularly robust source of data: it is based on a population-wide or *epidemiological* study of mental well-being, the Northern Ireland Study of Health and Stress (NISHS). As outlined in the report:

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<sup>61</sup> Available at: <http://www.nisra.gov.uk/census.html>

<sup>62</sup> Available at: <https://www.health-ni.gov.uk/publications/tables-health-survey-northern-ireland>

<sup>63</sup> Available at: <https://www.mentalhealth.org.uk/publications/mental-health-northern-ireland-fundamental-facts>

<sup>64</sup> Available at: <https://www.cvsni.org/media/1435/troubled-consequences-october-2011.pdf>

*Epidemiological research has the advantage that the results can be generalised to the population (individuals living in Northern Ireland) from which the information was obtained. Within the current context it is possible to generalise the results from the Northern Ireland Study of Health and Stress psychological/psychiatric interviews to those that would be expected if everyone in the society were to be interviewed; and where the appropriate procedures are followed, this can be done with a high degree of confidence. In other words, in the current study, information is being reported from a sample of respondents in Northern Ireland, and these results are being generalised to the wider society. Epidemiological research, upon which the current report is based, therefore represents a powerful tool in informing the planning, delivery and provision of effective mental health services. (CVS, 2011: 10)*

5. **Service user data collated by the Trauma Resource Centre (Trauma Resource Centre service user data):** The Trauma Resource Centre is a Statutory Mental Health service within the Belfast Health and Social Care Trust. It provides multi-disciplinary therapy (including Psychological Therapy, Occupational Therapy and Physiotherapy) for adults who have been affected by the Troubles/Conflict. The service user data drawn upon for this Equality Impact Assessment relates to the people assessed by the Trauma Resource Centre over the period November 2016 to November 2017 (n=236). This data is unpublished monitoring information held by the Trauma Resource Centre. Information has also been drawn from the Trauma Resource Centre Outcomes Report (2012) which highlighted that 96% of the population attending for treatment had clinical levels of Post-Traumatic Stress Disorder.



6. **Service user data collated by the Health and Social Care Board (HSCB current service user data):** this unpublished data is collated monthly from all five Health and Social Care Trusts by the Health and Social Care Board Performance Management and Service Improvement Directorate (PMSID). It includes data monitored in relation to *non-inpatient psychological therapies provision* covering the recent four-year period 2014/15 to 2017/18.
  
7. **Service user data collated by the Victims and Survivors Service (VSS service user data):** this refers to:
  - a. Data held in relation to individuals registered with the Victims and Survivors Service and in receipt of direct assistance from the organisation (through the *Individual Needs Programme*) in the 2018/19 financial year (n=6,010);
  - b. Data in relation to individuals accessing talking therapies from community/voluntary organisations funded by the Victims and Survivors Service (through the *Victims Support Programme*) (n=2,975); and
  - c. Data in relation to a sample of individuals accessing social support activities in community/voluntary organisations funded by the Victims and Survivors Service (through the *Victims Support Programme*) (n=3,151).
  
8. ***The Cost of the Troubles Study (Fay et al, 1999):***<sup>65</sup> This was the earliest significant study on mental health in relation to the Northern Ireland Conflict/Troubles, involving a questionnaire administered to 1,346 people to determine experience of the Conflict/Troubles, its impact, and assistance required and received on that basis.

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<sup>65</sup> Fay, M.T., Morrissey, M., Smyth, M. & Wong, T. (1999). *The Cost of the Troubles Study: Report on the Northern Ireland Survey*. INCORE: Derry/Londonderry.

9. ***Mapping Troubles-Related Deaths in Northern Ireland 1969-1998 (Fay et al, 1998):***<sup>66</sup> This report, published as part of the wider **Cost of the Troubles** research project (outlined above), produced critical insights into the scale, distribution, trends and impact of Conflict/Troubles related violence.
10. ***The Northern Ireland Peace Monitoring Report Number Five (Gray et al, 2018):***<sup>67</sup> This report synthesises a significant body of statistics, qualitative data, and policy information to evaluate the current state of peace, political activity, good relations and well-being in Northern Ireland in the broader context of the Good Friday/Belfast Agreement and its impact on politics, policing and society.
11. **Stakeholder engagement events** in February 2018 and February 2019, which included representatives from organisations that deliver services and support to Black and Minority Ethnic (BME) communities, Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) individuals and groups, refugees and asylum seekers, veterans, children and young people, families, and people living with Human Immunodeficiency Virus (HIV).
12. **The Regional Trauma Network Co-production forum**, the Partnership Alliance for Learning from Lived Experience (see **Annex 3**).

## Full Reference List

A full reference list of sources referred to and reviewed in compiling this assessment is included at **Annex 5**.

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<sup>66</sup> Fay, M.T., Morrissey, M. & Smyth, M. (1998). *Mapping Troubles-Related Deaths in Northern Ireland 1969-1998*. INCORE: Derry/Londonderry. (For information available online, see: <http://cain.ulst.ac.uk/issues/violence/cts/fay98.htm>.)

<sup>67</sup> Gray, A.M., Hamilton, J., Kelly, G., Lynn, B., Melaugh, M. & Robinson, G. (2018). *Northern Ireland Peace Monitoring Report Number 5*. Belfast: Community Relations Council. Available at: <https://www.community-relations.org.uk/publications/northern-ireland-peace-monitoring-report>.

## 7 KEY FINDINGS

As outlined in Section 1, this Equality Impact Assessment concerns the equality implications of the Health and Social Care element of the Regional Trauma Network. It considers the potential impact of the phased implementation process and clinical needs-based access criteria for each of the Section 75 equality categories.

The clinical needs-based access criteria are detailed below.

### Health and Social Care Regional Trauma Network Service Users: Clinical Needs-Based Access Criteria

- |          |  |
|----------|--|
| <b>1</b> | The service user has experienced one or more traumatic events as defined by established mental health classification systems (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition; International Classification of Diseases 11th Revision).   |
| <b>2</b> | The service user has clinical levels of Post-Traumatic Stress Disorder symptoms and trauma-related psychological difficulties for which they are seeking treatment. This clinical level of severity has been assessed by an appropriately qualified, registered practitioner using a Regional Trauma Network accepted measurement instrument or methodology. |
| <b>3</b> | The service user has levels of Post Traumatic Stress Disorder and trauma-related psychological difficulties that are moderate-severe in terms of intensity/complexity and cause significant impact on their social, occupational, or overall functioning.  |
| <b>4</b> | The service user is living in the community and can attend regularly and consistently as required for their treatment.   |
| <b>5</b> | The service user is motivated to formulate goals and make active changes to their life to improve their trauma-related psychological difficulties.   |
| <b>6</b> | The service user has the ability to engage in the appropriate therapy for their trauma-related psychological difficulties.   |

## 7: KEY FINDINGS

In conducting this Equality Impact Assessment, the following points are noted:

- Phase 1 is the first part of the incremental implementation of the Regional Trauma Network that involves providing enhanced access to services to people with a clinical need (as per Table 2) based on a particular type of trauma.
- Phase 1 is designed to test a concept of enhancing access to Health and Social Care Regional Trauma Network services.
- Phase 1 allows the Health and Social Care Board to understand and subsequently design Regional Trauma Network services that are accessible, acceptable and effective for children, young people and adults, as well as for individuals with significant levels of psychological trauma, irrespective of the origin of the trauma who experience barriers to accessing mental health services.
- The clinical service access criteria 1, 2, 3, and 5 listed above are ascertained on the basis of a comprehensive and collaborative clinical assessment of need<sup>68</sup> rather than on any aspect of an individual's identity in terms of Section 75 groups. As per all Health and Social Care services, this type of assessment process will apply in every case, including delivery of implementation Phase 1.
- From Phase 2 onwards children, young people and adults with clinically significant levels of psychological trauma, will have access to Regional Trauma Network services, irrespective of the origin of their trauma.
- Throughout Phase 1 all members of the Northern Ireland population will continue to have access to existing psychological therapies and trauma services in the Adult and Child Health and Social Care Directorates, via existing pathways, based on their clinical need and irrespective of the origin of their trauma.

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<sup>68</sup> As per National Institute for Health and Care Excellence (NICE) Guidelines NG116 (2018).

## 7.1 Equality of Opportunity

The analysis in this section outlines:

- Overarching potential inequalities in relation to Conflict/Troubles-related trauma, in terms of the implementation of Phase 1; and
- Equality implications for each of the Section 75 groups, in terms of the full implementation of the service model.

For each Section 75 group, the analysis is structured in three steps as follows:

- Regional statistics, existing service user data and secondary research that shed light on the profile of potential and actual service users across the phased implementation period;
- Particular needs identified in relation to the Regional Trauma Network service and access criteria on that basis; and
- Mitigating actions that the Health and Social Care Board and Trusts will take in order to reduce any potential or actual needs identified.

In considering potential impacts for each Section 75 equality category, the Health and Social Care Board acknowledges the complexity of intersectional identity and lived experience, and that individuals may identify with more than one group descriptor.

### ***Geography and Inequality***

To obtain a sense of the potential geographic prevalence and distribution of Conflict/Troubles-related trauma specifically, it is helpful to consider the Cost of the Troubles study (Fay et al, 1998) findings in relation to Conflict/Troubles-related deaths, since it is reasonable to associate such deaths with experience of traumatic violence among survivors. The research found that:

- Calculating the rate of Conflict/Troubles-related deaths by ward found a concentration of deaths in Belfast with only 15 of the 57 highest ranking wards outside the Belfast area. Derry/Londonderry and Armagh account for most of the remaining wards.
- Wards with high deprivation scores predominate amongst those with the largest number of deaths.

The epidemiological research cited above provides an insight into the geographical spread of the onset of mental health disorders<sup>69</sup> following a traumatic event associated with the Conflict/Troubles. The researchers acknowledge that it is not possible to state with certainty whether there is an absolute causal link between the event and the disorder; nevertheless, the data is informative for the purposes of this assessment of geographical spread. The analysis is conducted to show the prevalence of these disorders among those who experienced a Conflict/Troubles-related event *by current Health and Social Care Trust area*. It reveals that between 40% and 50% of individuals living across all five Health and Social Care Trust areas who experienced a conflict-related traumatic event had a post-conflict mental health disorder (see CVS, 2011: 48-49).

The Victims and Survivors Service service user data sample provides information consistent with these findings: it shows that

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<sup>69</sup> In this research, 'disorders' designates a range of mental health disorders including anxiety disorders, mood disorders, substance disorders, and impulse-control disorders. Post-Traumatic Stress Disorder (PTSD) specifically falls into the category of anxiety disorders.

individuals registered with the Victims and Survivors Service for support and services come from across all six counties of Northern Ireland and therefore all five Health and Social Care Trust areas.

Health and Social Care Board current service user data reflects on the distribution of the Northern Ireland population across the five Health and Social Care Trust areas, and considers the rate of referral for psychological therapies in this context. This internal monitoring data confirms both a regional need for psychological therapy services and an increasing level of need for specialist trauma care.

A relationship between rates of Troubles/Conflict-related deaths and mental ill-health has been identified that highlights the correlation between key social determinants, including economic inequality and suicide rates.

Northern Ireland currently has the highest rate of suicide compared to any other region in the United Kingdom.<sup>70</sup> Inequalities between the 20% most deprived areas (defined using the NISRA Northern Ireland Multiple Deprivation Measure) and Northern Ireland as a whole are measured. In 2014, the Northern Ireland suicide rate was 16.2 deaths per 100,000 population in 2010-2012 (DHSSPS, 2014).<sup>71</sup> The rate in the most deprived areas was 30.7 suicides per 100,000, three times higher than in the least deprived areas (10.1 deaths per 100,000 population). Research suggests that traumatic events associated with the Northern Ireland Conflict/Troubles may be associated with suicidal ideation and plans, and this effect appears to be in addition to that explained by the presence of mental disorders (O'Neill et al, 2014).<sup>72</sup>

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<sup>70</sup> *Irish News*, 1 August 2018

(<https://www.irishnews.com/news/northernirelandnews/2018/08/01/news/suicide-rates-increase-in-northern-ireland-1396249/>) - refer to most recent statistics here: <https://www.nisra.gov.uk/publications/suicide-statistics>

<sup>71</sup> Department of Health, Social Services and Public Safety Northern Ireland. 2014. *Northern Ireland Health and Social Care Inequalities Monitoring System Regional Report*. Available at: <http://www.dhsspsni.gov.uk/hscims-2014-bulletin.pdf>

<sup>72</sup> O'Neill S, Ferry F, Murphy S, Corry C, Bolton D, et al. (2014) *Patterns of Suicidal Ideation and Behaviour in Northern Ireland and Associations with Conflict Related Trauma*. PLoS

### ***Rural Needs***

The Health and Social Care Board is cognisant of its duty to give due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services.<sup>73</sup>

In line with this duty, the Health and Social Care Board is conducting a Rural Needs Assessment in conjunction with this Equality Impact Assessment. This process will be conducted in close consultation with statutory and community and voluntary sector partners, including rural network representatives. It will ensure any particular needs arising and/or potential impacts on equality of access for those in rural areas are identified and monitored, and mitigating actions implemented.

### ***Summary***

In summary, the data on geographical distribution of the potential prevalence and distribution of Conflict/Troubles-related trauma and the growing need for psychological trauma therapy services shows that populations across all five Health and Social Care Trusts are likely to need Health and Social Care Regional Trauma Network services from Phase 1 onwards. A review of the data also suggests that people coming from areas of economic and social deprivation would likely be overrepresented amongst those in need of the service.

All Health and Social Care services are provided on the basis of clinical need, and from Phase 2 onwards Health and Social Care Regional Trauma Network services will be available to children, young people and adults who need psychological therapy to address significant trauma-related difficulties, irrespective of the origin of the trauma.

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ONE 9(3): e91532. Available at:

<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0091532>

<sup>73</sup> Per the Rural Needs Act (Northern Ireland) 2016: guidance and further information available here: <https://www.daera-ni.gov.uk/articles/rural-needs>



The needs of individuals who do not identify as victims/survivors during Phase 1 of the Health and Social Care element of the Regional Trauma Network implementation will be met by the existing provision of psychological therapies and trauma services in the Adult and Child Directorates within the Health and Social Care system, via existing pathways, based on their clinical need and irrespective of the origin of their trauma. A key role for the Regional Trauma Network will be to gather and examine new evidence in relation to levels of need in this area, and develop recommendations for wider service developments and improvements on that basis.

**Mitigating measures to address the impact of issues arising from a consideration of *Geography and Inequality*:**

- 1** From Phase 1 onwards, throughout the full implementation of the Regional Trauma Network service model, the five Health and Wellbeing Case Managers employed by the Victims and Survivors Service are aligned to and work directly with each Health and Social Care Trust. They are authorised through the 2016 Partnership Agreement between the Department of Health and The Executive Office to comprehensively assess needs and make referrals directly into the regional Health and Social Care Trust Local Trauma Teams of individuals who fulfil the Victims Order (2006), working with all agencies to ensure any geographic barriers to accessing services are overcome.
- 2** In line with its statutory duty, the Health and Social Care Board will conduct a Rural Needs Assessment in relation to the development and implementation of all phases of the Health and Social Care element of the Regional Trauma Network. This will ensure any particular needs arising and/or potential impacts on equality of access for those in rural areas are identified and monitored, and mitigating actions implemented.

**Mitigating measures to address the impact of issues arising from a consideration of *Geography and Inequality*:**

- 3** During implementation Phase 1, 100% of the population will continue to have access to existing provision of psychological therapies and trauma services in the Adult and Child Directorates of the Health and Social Care system, based on their clinical need and irrespective of the origin of their trauma.
- 4** All phases of the Health and Social Care element of the Regional Trauma Network are being designed to ensure there is parity of access to the highest quality trauma services across the region irrespective of where an individual lives. Regional Trauma Network therapists will ascertain if any barriers exist and work with the individual or other agencies to overcome these.
- 5** The Partnership Alliance for Learning from Lived Experience, the Regional Trauma Network Co-Production Forum, will advise the Regional Trauma Network Management of barriers to accessing services based on religion. This will inform the design of how, when, and where services are delivered. The Partnership Alliance for Learning from Lived Experience recruitment process will ensure the membership is representative of the demographic of the Northern Ireland population.

## **Gender**

In 2011, the Northern Ireland population was determined to include 1,810,863 people, of whom 49% were male and 51% were female (Census, 2011).

The size of the resident population in Northern Ireland at 30 June 2017 was estimated to be 1,870,834 people.<sup>74</sup> Just over half (50.8%) of the population were estimated to be female, with 950,600 females compared to 920,200 males.<sup>75</sup>

The annual rate of suicide for 2014 in Northern Ireland was higher for males (23.1 per 100,000) than for females (6.5 per 100,000). Data on 2014 suicide rates by gender shows that three quarters (n=207) were male (DHSSPS, 2014).

Epidemiological research has found that an estimated 39% of the Northern Ireland population, or around 524,000 individuals, have experienced a Conflict/Troubles-related traumatic event (CVS, 2011: 6, 27). Of that number, 61% are estimated to be males and 39% females.

Service user data from the Trauma Resource Centre bear a strong correlation with these epidemiological research findings. They show that in the period November 2016 to November 2017, more than three times as many men were assessed for services as women. Figure 1 below shows the gender breakdown for assessments over this period.

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<sup>74</sup> Northern Ireland Statistical and Research Agency (NISRA) data published online on 30 June 2018. Available at: <https://www.nisra.gov.uk/news/2017-mid-year-population-estimates-northern-ireland>

<sup>75</sup> See Northern Ireland Statistical and Research Agency (NISRA) infographic available at: <http://www.ninis2.nisra.gov.uk/InteractiveMaps/DataVis/NI%20Population%202017.pdf>

**Figure 1: Trauma Resource Centre Assessments Nov2016-Nov2017: Gender Distribution**

Gender	Number
Male	171
Female	35
Not Specified	30
<b>Total</b>	<b>236</b>

In contrast, service user data from the Victims and Survivors Service shows that more women than men access talking therapies and social support activities through the *Victims Support Programme*. This is shown in Figure 2 below.

**Figure 2: Victims and Survivors Service – Service User Data: Gender Distribution of Individuals Accessing Talking Therapies and Social Support Activities through the *Victims Support Programme***

Gender	Talking Therapies	Social Support Activities
Male	1,274	1,318
Female	1,701	1,833
<b>Total</b>	<b>2,975</b>	<b>3,151</b>

Victims and Survivors Service service user data in relation to the *Individual Needs Programme* shows that the number of men and women registered for support are approximately the same. This is shown in Figure 3 below.

**Figure 3: Victims and Survivors Service – Service User Data: Gender Distribution of Individuals Accessing Support through the *Individual Needs Programme***

Gender	Number
Male	2,948
Female	3,062
<b>Total</b>	<b>6,010</b>

These figures may reflect the prevalence of need and/or trends in help-seeking behaviour between men and women. They may also be influenced by the nature of the services available.

Research published as part of the Cost of the Troubles study (Fay et al, 1998) found that the overwhelming majority of those killed in the Conflict/Troubles were male, with the death risk highest in the younger age groups in the 20-24 age group, and almost 26% of all victims aged 21 or younger. This suggests that women may have been disproportionately impacted as witnesses and bereaved survivors of Conflict/Troubles-related traumatic violence, and as carers and household leaders in the aftermath.

This observation is reinforced by emerging scholarship and grassroots engagement and activism that argue for the importance of adopting a gender lens when considering the impact of the Conflict/Troubles (Legacy Gender Integration Group, 2015).<sup>76</sup> This trend is in keeping with a broader international acknowledgement of the role of women and girls in conflict and peacebuilding, and the health and well-being implications and impact of this dynamic (Conciliation Resources, 2014).<sup>77</sup>

<sup>76</sup> Legacy Gender Integration Group. (2015). *Gender Principles for Dealing with the Legacy of the Past*. Available at: [https://www.ulster.ac.uk/\\_data/assets/pdf\\_file/0009/66285/Gender-Principle-Report-Sept-2015\\_Final-Version.pdf](https://www.ulster.ac.uk/_data/assets/pdf_file/0009/66285/Gender-Principle-Report-Sept-2015_Final-Version.pdf)

<sup>77</sup> Conciliation Resources. (2014). *Gender in Peacebuilding*. Available at: [http://www.cr.org/downloads/CR\\_Gender\\_peacebuilding.pdf](http://www.cr.org/downloads/CR_Gender_peacebuilding.pdf)

The Police Service of Northern Ireland (PSNI) reported in 2017 that “the terrorist threat level to PSNI remains at “severe” (PSNI, 2017: 66)<sup>78</sup> and the incidence of paramilitary-style assaults and shooting remains high, with 87 such attacks occurring in a 12 month period in 2017-18 (Gray et al., 2018: 108).<sup>79</sup> This continuing violence predominantly, although not exclusively, involves and affects young men, and is assessed by researchers and policy analysts as part of the complex legacy of the Conflict/Troubles.<sup>80</sup>

The Northern Ireland Life and Times (NILT) survey provides important insight into help-seeking behaviours, with relevance to gender: in 2001 it asked the question: “Suppose you felt just a bit down or depressed. Who would you turn to first for help?”<sup>81</sup> The responses to this question are shown in Figure 4 below.

The information in Figure 4 shows that men who are married or in a partnership tend to turn to their partner for support when their mood is low, and that less than 10% of men turn to their General Practitioner (GP) or a health professional. They also show that women tend to turn to other sources of support more readily when in need, and in particular to *female* support networks including mothers, daughters, and sisters. This information suggests that men, and in particular single men, require additional supports to access services and treatment when they feel low, or experience mental health problems.

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<sup>78</sup> Police Service of Northern Ireland. (2017) *Annual Report and Accounts for the year ended 31 March 2017*. Available at: <https://www.psni.police.uk/globalassets/inside-the-psni/our-departments/finance-and-support-services/documents/main-report.pdf>. See also: <https://www.mi5.gov.uk/northern-ireland>

<sup>79</sup> See also: BBC News, 29 January 2018: “Paramilitary attacks ‘cause NHS problems’ says doctor” – Available at: <https://www.bbc.co.uk/news/uk-northern-ireland-42865859>

<sup>80</sup> For detailed analysis of a wide range of data in this context, see: Gray et al (2018).

<sup>81</sup> For details of the Northern Ireland Life and Times (NILT) survey and its findings, see: <https://www.ark.ac.uk/nilt/results/polatt.html>

**Figure 4: Northern Ireland Life and Times Survey Question: *Suppose you felt just a bit down or depressed. Who would you turn to first for help?***

Person I would turn to	Percentage of Respondents	
	MALES	FEMALES
Husband, wife, partner	58	35
Mother	7	10
Father	1	0
Daughter	1	9
Son	1	1
Sister	3	9
Brother	4	1
Other blood relative	0	1
In-law relative	0	1
Close friend	10	18
Neighbour	0	1
Someone you work with	0	1
Priest or member of the clergy	0	1
Family doctor	8	9
A psychologist/another professional counsellor	1	1
A self-help group	0	0
Someone else	0	1
No-one	5	2
Missing data	1	2

Limited data is available on the number of transgender people in Northern Ireland. However, research suggests that for the population as a whole:

- 140-160 individuals are affiliated with transgender groups;
- 120 individuals have presented with Gender Identity Dysphoria; and
- There are more transgender women than transgender men.<sup>82</sup>

Regional and international research highlights an increased risk of negative mental health outcomes for transgender people (Carmel & Erickson-Schroth, 2016),<sup>83</sup> and the negative impacts of experiences of discrimination and marginalisation, both direct and indirect, on the wider group of LGBTQ+ individuals are well established.

Monitoring of transgender identity is not reflected in the Trauma Resource Centre or Victims and Survivors Service service user data reviewed here. The level of need for accessible and supportive specialist mental health services for transgender people more generally is, however, demonstrated by research findings such as those published by the Scottish Government in 2012:<sup>84</sup> investigating the help-seeking behaviours of transgender people, the research found that more than half of the respondents (58%) felt that they had been so distressed at some point that they had needed to seek help or support urgently. When asked for more information about their experiences, 35% of those individuals had avoided seeking urgent help due to being trans or having a trans history. When participants did need urgent support they were most likely to contact their friends, followed by their General Practitioner (GP) or partner. Relatively few chose to use other National Health

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<sup>82</sup> McBride, R. (2011). *Healthcare issues for transgender people living in Northern Ireland*. Available at: <http://conflictresearch.org.uk/reports/equality-diversity/Healthcare-issues-for-transgender-individuals.pdf>

<sup>83</sup> Carmel, T. C. & Erickson-Schroth, L. (2016). 'Mental Health and the Transgender Population', *Journal of Psychosocial Nursing & Mental Health Services*, 54(12), pp. 44–48.

<sup>84</sup> McNeil, J., Bailey, L., Ellis, S., Morton, J., & Regan, M. (2012). *Trans mental health study 2012*. Available at [https://www.gires.org.uk/wp-content/uploads/2014/08/trans\\_mh\\_study.pdf](https://www.gires.org.uk/wp-content/uploads/2014/08/trans_mh_study.pdf)



Service support, choosing helplines or online groups over these; 18% also stated that they did nothing when in need of crisis support.

### **Summary**

Taking into account all of the information above, it is reasonable to conclude that while both men and women will be represented among those in need of Regional Trauma Network services, slightly more men may require treatment. Research has shown that men are less likely than women to display positive help-seeking attitudes, particularly in relation to common mental health issues (Wendt & Shafer, 2016).<sup>85</sup> In contrast to these findings, the service user data presented above appears to suggest there is positive help-seeking behaviour among men with Conflict/Troubles-related mental health and well-being needs. Nonetheless, in implementing all phases of the Health and Social Care element of the Regional Trauma Network, both men and women may need support to overcome social stigma and increase understanding of trauma to maximise access to the service for people with clinical levels of need.

Specific issues for women in relation to dependents and caring responsibilities will be addressed in section 3.1.7 *Dependant Status and Inequality*.

There is no specific data regarding transgender identity and the particular needs of this group at this early stage of implementing the Health and Social Care element of the Regional Trauma Network. Available research shows that it is reasonable to assume that transgender people will be under-represented among those in need of the service. This highlights the importance of monitoring uptake of services by transgender people, ensuring that service delivery is sensitive to the research findings discussed

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<sup>85</sup> Wendt, D. & Shafer, K. (2016). Gender and Attitudes about Mental Health Help Seeking: Results from National Data. *Health & Social Work*, 41:1 (e20-e28).

above and maximising opportunity of access and safety for transgender individuals.

All Health and Social Care services are provided on the basis of clinical need, and from Phase 2 onwards Health and Social Care Regional Trauma Network services will be available to children, young people, and adults who need psychological therapy to address significant trauma-related difficulties, irrespective of the origin of the trauma.

The needs of individuals who do not identify as victims/survivors during Implementation Phase 1 of the Health and Social Care element of the Regional Trauma Network will be met by the existing provision of psychological therapies and trauma services in the Adult and Child Directorates within the Health and Social Care system, via existing pathways, based on their clinical need and irrespective of the origin of their trauma. A key role for the Regional Trauma Network will be to gather and examine new evidence in relation to levels of need in relation to gender, and develop recommendations for wider service developments and improvements on that basis.

**Mitigating measures to address the impact of issues arising from a consideration of *Gender*:**

- 1** From Phase 1 onwards, throughout the full implementation of the Regional Trauma Network service model, the five Health and Wellbeing Case Managers employed by the Victims and Survivors Service are aligned to and work directly with each Health and Social Care Trust. They are authorised through the 2016 Partnership Agreement between the Department of Health and The Executive Office to comprehensively assess needs and make referrals directly into the regional Health and Social Care Local Trauma Teams of individuals who fulfil the Victims Order (2006), working with all agencies to ensure any barriers to accessing services due to gender are overcome.

**Mitigating measures to address the impact of issues arising from a consideration of *Gender*:**

- 2** All phases of the Health and Social Care element of the Regional Trauma Network are being designed to ensure there is parity of access to the highest quality trauma services across the region irrespective of an individual's gender. Regional Trauma Network therapists will ascertain if any barriers exist and work with the individual or other agencies to overcome these.
- 3** The Partnership Alliance for Learning from Lived Experience, the Regional Trauma Network Co-Production Forum, will advise the Regional Trauma Network Management of barriers to accessing services based on gender. This will inform the design of how, when, and where services are delivered. The Partnership Alliance for Learning from Lived Experience recruitment process will ensure the membership is representative of the demographic of the Northern Ireland population.
- 4** The Regional Trauma Network Training and Education Strategy will include delivery of Trauma awareness training with the aim of creating trauma-informed communities across the statutory, community, and voluntary sectors within Health and Social Care, Education, and Justice to reduce stigma and increase the understanding of trauma at a community level. This will include outreach to men's groups to encourage help seeking behaviour.
- 5** The Regional Trauma Network Management team will work closely with organisations representing the transgender community during the Phase 1 launch to better understand and overcome barriers to accessing services. Close work between voluntary and community sector organisations and mental health services in the area of trans support and outreach will enhance trans people's experiences of services, and the range of services that they access.

**Mitigating measures to address the impact of issues arising from a consideration of *Gender*:**

- 6** During implementation Phase 1, 100% of the population will continue to have access to existing provision of psychological therapies and trauma services in the Adult and Child Directorates of the Health and Social Care system, based on their clinical need and irrespective of the origin of their trauma.
- 7** The comprehensive assessment process for Regional Trauma Network services will take cognizance of an individual's gender and be paced accordingly. Collaborative and informed choice in relation to treatment options will also be respected.

## Age

Mid-year population estimates for the general population published by the Northern Ireland Statistics and Research Agency (NISRA) in 2018 show that:

- 74.1% of the population, or 1,386,796 people are aged 20 years and older; and
- 25.9% of the population or 484,038 people are aged 19 years old and younger.<sup>86</sup>

Health and Social Care Board current service user data draws on the NISRA statistics published in 2018, to show the age distribution of the Northern Ireland population across the five Health and Social Care Trust areas in three bands:

- 0 to 17 years: Children / Young People
- 18 to 64 years: Adults
- Over 65 years: Older People

The data shows that the vast majority of the population across the five Health and Social Care Trust areas is concentrated in the 18-64 years age band.

The Health and Social Care Board holds data in relation to children as part of Designated Statutory Function reporting from all five Health and Social Care Trusts. At September 2018 there were 2,266 children on the child protection register and 3,248 'looked after children'.

In 2017, a total of 22,737 children were recorded as being 'in need' in Northern Ireland; of that number, 20% were recorded as having a disability.<sup>87</sup>

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<sup>86</sup> See:

[http://www.ninis2.nisra.gov.uk/InteractiveMaps/Population%20Pyramid/2007\\_2017MYE/NINIS\\_Pyramid\\_2017.html](http://www.ninis2.nisra.gov.uk/InteractiveMaps/Population%20Pyramid/2007_2017MYE/NINIS_Pyramid_2017.html)

<sup>87</sup> A 'Child is in Need' if: a) *he or she is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development*

In 2011, epidemiological research profiled the age distribution of individuals who had experienced any Conflict/Troubles-related traumatic event by their age-group at the time of publication i.e. in 2011. This analysis was conducted across four age-bands, demonstrating that more than a third of individuals (36%) were aged 35-49. Around half of the individuals were evenly distributed across the categories 18-34 (26%) and 50-64 (24%), with a smaller proportion aged 65 and older (14%) (CVS, 2011: 29). The research also showed their age distribution at the time of the event itself: this showed that 80% of the people who had experienced a traumatic event were aged 29 or younger at the time (CVS, 2011: 30).

Belfast Health and Social Care Trust delivers two distinct specialist trauma services;

- The Trauma Resource Centre delivers services to adults and older people only to residents of the Belfast Health and Social Care Trust area with Conflict/Troubles related trauma; and
- The Family Trauma Centre delivers services across the region to children, young people and families with psychological trauma which includes but is not exclusively related to the Conflict/Troubles.

Trauma Resource Centre service user data shows that in the period November 2016 to November 2017, the majority of individuals assessed for treatment were aged 26 and older, with more than 60% of the individuals assessed aged 36-65. Figure 5

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*without the provision of services by an authority; b) his or her health or development is likely to be significantly impaired, or further impaired without the provision of such services; or c) he or she is disabled.* (Source: Children (Northern Ireland) Order 1995 – Guidance and Regulations). It is important to note, however, that there is no statutory requirement for a child with a disability to be registered with the Social Services; such issues may be dealt with by a GP only and Social Services may never be involved. The figures presented in this section therefore do not represent the prevalence of children with different disabilities in Northern Ireland but are rather a reflection of the service demand (DOH & NISRA, 2017).

below shows the detailed age breakdown for assessments over this period.

**Figure 5: Trauma Resource Centre Assessments Nov 2016 – Nov 2017: Age Distribution**

Age	Number
<18	0
18-25	11
26-35	49
36-45	46
46-55	48
56-65	51
>65	1
Not Specified	30
<b>Total</b>	<b>236</b>

This trend, where large numbers of individuals aged 36-65 are shown to access talking therapies in this area, is also reflected in the sample of service user data from the Victims and Survivors Service, as shown in Figure 6 below.

**Figure 6: Victims and Survivors Service – Service User Data: Age/Gender Distribution of Individuals Accessing Talking Therapies through the *Victims Support Programme***

Age	Number of MEN accessing talking therapies	Number of WOMEN accessing talking therapies
<b>0-17</b>	4	0
<b>18-25</b>	88	162
<b>26-35</b>	234	358
<b>36-45</b>	266	374
<b>46-55</b>	331	424
<b>56-65</b>	294	280
<b>66-75</b>	52	86
<b>76-85</b>	5	17
<b>Sub-total</b>	<b>1274</b>	<b>1701</b>
<b>TOTAL</b>	<b>2975</b>	

The Victims and Survivors Service service user data also shows that 160 individuals, or 5% of the service users, are older people aged 66 and older.

Overall, the age distribution which shows that more than 70% of service users are aged 36 and older is to be expected, given that the violence of the Conflict/Troubles began and was most intense over the period 1969 until 1997, when this age group was either children or young adults.

These observations are supported by the secondary research cited above: the Cost of the Troubles study (Fay et al, 1998)<sup>88</sup> found that for those killed between 1969 and 1998, the death risk highest in the younger age groups in the 20-24 age group, and

<sup>88</sup> Fay, M.T., Morrissey, M. & Smyth, M. (1998) *Mapping Troubles-Related Deaths in Northern Ireland 1969-1998*. INCORE: Derry Londonderry. (For information available online, see: <http://cain.ulst.ac.uk/issues/violence/cts/fay98.htm>.)



almost 26% of all victims aged 21 or younger. This demographic has aged over the intervening 20 years.

In contrast to the Trauma Resource Centre data, the Victims and Survivors Service service user sample shows that a large number of people aged 65 and older – 64 individuals or almost 22% of the sample – access support via Victims and Survivors Service funded organisations in the community and voluntary sector. These organisations deliver a broad range of Health and Well-being interventions from social support activities to psychological therapies. It is not possible to conclude from this information that this pattern of service access is a preference for this age group or an equality impact. Throughout all phases of implementation the Health and Social Care Board will work closely with Older Peoples Services and monitor equality of opportunity and access to Health and Social Care Regional Trauma Network services by older people and take mitigating actions as appropriate.

**Important note:** As per the reference to victims and survivors in the Stormont House Agreement, a priority in the Regional Trauma Network Implementation Phase 1 is to work in partnership with the Victims and Survivors Service and its network of funded organisations across the region to establish ready and safe access to trauma services for adults (age 18 and over) affected by Troubles/Conflict-related trauma. During this phase, a Children & Young People’s Pathway Development Working Group will be convened to design and develop a pathway to Regional Trauma Network services for children and young people, in line with the existing Child and Adolescent Mental Health Services (CAMHS) pathway.<sup>89</sup> Simultaneously, a pathway will also be developed for individuals with significant trauma symptoms that are not associated with Conflict/Troubles-related incident/s who experience barriers to accessing mental health services.

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<sup>89</sup> For more information, see: <http://www.hscboard.hscni.net/camhs-launch/> - full document available at:

[http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you\\_in\\_mind/21122018-HSCB-CAMHS-Pathway-Document.pdf](http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you_in_mind/21122018-HSCB-CAMHS-Pathway-Document.pdf)

## **Summary**

The Regional Trauma Network is being designed and developed as a lifespan service. The available data shows that there is a need for this service across all age ranges. During Phase 1, children and young people will continue to have access to the extensive range of existing psychological trauma services within Health and Social Care Trusts across the region, via existing pathways, based on their clinical need and irrespective of the origin of their trauma. Simultaneously, a Children and Young People's Pathway Development Working Group will explore the needs of children and young people, and will design an accessible and relevant service in line with the existing Child and Adolescent Mental Health Services (CAMHS) pathway.

Throughout the phased implementation of the Health and Social Care element of the Regional Trauma Network, the Health and Social Care Board is mindful that flexibility may need to be afforded to adults in employment, to enable them to attend regularly and consistently as required for their treatment. The location and time of Health and Social Care Regional Trauma Network service availability may therefore need to be tailored to the access requirements both of working-age adults, and older people with limited mobility.

The Health and Social Care Regional Trauma Network service will also need to support care-givers, on whom children and young people who require intervention rely, to enable regular and consistent attendance at appointments.

**Mitigating measures to address the impact of issues arising from a consideration of Age:**

- 1** From Phase 1 onwards, throughout the full implementation of the Regional Trauma Network service model, the Health and Wellbeing Case Managers are authorised through the 2016 Partnership Agreement between the Department of Health and The Executive Office to comprehensively assess needs and make referrals directly into the regional Health and Social Care Local Trauma Teams of individuals who fulfil the Victims Order (2006), working with all agencies to ensure any barriers to accessing services due to age are overcome. This will be particularly important for the older population who may require treatment for Post Traumatic Stress Disorder but who may also have more complex physical needs, the working age population, and caregivers of children who require treatment.
- 2** The Partnership Alliance for Learning from Lived Experience, the Regional Trauma Network Co-Production Forum, will advise the Regional Trauma Network Management of barriers to accessing services based on age. This will inform the design of how, when and where services are delivered. The Partnership Alliance for Learning from Lived Experience recruitment process will ensure the membership is representative of the demographic of the Northern Ireland population.
- 3** The comprehensive assessment process for Regional Trauma Network services will take cognizance of an individual's age and be paced accordingly. Collaborative and informed choice in relation to treatment options will also be respected.
- 4** During Phase 1, a Pathways Development Working Group will consider the way forward for improving access to trauma services for children and young people irrespective of the origin of their trauma. This process will consider the particular needs of this service user group, and will ensure

**Mitigating measures to address the impact of issues arising from a consideration of Age:**

issues arising are addressed by relevant mitigating actions, and monitored on an ongoing basis. It will also be conducted in line with the Department of Health's Co-production principles, ensuring the voices of younger people and young service users are included in the process.

**5** During implementation Phase 1, 100% of the population will continue to have access to existing provision of psychological therapies and trauma services in the Adult and Child Directorates of the Health and Social Care system, via existing pathways, based on their clinical need and irrespective of the origin of their trauma or their age.

**6** All phases of the Health and Social Care element of the Regional Trauma Network are being designed to ensure there is parity of access to the highest quality trauma services across the region irrespective of age. Regional Trauma Network therapists will ascertain if any barriers exist and work with the individual or other agencies to overcome these.

**7** The Health and Social Care Regional Trauma Network service will support care-givers, on whom children and young people who require intervention rely, to enable regular and consistent attendance at appointments.

## ***Religion***

At a population level, the most recent Census data (2011) reveals that:

- 45.14% (817, 424) of the population were either Catholic or brought up as Catholic.
- 48.36% (875, 733) stated that they were Protestant or brought up as Protestant.
- 0.92% (16, 660) of the population belonged to or had been brought up in other religions and Philosophies.
- 5.59% (101, 227) neither belonged to, nor had been brought up in a religion.

Whilst the majority of the population identify as either Catholic or Protestant, the demographic of the Northern Ireland population is changing as shown in the statistics outlined below in Section 3.1.9. Other religions and philosophies represented in Northern Ireland, involving 16,600 people, include Judaism, Islam, Hinduism and the Baha'i Faith.

Many minority ethnic communities have close social networks and strong cultural beliefs and practices, which can promote health and social well-being. However, some health issues and risk factors for ill health are more prevalent in minority ethnic communities. There is a need for more local data collection and monitoring of ethnicity and race categories across health and social care and other sectors, to provide more accurate data to inform targeted action to address health inequalities. The Health Alliance has identified the failure of some services to meet migrants' cultural or religious needs as one of the difficulties encountered by minority ethnic communities when trying to access health and social care services.<sup>90</sup>

The epidemiological research (CVS, 2011) referenced above does not analyse the prevalence of trauma or experience of

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<sup>90</sup> See: <http://healthallianceni.com/health-social-wellbeing/bme-groups/>

Conflict/Troubles-related traumatic incidents in terms of religious background.

Neither the Health and Social Care Board nor the Victims and Survivors Service monitor the religious background of their service users.

Contemporary analysis of the structures and dynamics of Northern Ireland society highlights persistent segregation between Catholic/Nationalist/ Republican (CNR) groups and communities on one hand, and Protestant/ Unionist/ Loyalist (PUL) communities on the other hand. In 2007, it was estimated that 35–40 per cent of Protestants and Catholics live in communities divided along ethno-sectarian lines (Hughes et al, 2007),<sup>91</sup> and more recent empirical research underlines pervasive problems associated with building trust and developing and maintaining peaceful and confident social interactions and engagement across community, religious and political divisions (see Gray et al, 2018).<sup>92</sup>

### **Summary**

Based on the available data, it can be reasonably assumed that people from all religious backgrounds may have a clinical need for Health and Social Care Regional Trauma Network services throughout the phased implementation period; however, individuals from religions other than Catholic and Protestant backgrounds may be under-represented in Phase 1. Given that the population was almost exclusively indigenous to Northern Ireland and therefore predominately Catholic or Protestant during the period of the Conflict/Troubles, it is to be expected that the majority of individuals experiencing Conflict/Troubles-related Post Traumatic Stress Disorder and Complex Post Traumatic Stress Disorder will be from these religious backgrounds.

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<sup>91</sup> Hughes, J., Campbell, A., Hewstone, M, & Cairns, E. (2007). Segregation in Northern Ireland: Implications for Community Relations Policy. *Policy Studies*, 28: 1(33-53).

<sup>92</sup> See also: Kelly, G. (2012). *Progressing Good Relations and Reconciliation in Post-Agreement Northern Ireland*. Derry/Londonderry: INCORE. Available at: [http://uir.ulster.ac.uk/21681/1/Reconciliation\\_Research\\_Report\\_Kelly.pdf](http://uir.ulster.ac.uk/21681/1/Reconciliation_Research_Report_Kelly.pdf)

As noted previously, during Phase 1, work will be undertaken to develop a pathway for individuals with significant trauma symptoms that are not associated with Conflict/Troubles-related incident/s who experience barriers to accessing mental health services. This will involve significant engagement with organisations representing those in the population from other religions and philosophies, to ensure the Health and Social Care Board understands the particular cultural and religious barriers to engaging safely and effectively in Health and Social Care. Ongoing data collection and monitoring will ensure any identified inequalities and barriers are mitigated against.

The wider context of social division, ongoing threat, and real violence, and the impact of this context on people with Conflict/Troubles-related trauma, are important considerations for the implementation and delivery of all phases of the Health and Social Care element of the Regional Trauma Network. They underline the need for a regional service that can accommodate individuals who need treatment in locations where they feel safe. They also underline the importance of ensuring that the Health and Social Care staff members responsible for conducting assessments and providing treatment deliver neutral, non-judgemental care, governed by robust standards. Key service user and carer values underpinning these standards include: dignity, respect, independence, rights, choice, safety and confidentiality.

**Mitigating measures to address the impact of issues arising from a consideration of *Religion*:**

- 1** From Phase 1 onwards, throughout the full implementation of the Regional Trauma Network service model, the Health and Wellbeing Case Managers are authorised through the 2016 Partnership Agreement between the Department of Health and The Executive Office to comprehensively assess needs and make referrals directly into the regional Health and Social Care Local Trauma Teams of individuals who fulfil the Victims Order (2006), working with all agencies to ensure any barriers to accessing services due to religion are overcome. This will include ensuring the individual feels safe.
- 2** The comprehensive assessment process will ascertain if any barriers to accessing treatment exist due to an individual's particular religious beliefs, and flexibility of service provision will be enabled to overcome these, e.g. a female therapist may be preferred in some religious cultures.
- 3** The Partnership Alliance for Learning from Lived Experience, the Regional Trauma Network Co-Production Forum, will advise the Regional Trauma Network Management of barriers to accessing services based on religion. This will inform the design of how, when, and where services are delivered. The Partnership Alliance for Learning from Lived Experience recruitment process will ensure the membership is representative of the demographic of the Northern Ireland population.
- 4** During Phase 1, work will be undertaken to develop a pathway for individuals with significant trauma symptoms that are not associated with Conflict/Troubles-related incident/s who experience barriers to accessing mental health services. This will involve significant engagement with organisations representing those in the population from other religions and philosophies, to ensure the Health and Social Care Board understands the particular cultural and religious barriers to engaging safely and effectively in Health and Social Care services.



**Mitigating measures to address the impact of issues arising from a consideration of *Religion*:**

- 5** During implementation Phase 1, 100% of the population will continue to have access to existing provision of psychological therapies and trauma services in the Adult and Child Directorates of the Health and Social Care system, via existing pathways, based on their clinical need and irrespective of the origin of their trauma or their religion.
- 6** All phases of the Health and Social Care element of the Regional Trauma Network are being designed to ensure there is parity of access to the highest quality trauma services across the region irrespective of religion. Regional Trauma Network therapists will ascertain if any barriers exist and work with the individual or other agencies to overcome these.

### ***Political Opinion***

At a population level, the Northern Ireland Life and Times (NILT) survey is a key source that provides important insight into political opinions held by people in this region. It asks the question: “Generally speaking, do you think of yourself as a unionist, a nationalist, or neither?” The responses to this question in the most recent survey (2017)<sup>93</sup> are shown in Figure 7 below.

**Figure 7: Northern Ireland Life and Times Survey Question: *Generally speaking, do you think of yourself as a unionist, a nationalist or neither?***

Category	Percentage of respondents
<b>Unionist</b>	32%
<b>Nationalist</b>	21%
<b>Neither</b>	45%
<b>(Other)</b>	1%
<b>Don't know</b>	2%

A significant proportion of the Northern Ireland population does not vote in elections, including young people in particular.

No data exists on the political opinion of the population of those from other religions and philosophies outlined in Section 3.1.4.

The epidemiological research (CVS, 2011) referenced above does not analyse the prevalence of trauma or experience of Conflict/Troubles-related traumatic incidents in terms of political background.

<sup>93</sup> For details of the Northern Ireland Life and Times (NILT) survey and its findings, see: <https://www.ark.ac.uk/nilt/results/polatt.html>

Similarly, neither the Health and Social Care Board nor the Victims and Survivors Service monitor the political opinion of their service users.

Contemporary analysis of the structures and dynamics of Northern Ireland society highlights persistent segregation between Catholic/ Nationalist/ Republican (CNR) groups and communities on one hand, and Protestant/ Unionist/ Loyalist (PUL) communities on the other hand. In 2007, it was estimated that 35–40 per cent of Protestants and Catholics live in communities divided along ethno-sectarian lines,<sup>94</sup> and more recent empirical research underlines pervasive problems associated with building trust and developing and maintaining peaceful and confident social interactions and engagement across community, religious and political divisions (see Gray et al, 2018).<sup>95</sup>

In this context of societal division and segregation, the Police Service of Northern Ireland (PSNI) reported in 2017 that “the terrorist threat level to PSNI remains at “severe””,<sup>96</sup> and the incidence of paramilitary-style assaults and shooting remains high, with 87 such attacks occurring in a 12 month period in 2017-18 (Gray et al, 2018).<sup>97</sup>

These continuing and pervasive issues are analysed and assessed by researchers and policy analysts as part of the complex legacy of the Conflict/Troubles.<sup>98</sup>

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<sup>94</sup> Hughes, J., Campbell, A., Hewstone, M., & Cairns, E. (2007). Segregation in Northern Ireland: Implications for Community Relations Policy. *Policy Studies*, 28: 1(33-53).

<sup>95</sup> See also: Kelly, G. (2012). *Progressing Good Relations and Reconciliation in Post-Agreement Northern Ireland*. Derry/Londonderry: INCORE. Available at: [http://uir.ulster.ac.uk/21681/1/Reconciliation\\_Research\\_Report\\_Kelly.pdf](http://uir.ulster.ac.uk/21681/1/Reconciliation_Research_Report_Kelly.pdf)

<sup>96</sup> Police Service of Northern Ireland. (2017) *Annual Report and Accounts for the year ended 31 March 2017*. Available at: <https://www.psni.police.uk/globalassets/inside-the-psni/our-departments/finance-and-support-services/documents/main-report.pdf>. See also: <https://www.mi5.gov.uk/northern-ireland>

<sup>97</sup> See also: BBC News, 29 January 2018: “Paramilitary attacks ‘cause NHS problems’ says doctor” – Available at: <https://www.bbc.co.uk/news/uk-northern-ireland-42865859>

<sup>98</sup> For detailed analysis of a wide range of data in this context, see: Gray et al (2018).

## **Summary**

Based on the available data, it can be reasonably assumed that people from all political backgrounds may have a clinical need for Health and Social Care Regional Trauma Network services throughout the phased implementation period.

The wider context of social division, ongoing threat, and real violence, and the impact of this context on people with Conflict/Troubles-related trauma, as well as the data in relation to Ethnicity outlined below in section 3.1.8, are important considerations for the delivery of all of the implementation phases of the Health and Social Care element of the Regional Trauma Network. They underline the need for a regional service that can accommodate individuals who need treatment in locations where they feel safe. They also underline the importance of ensuring that the Health and Social Care staff members responsible for conducting assessments and providing treatment deliver neutral, non-judgemental care, governed by robust standards. Key service user and carer values underpinning these standards include dignity, respect, independence, rights, choice, safety and confidentiality.

### **Mitigating measures to address the impact of issues arising from a consideration of *Political Opinion*:**

- 1** From Phase 1 onwards, throughout the full implementation of the Regional Trauma Network service model, the Health and Wellbeing Case Managers are authorised through the 2016 Partnership Agreement between the Department of Health and The Executive Office to comprehensively assess needs and make referrals directly into the regional Health and Social Care Local Trauma Teams of individuals who fulfil the Victims Order (2006), working with all agencies to ensure any barriers to accessing services due to political opinion are overcome. This will be particularly important in relation to the person seeking treatment feeling safe.

**Mitigating measures to address the impact of issues arising from a consideration of *Political Opinion*:**

- 2** Political Opinion is neither sought nor deemed relevant when providing Health and Social Care, however, the comprehensive assessment process will identify if an individual feels there are any barriers to accessing treatment due to their particular political opinion. Flexibility of service provision may be enabled to overcome these, e.g. a venue that is conducive to treatment but feels safe for the individual.
- 3** The Partnership Alliance for Learning from Lived Experience, the Re Co-Production Forum, will advise the Regional Trauma Network Management of barriers to accessing services based on political opinion. This will inform the design of how, when, and where services are delivered. The Partnership Alliance for Learning from Lived Experience recruitment will ensure the membership is representative of the demographic of the Northern Ireland population.
- 4** During implementation Phase 1, 100% of the population will continue to have access to existing provision of psychological therapies and trauma services in the Adult and Child Directorates of the Health and Social Care system, via existing pathways, based on their clinical need and irrespective of the origin of their trauma.
- 5** All phases of the Health and Social Care element of the Regional Trauma Network are being designed to ensure there is parity of access to the highest quality trauma services across the region irrespective of political opinion. Regional Trauma Network therapists will ascertain if any barriers exist and work with the individual or other agencies to overcome these.

### ***Marital Status***

The most recent census (Census, 2011) showed that, across the Northern Ireland population:

- 47.56% (680,840), or almost one in two of people aged 16 or over were married.
- 36.14% (517,359) were single.
- 0.09% (1,288) were registered in same-sex civil partnerships.
- 9.43% (134,994) were either divorced, separated, or formerly in a same-sex partnership.
- 6.78% (97,058) were either widowed or a surviving partner.

Annual Reports of the Registrar General for Northern Ireland show that between 2005 and 2017 inclusive, 1,202 civil partnerships were registered in Northern Ireland.

The Northern Ireland Life and Times (NILT) survey, also referenced in section 3.1.1 above, provides insight into help-seeking behaviours, with relevance to marital status: in 2001 it asked the question: “Suppose you felt just a bit down or depressed. Who would you turn to first for help?”<sup>99</sup> The responses to this question are shown in Figure 8 below.

The data in Figure 8 show that men who are married or in a partnership tend to turn to their partner for support when their mood is low, and that less than 10% of men turn to their General Practitioner (GP) or a health professional. They also show that women tend to turn to other sources of support more readily when in need, and in particular to female support networks including mothers, daughters and sisters. This information suggests that men, and in particular *single men*, require additional supports to access services and treatment when they feel low, or experience mental health problems.

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<sup>99</sup> For details of the Northern Ireland Life and Times (NILT) survey and its findings, see: <https://www.ark.ac.uk/nilt/results/polatt.html>

**Figure 8: The Northern Ireland Life and Times Survey**  
**Question: *Suppose you felt just a bit down or depressed.***  
***Who would you turn to first for help?***

Person I would turn to	Percentage of Respondents	
	MALES	FEMALE S
Husband, wife, partner	58	35
Mother	7	10
Father	1	0
Daughter	1	9
Son	1	1
Sister	3	9
Brother	4	1
Other blood relative	0	1
In-law relative	0	1
Close friend	10	18
Neighbour	0	1
Someone you work with	0	1
Priest or member of the clergy	0	1
Family doctor	8	9
A psychologist /another professional counsellor	1	1
A self-help group	0	0
Someone else	0	1
No-one	5	2
Missing data	1	2

Trauma Resource Centre service user data shows that in the period November 2016 to November 2017, almost half (47%) of the individuals assessed for treatment were single (n=110).

The data also shows that more than a third (37%) of the individuals assessed were married, divorced/separated or selected status 'other'. This information is shown in Figure 9 below.

**Figure 9: Trauma Resource Centre Assessments Nov 2016 – Nov 2017: Marital Status**

Marital Status	Number
1 Single	110
2 Married	33
3 Separated	29
4 Divorced	21
5 Other	5
Not Specified	38
<b>Total</b>	<b>236</b>

Neither the Health and Social Care Board current service user data for non-inpatient psychological therapies nor the Victims and Survivors Service service user data sample currently provides information in relation to marital status.

### **Summary**

Based on the available data, it can be reasonably assumed that the people who will need to access Health and Social Care Regional Trauma Network services from Phase 1 onwards will include individuals who identify with the full range of marriage status groups (i.e. married, single, same-sex civil partnership, divorced, separated, formerly in a same-sex partnership or widowed/surviving partner).



In implementing the Health and Social Care element both of Phase 1 of the Regional Trauma Network, and the full service, the Health and Social Care Board is mindful that additional supports may be required by single people and single men in particular, in terms of both coming forward to seek help, and attending regularly and consistently as required for their treatment.

**Mitigating measures to address the impact of issues arising from a consideration of *Marital Status*:**

- 1** From Phase 1 onwards, throughout the full implementation of the Regional Trauma Network service model, the Health and Wellbeing Case Managers are authorised through the 2016 Partnership Agreement between the Department of Health and The Executive Office to comprehensively assess needs and make referrals directly into the regional Health and Social Care Local Trauma Teams of individuals who fulfil the Victims Order (2006), working with all agencies to ensure any barriers to accessing services due to marital status are overcome. Learning from this process will be incorporated into the delivery of the full Regional Trauma Network service.
- 2** The Partnership Alliance for Learning from Lived Experience, the Regional Trauma Network Co-Production Forum, will advise the Regional Trauma Network Management of barriers to accessing services based on marital status. This will inform the design of how, when, and where services are delivered. The Partnership Alliance for Learning from Lived Experience recruitment process will ensure the membership is representative of the demographic of the Northern Ireland population.
- 3** The Regional Trauma Network Training and Education Strategy will include delivery of Trauma awareness training with the aim of creating trauma-informed communities across the statutory, community, and voluntary sectors within Health and Social Care, Education, and Justice. A

**Mitigating measures to address the impact of issues arising from a consideration of *Marital Status*:**

core aim of this activity will be to reduce stigma and increase the understanding of trauma at a community level, and to engage with men’s groups, so that single men in particular are encouraged to access services.

**4** Individuals will have access to high quality services within the Health and Social Care Regional Trauma Network local trauma teams which recognise the impact of living with someone suffering from Post Traumatic Stress Disorder. This approach improves engagement with services and outcomes for recovery.

**5** During Phase 1, 100% of the population will continue to have access to existing provision of psychological therapies and trauma services in the Adult and Child Directorates of the Health and Social Care system, via existing pathways, based on their clinical need and irrespective of the origin of their trauma.

**6** All phases of the Health and Social Care element of the Regional Trauma Network are being designed to ensure there is parity of access to the highest quality trauma services across the region irrespective of marital status. Regional Trauma Network therapists will ascertain if any barriers exist and work with the individual or other agencies to overcome these.

**7** The comprehensive assessment process for Regional Trauma Network services will take cognizance of an individual’s marital status and be paced accordingly. Collaborative and informed choice in relation to treatment options will also be respected.

### ***Dependant Status***

Dependant status relates to both parenting and wider care responsibilities, i.e. looking after an ill, older, or disabled family member, friend, or partner for few hours a week, or full time.

The most recent census (Census, 2011) revealed that 33.9% of all households in Northern Ireland, which equated to 238,094 households, had dependent children. Of this number, 115,959 were lone parent households. 16,691 of these were male-headed households, and 99,268 were female-headed households.

The census also showed that approximately one-in-eight residents in Northern Ireland have carer responsibilities, which equates to around 220,000 people. Data that is available in relation to the characteristics and circumstances of carers shows that:<sup>100</sup>

- More than 60% of carers are aged between 35 and 64 years old.
- A substantial proportion of carers have a long-term health issue or disability themselves.
- Many carers report that caring results in a negative and often lasting impact on their general physical and mental health.
- Many carers report that caring responsibilities create and exacerbate financial hardship, especially when the role requires them to leave work or reduce working hours.
- Young carers account for 4% of all carers in Northern Ireland.
- Around 6,700 young people (aged 0-17) provide between 1 and 19 hours of unpaid care per week. An additional 960

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<sup>100</sup> See: Russell, R. (2017). *Background Information and Statistics on Carers in Northern Ireland – Research and Information Service Briefing Paper*. Belfast: Northern Ireland Assembly. Available at:

<http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2017-2022/2017/health/2517.pdf> ; and

See: Carers NI. (2017). *State of Caring in Northern Ireland 2017*. Available at: <https://www.carersuk.org/northernireland/policy/policy-library/state-of-caring-in-northern-ireland-2017-2>

young people provide 20 – 49 hours of unpaid care per week, and around 820 for 50 hours or more per week.

In 2017 the Northern Ireland Life and Times (NILT) survey<sup>101</sup> found that women were more likely than men to confirm that they carry carer responsibilities.

Analysis of Carers Allowance claims by the Northern Ireland Council for Voluntary Action (NICVA) and The Detail Data shows that 64% of carers are women. The same research suggests that almost half of carers have been caring for 35 hours or more a week for longer than five years.<sup>102</sup>

Dependant status is not currently reflected in the Health and Social Care Board current internal service user data for non-inpatient psychological therapies, the Trauma Resource Centre service user data, or the Victims and Survivors Service service user data sample.

The epidemiological research (CVS, 2011) on the impact of Conflict/Troubles-related traumatic events does not monitor or reflect dependant status.

### **Summary**

Based on the available data, it can be reasonably assumed that the people who will need to access Health and Social Care Regional Trauma Network services from Phase 1 onwards will include individuals both with and without dependant responsibilities, with a potential for slightly more women and increasing numbers of younger people with both parenting and carer responsibilities represented.

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<sup>101</sup> For details of the Northern Ireland Life and Times (NILT) survey and its findings, see: <https://www.ark.ac.uk/nilt/results/polatt.html>

<sup>102</sup> See: <http://data.nicva.org/article/who-cares-about-carers>

In implementing the Health and Social Care element both of Phase 1 of the Regional Trauma Network, and the full service, additional supports may be required by single parents and carers. This may include requirements for flexibility and arrangements that support individuals both to come forward to seek help and to attend regularly and consistently as required for their treatment.

**Mitigating measures to address the impact of issues arising from a consideration of *Dependant Status*:**

- 1** From Phase 1 onwards, throughout the full implementation of the Regional Trauma Network service model, the Health and Wellbeing Case Managers are authorised through the 2016 Partnership Agreement between the Department of Health and The Executive Office to comprehensively assess needs and make referrals directly into the regional Health and Social Care Local Trauma Teams of individuals who fulfil the Victims Order (2006), working with all agencies to ensure any barriers to accessing services due to caring responsibilities are overcome. Learning from this process will be incorporated into the delivery of the full Regional Trauma Network service.
- 2** The Partnership Alliance for Learning from Lived Experience, the Regional Trauma Network Co-Production Forum, will advise the Regional Trauma Network Management of barriers to accessing services based on dependant status. This will inform the design of how, when, and where services are delivered. The Partnership Alliance for Learning from Lived Experience, recruitment process will ensure the membership is representative of the demographic of the Northern Ireland population.
- 3** Individuals will have access to high quality, evidence-based family therapy approaches within the Health and Social Care Regional Trauma Network local trauma teams that recognise the impact of living with someone suffering from Post Traumatic Stress Disorder. This approach improves engagement with services and outcomes for recovery.

**Mitigating measures to address the impact of issues arising from a consideration of *Dependant Status*:**

- 4 During Phase 1, a Pathways Development Working Group will consider the way forward for improving access to trauma services for children and young people, in line with the existing Child and Adolescent Mental Health Services (CAMHS) pathway,<sup>103</sup> which includes consideration of the needs of young carers. This process will consider the particular needs of this service user group, and will ensure issues arising are addressed by relevant mitigating actions, and monitored on an ongoing basis.
- 5 During implementation Phase 1, 100% of the population will continue to have access to existing provision of psychological therapies and trauma services in the Adult and Child Directorates of the Health and Social Care system, based on their clinical need and irrespective of the origin of their trauma.
- 6 All phases of the Health and Social Care element of the Regional Trauma Network are being designed to ensure there is parity of access to the highest quality trauma services across the region irrespective of dependant status. Regional Trauma Network therapists will ascertain if any barriers exist and work with the individual or other agencies to overcome these.
- 7 The comprehensive assessment process for Regional Trauma Network services will take cognizance of an individual's dependant status and be paced accordingly. This may include requirements for flexibility and arrangements that support individuals both to come forward to seek help and to attend regularly and consistently as required for their treatment. Collaborative and informed choice in relation to treatment options will also be respected and in line with Health and Social Care responsibilities carers will be offered a Carers Needs Assessment and carer support services.

<sup>103</sup> For more information, see: <http://www.hscboard.hscni.net/camhs-launch/> - full document available at:

[http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you\\_in\\_mind/21122018-HSCB-CAMHS-Pathway-Document.pdf](http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you_in_mind/21122018-HSCB-CAMHS-Pathway-Document.pdf)

## ***Disability***

The most recent census (Census, 2011) revealed that 20.69% of the population (or 374,668 people) regard themselves as having a disability or long-term health problem, which has an impact on their day to day activities. 68.57% of the population (1,241,709 people) have no long-term health condition.

Specific long-term health conditions identified across the population (Census, 2011) include:

- Deafness or partial hearing loss – 5.14% (93,078 people)
- Blindness or partial sight loss – 1.7% (30,785 people)
- Communication Difficulty – 1.65% (29,879 people)
- Mobility or Dexterity Difficulty – 11.44% (207,163 people)
- A learning, intellectual, social or behavioural difficulty – 2.22% (40,201 people)
- An emotional, psychological or mental health condition – 5.83% (105,573 people)
- Long-term pain or discomfort – 10.10% (182,897 people)
- Shortness of breath or difficulty breathing – 8.72% (157,907 people)
- Frequent confusion or memory loss – 1.97% (35,674 people)
- A chronic illness (such as cancer, HIV, diabetes, heart disease or epilepsy) – 6.55% (118,612 people)
- Other condition – 5.22% (94,527 people)

On Census Day 2011, two-fifths (40%) of households contained at least one person with a long-term health problem or disability. Of those households, 9.2% had dependent children, and 31% none.

The most recent official statistics collected via the Health Survey Northern Ireland (2017)<sup>104</sup> show that:

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<sup>104</sup> For more information on Health Survey NI (2016/17) see: <https://www.health-ni.gov.uk/publications/tables-health-survey-northern-ireland>

- 42% of respondents reported a longstanding illness (30% limiting and 12% non-limiting illness);
- 27% of Males reported a limiting longstanding illness, while 12% reported a non-limiting longstanding illness;
- 33% of Females reported a limiting longstanding illness, while 12% reported a non-limiting longstanding illness;
- Prevalence of disability increases with age: limiting longstanding illness increases from 15% among young adults aged 25 -34 years to 61% among those who are aged 75 years old;
- Around a fifth of respondents (18%) scored highly on the GHQ12 (a mental health screening tool) suggesting they may have a mental health problem; and
- Respondents in the most deprived areas (22%) continue to be more likely to record a high GHQ12 (mental health screening tool) score than those in the least deprived areas (15%).

Research shows significant associations between the experience of traumatic events, Post Traumatic Stress Disorder and chronic physical health conditions (Ferry et al, 2008).<sup>105</sup>

Epidemiological research published by the Commission for Victims and Survivors considers the association of Troubles/Conflict-related trauma and ‘post-conflict’ disorders with chronic physical health conditions. It finds that almost one in five individuals (19.8%) who have had a Conflict/Troubles-related experience have had arthritis or rheumatism at some point in their life, compared to 24.1% who experienced a non-conflict related traumatic event, and 13.9% of those who did not experience any traumatic event. Individuals who experienced a traumatic event, whether Conflict/Troubles-related or otherwise, were more likely than those who did not experience any type of traumatic event to

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<sup>105</sup> Ferry, F., Bolton, D., Bunting, B., Devine, B., McCann, S. & Murphy, S. (2008). *Trauma, Health and Conflict in Northern Ireland: A study of the epidemiology of trauma related disorders and qualitative investigation of the impact of trauma on the individual*. Londonderry & Omagh: The Northern Ireland Centre for Trauma and Transformation & The Psychology Research Institute, University of Ulster.



have a specific chronic physical health condition (CVS, 2011: 19, 54-56).

A report commissioned by the Northern Ireland Community Relations Council (Breen-Smyth, 2012)<sup>106</sup> noted a lack of evidence-based research on disability as a result of the Troubles/Conflict. It considers the needs of individuals who have 'life threatening or disfiguring physical injuries', and makes the following key observations:

- No comprehensive census of those injured is available; therefore, it is not easy to provide a definitive estimate of the number of people who are living with injury as a result of the Troubles/Conflict.
- The size of the population of those injured as a result of the Troubles/Conflict will depend upon how 'injury' is defined.
- Current estimates of numbers of people injured range from 8,383 to 100,000: this variation is due to disparities in definition and changing practices in record keeping, including the destruction of some records.
- Many people sustained severe and traumatic injuries, which have had long-term effects on all aspects of their lives.
- Injuries included blast and gunshot damage, loss of limbs, and loss of hearing and vision.
- Some people have injuries that are not visible, for example, as a result of embedded shrapnel or gunshot wounds, which continue to cause pain and distress.
- Those with injuries that are not as visible report a sense that they are suspected of malingering and a lack of sympathy with their condition.
- The majority of people injured in the Troubles/Conflict are now experiencing deteriorating health and increased dependency due to the combination of ageing and the limitations placed on them by their injuries.

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<sup>106</sup> Breen-Smyth, M. (2012). *The needs of individuals and their families injured as a result of the Troubles in Northern Ireland*. Belfast: WAVE Trauma Centre. Available at: <http://www.wavetraumacentre.org.uk/campaigns/the-injured-campaign-recognition-for-all>

- Injured people expressed concern about both the lack of access to services such as emotional support, counselling, psychological treatment of trauma symptoms, family support, and care for carers.
- In most cases, partners and families, including children, are the primary carers of injured people and cope with the long-term physical and psychological effects of injury, disability, and caring on both themselves and their injured relatives.

The Northern Ireland Statistics and Research Agency's (NISRA) September 2010 Omnibus Survey incorporated questions on behalf of the CVS relating to victims and survivors of the Troubles/Conflict. The questions sought to obtain population-based estimates of the proportion of people in Northern Ireland who were affected in a direct way by the violence. The results indicated that an average of 6% of the population had suffered physical injury as a result of the Troubles/Conflict (CVS, 2014: 15).

Neither the Health and Social Care Board current service user data for *non-inpatient psychological therapies* nor the Trauma Resource Centre service user data reflect information in relation to disability.

The Victims and Survivors Service service user data samples show that 877 individuals in receipt of direct support from the organisation qualify for the High Rate Care Component of Disability Living Allowance (or the equivalent Personal Independence Payment provision). No data is available in relation to Mobility Component claimants, as this information is not collated by the Victims and Survivors Service. 230 individuals currently access direct support to cope with persistent and chronic pain.

### **Summary**

Based on the available data, it may be concluded that the prevalence of disability reflected in the statistics cited above will be represented in the population accessing Health and Social Care

Regional Trauma Network services from Phase 1 onwards, with a potential for more people with chronic pain, chronic physical health conditions, and mobility issues needing treatment across the phased implementation process.

Flexibility may need to be afforded to people with significant physical disability, to enable them to attend regularly and consistently as required for their treatment, e.g. the location and time of Health and Social Care Regional Trauma Network service availability may need to be tailored to the access requirements of the individual.

Those with a hearing impairment may have additional communication issues when both accessing and using the service, which may require engaging sign language interpreters, and those with impaired vision may require information to be provided in different formats e.g. audio format/braille/large print.

The Health and Social Care Board recognises that individuals with cognitive/learning disabilities may have trauma-related psychological difficulties and specialised needs on this basis. The future design and development of Regional Trauma Network services will take this into account.

On balance, it may be concluded that the Health and Social Care element of the Regional Trauma Network will have a positive impact across its phased implementation process on individuals with disabilities who may be in clinical need of this service, as well as for their carers and family members.

**Mitigating measures to address the impact of issues arising from a consideration of *Disability*:**

- 1 The Health and Social Care aspect of the Regional Trauma Network will be available across the region and access to services will be based solely on clinical need. The comprehensive assessment process will ascertain if any barriers to access treatment exists due to an individual's disability or disabilities, and flexibility of service provision will be required to overcome these.
- 2 The comprehensive assessment process for Regional Trauma Network services will take cognizance of an individual's disability or disabilities and be paced accordingly. Collaborative and informed choice in relation to treatment options will be respected.
- 3 From Phase 1 onwards, throughout the full implementation of the Regional Trauma Network service model, the Health and Wellbeing Case Managers are authorised through the 2016 Partnership Agreement between the Department of Health and The Executive Office to comprehensively assess needs and make referrals directly into the regional Health and Social Care Local Trauma Teams of individuals who fulfil the Victims Order (2006), working with all agencies to ensure any barriers to accessing services due to disability are overcome. This is particularly important in relation to the population who both have complex physical and/or mental health needs and require treatment for Post Traumatic Stress Disorder or Complex Post Traumatic Stress Disorder. Learning from this process will be incorporated into the delivery of the full Regional Trauma Network service.
- 4 The Partnership Alliance for Learning from Lived Experience, the Regional Trauma Network Co-Production Forum, will advise the Regional Trauma Network Management of barriers to accessing services based on disability. This will inform the design of how, when, and where services are delivered. The Partnership Alliance for Learning from Lived

**Mitigating measures to address the impact of issues arising from a consideration of *Disability*:**

Experience recruitment process will ensure the membership is representative of the demographic of the Northern Ireland population.

**5** The Regional Trauma Network Training and Education Strategy will include evidence-based training in treating individuals with Post Traumatic Stress Disorder who also have visual and/or hearing impairment, in line with current national and international guidelines.

**6** Tailored information and treatment options will be provided for those with physical and/or mental health impairments or disabilities in line with the Health and Social Care Board *Accessible Formats Policy for the Provision of Information*<sup>107</sup> and the Health and Social Care Board *Disability Action Plan*.<sup>108</sup>

**7** During implementation Phase 1, 100% of the population will continue to have access to existing provision of psychological therapies and trauma services in the Adult and Child Directorates of the Health and Social Care system, via existing pathways, based on their clinical need and irrespective of the origin of their trauma.

**8** All phases of the Health and Social Care element of the Regional Trauma Network are being designed to ensure there is parity of access to the highest quality trauma services across the region irrespective of disability. Regional Trauma Network therapists will ascertain if any barriers exist and work with the individual or other agencies to overcome these.

<sup>107</sup> Available at:

[http://www.hscbusiness.hscni.net/pdf/Accessible\\_Formats\\_Policy\\_Version\\_0.2\\_Jan\\_2015.pdf](http://www.hscbusiness.hscni.net/pdf/Accessible_Formats_Policy_Version_0.2_Jan_2015.pdf)

<sup>108</sup> Available at: <http://www.hscboard.hscni.net/download/PUBLICATIONS/EQUALITY/HSCB-Disability-Action-Plan-April-2018.pdf>

## ***Ethnicity***

The most recent census (Census, 2011) revealed that 1.8% of the usual resident population (or 32,596 people) belonged to minority ethnic groups.

Information collected as part of the census shows that the ethnic distribution of the population is as follows:

- |                                   |                                     |
|-----------------------------------|-------------------------------------|
| - White: 98.21%<br>(1,778,449)    | - Irish Traveller: 0.07%<br>(1,268) |
| - Chinese: 0.35% (6,338)          | - Pakistani: 0.06% (1,087)          |
| - Indian: 0.34% (6,157)           | - Black Other: 0.05% (905)          |
| - Other Asian: 0.28%<br>(5,070)   | - Bangladeshi: 0.03% (543)          |
| - Mixed: 0.33% (5,976)            | - Black Caribbean: 0.02%<br>(362)   |
| - Black African: 0.13%<br>(2,354) | - Other: 0.13% (2,354)              |

Migration patterns have changed in Northern Ireland in the intervening period, and it can be expected that this ethnic breakdown is currently changing.

Data compiled by the Northern Ireland Assembly Research and Information Service in 2016 (Russell, 2016)<sup>109</sup> found that:

- Between 2000 and 2014, an estimated 175,000 long-term international migrants came to Northern Ireland, while 143,000 left, leaving a net total of 32,000. Local government districts in the west and south-west of Northern Ireland saw the largest net inflow of new residents, in particular: Mid Ulster (9,800), Armagh, Banbridge & Craigavon (9,300) and Newry, Mourne & Down (6,000).

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<sup>109</sup> See: Russell, R. (2016). *International Migration in Northern Ireland: an Update – Research and Information Service Research Paper*. Belfast: Northern Ireland Assembly. Available at: <http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2016-2021/2016/general/3916.pdf>

- Poland continues to be the most popular country of origin for international migrants coming to live in Northern Ireland. During 2014 and 2015, however, migration from Romania rose substantially, albeit from a low baseline.
- Around 1,000 members of the Roma community, mostly from Romania, are thought to live in Northern Ireland, mainly South Belfast.
- International migration impacts upon the host community in a myriad number of ways, including maternity services, school enrolments, social housing, health and social care and hate crime.
- Births to mothers born outside the United Kingdom and Ireland now account for over 10% of all births in Northern Ireland each year. In 2014, 18% of all births in the Mid Ulster local government district were to non-UK and Ireland mothers, followed by Armagh, Banbridge & Craigavon (15%), Belfast (15%), Fermanagh & Omagh (14%) and Newry, Mourne & Down (14%).

In 2017, the Northern Ireland Policing Board conducted a *Thematic Review of Policing Race Hate Crime* (NIPB, 2017)<sup>110</sup> which reported the following:

- In Northern Ireland, a race hate incident is reported approximately every seven hours.
- Racist hate crimes are the second most common type of hate crime recorded by the Police Service of Northern Ireland, with sectarian hate crime being the most common.
- The levels of racist hate crimes recorded by the Police Service of Northern Ireland began to decline in 2010/11 following a peak in 2009/10 however they began to increase again in 2012/13.
- There was a significant increase in reported racially motivated hate incidents in Northern Ireland in 2014/15

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<sup>110</sup> Northern Ireland Policing Board (NIPB). (2017). *Thematic Review of Policing Race Hate Crime*. Available at: <https://www.nipolicingboard.org.uk/sites/nipb/files/media-files/race-hate-crime-thematic-review.PDF>

when racist hate crime reached its highest level ever recorded: 1,356 incidents within which there were 920 crimes.

The latest *Northern Ireland Peace Monitoring Report* (Gray et al, 2018) analyses a wide range of data, including Police Service of Northern Ireland figures for 2016-2017 that show:

- The victims of hate crimes in Northern Ireland are primarily white.
- Of the 321 racist crimes reported against white people in 2016-17, 31% were against people from the United Kingdom/Ireland, 25% against people from Poland and 10% against those from Lithuania.
- There is a difference in who is a victim of racist hate crimes between 2007-08 and a decade later with the percentage of those who are white dropping from 65% to 52%, those who are Asian dropping from 19% to 12%, and a rise in crimes against those who are black from 6% to 17%.

These statistics must be viewed in context i.e. recognising the tiny numbers of minority ethnic communities at the population level (as shown above).

While the Health and Social Care Board, Trauma Resource Centre, and Victims and Survivors Service service user data does not record data on ethnicity, Health and Social Care Interpreting Service statistics reveal a trend of increasing numbers of ethnic minority groups requiring support to access healthcare services in the region over the last 15 years. These data show a dramatic rise in requests for interpreters from 1,850 in 2004-2005 to 106,541 requests in 2016-2017. The most popularly requested languages are:



## 7: EQIA KEY FINDINGS – ETHNICITY

1. Polish: 31,220	11. Chinese – Cantonese: 2,858
2. Lithuanian: 15,866	12. Russian: 2,541
3. Romanian: 8,975	13. Latvian: 2,042
4. Portuguese: 8,323	14. Somali: 1,151
5. Arabic: 6,203	15. Czech: 855
6. Slovak: 5,356	16. Chinese – Hakka: 748
7. Tetum: 5,319	17. Spanish: 589
8. Chinese – Mandarin: 5,103	18. Farsi: 515
9. Bulgarian: 3,421	19. Bengali: 369
10. Hungarian: 3,387	20. Urdu: 297

Furthermore the Health and Social Care system in Northern Ireland has found that:

*“Members of Black and Minority Ethnic communities often have difficulties accessing health services for a number of reasons. This can be exacerbated when it comes to mental health. There are disparities and inequalities, not only in the rate of mental health issues experienced by Black and Minority Ethnic communities, who tend to experience more mental health problems than other communities, but also in their experience of the service and the outcomes, which are often poor.”<sup>111</sup>*

The Health Alliance notes well documented difficulties encountered by minority ethnic communities in trying to access health and social care. These include:

- Language difficulties;
- Lack of awareness and lack of appropriate information on the services available;
- The need for a permanent address in order to register with a General Practitioner;

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<sup>111</sup> Eoin Rooney, NHSCT and Ballymena Inter-ethnic Forum, 2013 – cited in Belfast Health & Social Care Trust (BHSCT) & Aware Defeat Depression. (2014). *Ethnic Minorities Mental Health Toolkit: A Guide for Practitioners*. (p. 3). Available at: [http://www.belfasttrust.hscni.net/pdf/BME\\_Cultural\\_Awareness\\_Document\\_sml.pdf](http://www.belfasttrust.hscni.net/pdf/BME_Cultural_Awareness_Document_sml.pdf)

- Fears about entitlement to health care;
- Difficulty in coming to grips with a health care system that is different to what exists in their country of origin;
- The failure of some services to meet migrants' cultural or religious needs;
- Institutional racism and the negative attitudes of some health care staff; and
- Immigration restrictions.<sup>112</sup>

### **Summary**

The data above highlights the need for services for a growing population of Black and Minority Ethnic communities, who may be subject to discrimination, intimidation, and hate crimes. Wider contextual information that is important to take into account in this regard includes the fact that migrants arriving in Northern Ireland may arrive as refugees or asylum seekers, and may have survived abuse, violence, and trauma prior to the challenges and potential isolation they may experience in this country. The existing Health and Social Care *Ethnic Minorities Mental Health Toolkit* considers these and a range of other factors that may impact on the well-being of individuals from migrant and Black and Minority Ethnic communities, and their needs in terms of accessing Health and Social Care services.

During the Phase 1 implementation process the Regional Trauma Network Management Team will actively engage with organisations that are representing the populations outlined above to seek to establish a Working Group to improve access to trauma services for individuals who experience barriers to accessing mental health services, including Black and Minority Ethnic and migrant communities, with significant trauma symptoms that are not associated with a Conflict/Troubles-related incident(s).

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<sup>112</sup> See: <http://healthallianceni.com/health-social-wellbeing/bme-groups/>

### Mitigating measures to address the impact of issues arising from a consideration of *Ethnicity*:

- 1** During Phase 1, a Pathways Development Working Group will consider the way forward for improving access to trauma services for individuals with significant trauma symptoms that are not associated with a Conflict/Troubles-related incident(s) who experience barriers to accessing mental health services. This process will consider the needs of this service user group, and will ensure issues arising are addressed by mitigating actions, and monitored on an ongoing basis. It will be conducted in line with the Department of Health Co-Production principles, ensuring voices of people from Black and Minority Ethnic and migrant backgrounds and their advocates are included in the process.
- 2** Throughout all Phases of implementation of the Health and Social Care aspect of the Regional Trauma Network will be available across the region and access to services will be based solely on clinical need and not based on ethnicity or language preference. Phase 1 will focus on those who have been impacted by the Troubles/ Conflict and from Phase 2 onwards the service will be available for anyone based on clinical need and irrespective of the origin of their trauma. Regional Trauma Network therapists will ascertain if any barriers exist and work with the individual or other agencies to overcome these.
- 3** From Phase 1 onwards, the Health and Wellbeing Case Managers are authorised through the 2016 Partnership Agreement between the Department of Health and The Executive Office to comprehensively assess needs and make referrals directly into the regional Health and Social Care Local Trauma Teams of individuals who fulfil the Victims Order (2006), working with all agencies to ensure any barriers to accessing services due to ethnicity are overcome.

### Mitigating measures to address the impact of issues arising from a consideration of *Ethnicity*:

- 4 The comprehensive assessment process for Regional Trauma Network services will take cognizance of an individual's ethnic background. This may include requirements for flexibility and arrangements that support individuals both to come forward to seek help and to attend regularly and consistently as required for their treatment. Collaborative and informed choice in relation to treatment options will be respected.
- 5 The Partnership Alliance for Learning from Lived Experience, the Regional Trauma Network Co-Production Forum, will advise the Regional Trauma Network Management of barriers to accessing services based on ethnicity. This will inform the design of how, when, and where services are delivered. The Partnership Alliance for Learning from Lived Experience recruitment will ensure the membership will include representatives from Black and Minority Ethnic communities.
- 6 Health and Social Care Regional Trauma Network information, assessment, and treatment options will be provided in tailored formats, in line with the Health and Social Care *Accessible Formats Policy for the Provision of Information* and the Health and Social Care *Ethnic Minorities Mental Health Toolkit: A Guide for Practitioners*. This may include for example the provision of interpreters, and easy read and translated versions of written information.
- 7 The Regional Trauma Network Training and Education Strategy will include delivery of Trauma awareness training with the aim of creating trauma-informed communities across the statutory, community, and voluntary sectors, including outreach to Black and Minority Ethnic support networks. A core aim of this activity will be to reduce stigma and increase the understanding of trauma, so that people from Black and Minority Ethnic backgrounds in particular are encouraged to access services.

**Mitigating measures to address the impact of issues arising from a consideration of *Ethnicity*:**

- 8** During implementation Phase 1, 100% of the population will continue to have access to existing provision of psychological therapies and trauma services in the Adult and Child Directorates of the Health and Social Care system, via existing pathways, based on their clinical need and irrespective of the origin of their trauma.

## **Sexual Orientation**

Publicly available statistics on sexual orientation at a population level suggest that between 5% and 10% of the population may identify as lesbian, gay or bisexual.

In 2016, the Annual Population Survey<sup>113</sup> showed that:

- 93.4% of the UK population identified as heterosexual or straight and
- 2.0% of the population identified themselves as lesbian, gay or bisexual (LGB). This comprised of:
  - o 1.2% identifying as gay or lesbian
  - o 0.8% identifying as bisexual
- A further 0.5% of the population identified themselves as “Other”, which means that they did not consider themselves to fit into the heterosexual or straight, bisexual, gay or lesbian categories.
- A further 4.1% refused or did not know how to identify themselves.
- The population aged 16 to 24 were the age group most likely to identify as lesbian, gay, or bisexual in 2016 (4.1%).
- More males (2.3%) than females (1.6%) identified themselves as lesbian, gay, or bisexual in 2016.
- The population who identified as lesbian, gay, or bisexual in 2016 were most likely to be single, never married or civil partnered, at 70.7%.

Regional and international research highlights increased levels of common mental health problems, such as depression, anxiety and stress among people from lesbian, gay, bisexual, transgender, and queer (LGBTQ+) backgrounds (National Institute for Mental Health in England, 2012).<sup>114</sup> Same-sex-attracted respondents are more

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<sup>113</sup> See: <https://beta.ukdataservice.ac.uk/datacatalogue/series/series?id=200002#!/access>

<sup>114</sup> See: National Institute for Mental Health in England. (2012). *Mental disorders, suicide, and deliberate self-harm in lesbian, gay and bisexual people a systematic review*. Available at:

than twice as likely as respondents who were only attracted to people of the opposite sex to have higher levels of psychiatric disorder (Schubotz & O’Hara, 2011).<sup>115</sup>

Research has also demonstrated that lesbian, gay, or bisexual people report poorer experiences when accessing health and social care, are likely to delay access to healthcare based on previous negative experiences and fear of negative attitudes of health workers specifically in relation to their sexual orientation, and may have poorer health outcomes than their heterosexual peers.<sup>116</sup>

The negative impacts of experiences of discrimination and marginalisation, both direct and indirect, on lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals and groups are also well established.

A report published by the Rainbow Project (O’Hara, 2013),<sup>117</sup> based on research conducted with more than 500 individuals that identified as lesbian, gay, bisexual, transgender, and queer (LGBTQ+) found that:

- 35.3% of respondents had experienced self-harm;
- 25.7% had experienced a suicide attempt;
- 46.9% had experienced suicidal ideation; and
- 70.9% had experienced depression.

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<https://www.mindout.org.uk/wp-content/uploads/2012/06/self-harm-in-lesbian-gay-and-bisexual-people.pdf>

<sup>115</sup> Schubotz, D. & O’Hara, M. (2011). Shared Future? Exclusion, Stigmatization, and Mental Health of Same-Sex-Attracted Young People in Northern Ireland. *Youth and Society*, 43 (2): 488-508.

<sup>116</sup> See: Elliot, M. et al. (2015). Sexual Minorities in England Have Poorer Health and Worse Health Care Experiences: A National Survey, *Journal of General Internal Medicine*, 30 (1): 9-16; Light, B. et al. (2011). *Lesbian, Gay & Bisexual Women in the North West: A Multi-Method Study of Cervical Screening Attitudes, Experiences and Uptake*. The Lesbian & Gay Foundation and University of Salford.

<sup>117</sup> O’Hara, M. (2013). *Through Our Minds: Exploring the Emotional Health and Wellbeing of Lesbian, Gay, Bisexual and Transgender People in Northern Ireland*. Available at: <https://www.rainbow-project.org/Handlers/Download.ashx?IDMF=fce626f4-de30-40d4-bf4f-43dd4afc39ea>

The respondents also reported common experiences of invisibility, homophobia/transphobia, and a range of violence from threats to physical violence, whether direct or indirect. As a result of their actual or perceived sexual orientation and/or gender identity:

- 65.8% had been verbally assaulted at least once;
- 43.3% had been threatened with physical violence at least once;
- 33% had been threatened to be 'outed' at least once;
- 34.7% had experienced discrimination in accessing goods, facilities or services at least once.

The research noted this evidence indicates a level of intolerance that is a common experience for lesbian, gay, bisexual, transgender, and queer (LGBTQ+) people in Northern Ireland, and that this intolerance is a clear indicator for risk of experiencing poorer emotional health and well-being outcomes.

Current Health and Social Care, Trauma Resource Centre and Victims and Survivors Service service user data does not record information in relation to sexual orientation.

### ***Summary***

Based on the available data, it can be reasonably assumed that the prevalence of lesbian, gay, and bisexual people reflected in the statistics cited above will be represented in the population accessing Health and Social Care Regional Trauma Network services from Phase 1 onwards, with a potential for slightly more lesbian, gay, and bisexual people needing treatment across the phased implementation process.

At every stage of the phased implementation of the Health and Social Care element of the Regional Trauma Network, it will be important for the Health and Social Care Board to create a safe environment for lesbian, gay, and bisexual people who may feel stigmatised and fearful, and who may not have discussed their



sexual orientation with anyone else. Acknowledging this responsibility highlights the need for a regional service that can accommodate individuals who need treatment in locations where they feel safe, and the importance of ensuring that Health and Social Care staff responsible for conducting assessments and providing treatment deliver neutral, non-judgemental care, governed by robust standards. Key service user and carer values underpinning these standards include: dignity, respect, independence, rights, choice, safety, and confidentiality.

**Mitigating measures to address the impact of issues arising from a consideration of *Sexual Orientation*:**

- 1** During Phase 1, the Pathway Development Working Group will consider the way forward for improving access to trauma services for children and young people in line with the regional Child and Adolescent Mental Health Services (CAMHS) care pathway,<sup>118</sup> and for individuals with significant trauma symptoms that are not associated with a Conflict/Troubles-related incident(s) who experience barriers to accessing mental health services. This will include specific consideration of lesbian, gay, and bisexual young people and adults and the particular needs of these service users, and will ensure issues arising are addressed by relevant mitigating actions, and monitored on an ongoing basis. It will also be conducted in line with the Department of Health's Co-production principles, ensuring the voices of lesbian, gay, and bisexual service users are included in the process.
- 2** From Phase 1 onwards, the Health and Wellbeing Case Managers are authorised through the 2016 Partnership Agreement between the Department of Health and The

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<sup>118</sup> For more information, see: <http://www.hscboard.hscni.net/camhs-launch/> - full document available at:  
[http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you\\_in\\_mind/21122018-HSCB-CAMHS-Pathway-Document.pdf](http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you_in_mind/21122018-HSCB-CAMHS-Pathway-Document.pdf)

**Mitigating measures to address the impact of issues arising from a consideration of *Sexual Orientation*:**

Executive Office to comprehensively assess needs and make referrals directly into the regional Health and Social Care Local Trauma Teams of individuals who fulfil the Victims Order (2006), working with all agencies to ensure any barriers to accessing services due to sexual orientation are overcome.

**3** The comprehensive assessment process for Regional Trauma Network services will take cognizance of an individual’s sexual orientation. Collaborative and informed choice in relation to treatment options will be respected.

**4** The Partnership Alliance for Learning from Lived Experience, the Regional Trauma Network Co-Production Forum, will advise the Regional Trauma Network Management of barriers to accessing services based on sexual orientation. This will inform the design of how, when, and where services are delivered. The Partnership Alliance for Learning from Lived Experience recruitment process will ensure the membership includes representatives from the lesbian, gay, and bisexual community.

**5** The Regional Trauma Network Training and Education Strategy will include delivery of Trauma awareness training with the aim of creating trauma-informed communities across the statutory, community, and voluntary sectors, including outreach to lesbian, gay, and bisexual support networks. A core aim of this activity will be to reduce stigma and increase the understanding of trauma, so that people from lesbian, gay, and bisexual backgrounds in particular are encouraged to access services.

**6** All Health and Social Care Staff involved in the delivery of the Regional Trauma Network will be held accountable for the delivery of neutral, non-judgemental, and confidential care, governed by the values and robust standards of confidentiality that underpin all Health and Social Care services. They will also be required to undergo equality and diversity training, including the (already mandatory) Health and Social Care e-Learning module *Making a Difference*.

**Mitigating measures to address the impact of issues arising from a consideration of *Sexual Orientation*:**

- 7** During implementation Phase 1, 100% of the population will continue to have access to existing provision of psychological therapies and trauma services in the Adult and Child Directorates of the Health and Social Care system, via existing pathways, based on their clinical need and irrespective of the origin of their trauma.
- 8** All phases of the Health and Social Care element of the Regional Trauma Network are being designed to ensure there is parity of access to the highest quality trauma services across the region irrespective of sexual orientation. Regional Trauma Network therapists will ascertain if any barriers exist and work with the individual or other agencies to overcome these.

## 7.2 Good Relations

The Health and Social Care Board approach to considering and promoting good relations in the context of the design, development, and implementation of the Regional Trauma Network is underpinned by core Health and Social Care values of respect and dignity.

This section of the Equality Impact Assessment focuses on the actions the Health and Social Care Board will take to ensure the Regional Trauma Network meets the needs of service users and staff who form part of a multicultural, multi-faith society which, as noted above, still faces challenges in terms of the legacy of division and violent conflict.

The Health and Social Care element of the Regional Trauma Network aims to improve access to the highest quality trauma services for the population of Northern Ireland by creating a specialised local trauma team in each Health and Social Care Trust. These teams will work closely with the community and voluntary sector, will deliver nationally and internationally recommended evidence-based trauma treatments, and will develop research, training and education strategies that will inform future national and international practice in relation to addressing the needs of children, young people and adults with clinically significant levels of psychological trauma, including Post Traumatic Stress Disorder and Complex Post Traumatic Stress Disorder.

Reducing health inequalities and the promotion of good relations is integral to fulfilling this overarching purpose.

This Equality Impact Assessment has highlighted the need for Health and Social Care specialised trauma services across the lifespan and for all communities, irrespective of the origin of an individual's trauma. The implementation and delivery of the Regional Trauma Network, therefore, must ensure that everyone

irrespective of religion, race, or political opinion feels safe, welcome, and comfortable accessing services, regardless of where they are located.

While the Regional Trauma Network Implementation Phase 1 focuses on the specific pathway for victims and survivors of the Conflict/Troubles, the Health and Social Care element of the fully implemented Regional Trauma Network is for anyone who needs specialised psychological trauma care, irrespective of the origin of the trauma.

The key themes and actions the Regional Trauma Network will develop throughout its design and implementation in order to promote and protect good relations include:

- Synthesis with national, regional and local strategies including in particular:
  - o *Together: Building a United Community*.<sup>119</sup> This strategy outlines a vision based on equality of opportunity, the desirability of good relations and reconciliation. It provides the framework for government action in tackling sectarianism, racism and other forms of intolerance while seeking to address division, hate and separation.
  - o The current draft *Programme for Government*<sup>120</sup> and *Racial Equality Strategy*.<sup>121</sup>
  - o The PEACE IV Programme.<sup>122</sup>
- The Partnership Agreement (2016) between the Department of Health and The Executive Office. This outlines how the Victims and Survivors Service will interface with Health and

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<sup>119</sup> See: <https://www.executiveoffice-ni.gov.uk/articles/about-together-building-united-community-tbuc>

<sup>120</sup> See: <https://www.northernireland.gov.uk/programme-government>

<sup>121</sup> See: <https://www.executiveoffice-ni.gov.uk/articles/racial-equality>

<sup>122</sup> See:

[https://www.seupb.eu/sites/default/files/styles/file\\_entity\\_browser\\_thumbnail/public/PEACE%20Content%20Type/PIV\\_CitizensSummary\\_English\\_Version11.pdf](https://www.seupb.eu/sites/default/files/styles/file_entity_browser_thumbnail/public/PEACE%20Content%20Type/PIV_CitizensSummary_English_Version11.pdf)

Social Care services to ensure relevant, timely, accessible, and comprehensive trauma care for those whose mental health has been impacted by the Troubles/Conflict. As outlined above, the Partnership Agreement is linked to the PEACE IV European Union Programme for Peace and Reconciliation,<sup>123</sup> which named the Victims and Survivors Service as Lead Partner in 2015 to deliver a *Victims and Survivors Programme* as part of the *Shared Spaces and Services* workstream. The *Victims and Survivors Programme* aims specifically to improve the health and wellbeing of victims and survivors and to build capacity within the sector to deliver high quality services.

- The Regional Trauma Network Training and Education Strategy will be co-designed by its bespoke Co-production/service user reference group, the Partnership Alliance for Learning from Lived Experience. The membership of the Partnership Alliance for Learning from Lived Experience will reflect the diversity of the population of Northern Ireland.
- Relevant training will be identified and accessed/delivered to ensure the Health and Social Care element of the Regional Trauma Network is accessible, acceptable, and effective to all those who need it.
- Close working and partnerships with a broad range of organisations and local communities will be established to ensure a full understanding of their needs in accessing services, e.g. language barriers, safety issues, and others outlined above.

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<sup>123</sup> For information on the PEACE IV Programme, see: <https://www.seupb.eu/piv-overview> - Citizens' Summary Document available at: <https://seupb.eu/sites/default/files/styles/PEACEIV/PEACE%20IV%20-%20%20Draft%203.pdf>

## 7: EQIA KEY FINDINGS – GOOD RELATIONS

Recent empirical research underlines pervasive problems associated with building trust and developing and maintaining peaceful and confident social interactions and engagement across community, religious, and political divisions. These continuing and pervasive issues are analysed and assessed by researchers and policy analysts as part of the complex legacy of the Conflict/Troubles (see Gray et al, 2018).<sup>124</sup>

By providing effective trauma care to individuals severely impacted by the violence and other dynamics of the Conflict/Troubles, the Health and Social Care element of the Regional Trauma Network may support individuals' capacity to build trust and develop and maintain peaceful and confident social interactions and engagement across religious, political, and ethnic divisions.

These potential positive impacts are noted, but should not be overstated.

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<sup>124</sup> See also: Kelly, G. (2012). *Progressing Good Relations and Reconciliation in Post-Agreement Northern Ireland*. Derry/Londonderry: INCORE. Available at: [http://uir.ulster.ac.uk/21681/1/Reconciliation\\_Research\\_Report\\_Kelly.pdf](http://uir.ulster.ac.uk/21681/1/Reconciliation_Research_Report_Kelly.pdf)

### 7.3 Disability Duties

The Health and Social Care Board is mindful of its duty as a public body under the Disability Discrimination (Northern Ireland) Order 2006 to:

*“...have due regard to:*

- ***promote positive attitudes*** towards disabled people, and
- ***encourage participation*** by disabled people in public life.

*This helps eliminate ignorance and prejudice towards disabled people. Whilst many people have positive attitudes towards disabled people, some express pity, fear, lack of respect and/or contempt. Negative attitudes can result in disabled people being rejected, avoided or subjected to physical or verbal attacks, jokes, bullying or other harassment. It can also result in their being rejected for jobs. Such behaviour can have a serious and long term impact on the lives of disabled people.”<sup>125</sup>*

The Health and Social Care Board acknowledges the importance of encouraging the participation of disabled people and promoting positive attitudes towards them. In line with this duty, the design, development and implementation of the Health and Social Care element of the Regional Trauma Network will be:

- Conducted in keeping with the overarching Health and Social Care Board *Disability Action Plan*,<sup>126</sup> and
- Underpinned by ongoing service-user involvement, including people with disabilities, and in line with the principles and ethos of Personal and Public Involvement and Co-

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<sup>125</sup> See: <https://www.equalityni.org/DisabilityDuties>

<sup>126</sup> Available at: <http://www.hscboard.hscni.net/download/PUBLICATIONS/EQUALITY/HSCB-Disability-Action-Plan-April-2018.pdf>



production as outlined in the Department of Health *Co-production Guide* (2014).<sup>127</sup>

The Health and Social Care Board will continue to work alongside Health and Social Care Equality and Personal and Public Involvement leads, carers, service users, and disabled people to ensure that all the Regional Trauma Network is an *accessible, acceptable, and effective* service for everyone, including people with a disability. To that end, the bespoke Regional Trauma Network Co-Production Forum, the Partnership Alliance for Learning from Lived Experience (see **Annex 3**), will include representation from individuals who have experience of physical and psychological disabilities.

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<sup>127</sup> To access the Department of Health (DoH) *Co-production Guide*, see: <https://www.health-ni.gov.uk/publications/co-production-guide-northern-ireland-connecting-and-realising-value-through-people>

## 7.4 Human Rights

The design, development, and implementation of the Health and Social Care element of the Regional Trauma Network are considered to have no negative implications or impacts with regard to human rights.

Notwithstanding this assessment, the Health and Social Care Board is cognizant of the importance of ensuring that appropriate controls, systems, governance, safe practice, and referral pathways are put in place across the Regional Trauma Network, and monitored on an ongoing basis for their application, effectiveness and proportionality.

Several of the target groups are vulnerable people or people at a particularly vulnerable point in their lives. The Health and Social Care Board therefore recognises the importance of ensuring necessary safeguards are in place. Specifically, the Regional Trauma Network will need to demonstrate its accountability in relation to safeguarding, information sharing and governance standards. To this end, the Health and Social Care Board and its key partners the Health and Social Care Trusts and the Victims and Survivors Service will need to have available for scrutiny evidence of key policies, procedures, and documentation being in place and utilised if/when needed, including for example:

- Data protection;
- Governance arrangements;
- Referral pathways;
- Information sharing protocols;
- Child protection/vulnerable adults staff training and policies;
- Evidence of the appropriate standards for treating trauma; and
- Evidence of staff training, accreditation, and qualifications and compliance with Child Protection and Adult Safeguarding duties within the Regional Trauma Network.

## CONCLUSIONS

### Summary and Assessment of Main Findings

Based on all of the information reviewed, this Equality Impact Assessment has made the following key findings:

1. An estimated 39% of the population have experienced a Conflict/Troubles-related traumatic event.
2. An estimated 8.8% of the Northern Ireland adult population met the criteria for Post Traumatic Stress Disorder at some point in their life while 5.1% met the criteria in the previous 12 months.
3. The prevalence of Post Traumatic Stress Disorder in Northern Ireland is the highest of all countries that have produced comparable estimates including the United States, other Western European countries and countries that have experienced civil conflict in their recent history.
4. The phased implementation of the Regional Trauma Network, involving collaborative working with partner organisations across the community, voluntary, and statutory sectors, is designed to enable a cumulative learning and development process, beginning with the design, testing, and implementation of a unique Case Manager pathway for victims and survivors of the Conflict/Troubles.
5. This approach is being tested to inform the design and delivery of accessible, acceptable, and effective trauma services for all children, young people, and adults in Northern Ireland with clinically significant levels of psychological trauma, irrespective of the origin of their trauma.
6. Whilst Phase 1 has a focus on providing access to Health and Social Care Regional Trauma Network services via

## CONCLUSIONS

Victims and Survivors Service Case Managers for adults with Post Traumatic Stress Disorder and Complex Post Traumatic Stress Disorder symptoms as a result of the Troubles/Conflict, given the intersectionality of individual identity, this group potentially includes representation from across all Section 75 categories within the population.

7. Access to the Health and Social Care Regional Trauma Network services will be based solely on clinical need and not based on any aspect of individual or group identity, whether in terms of gender, age, religion, political opinion, marital status, dependant status, disability, ethnicity, or sexual orientation.
8. During the phased implementation process, 100% of the Northern Ireland population will continue to have access to existing mental health and psychological trauma therapy Health and Social Care services via existing pathways.
9. Across all three implementation phases, needs are identified in relation to gender dynamics, those with dependents/carers, older people, and those with physical and psychological disabilities. These needs relate to supporting help-seeking behaviour, supporting safety, addressing stigma/perceived stigma associated with mental health needs, responding to communication challenges, and enabling access and engagement with therapy. This report details mitigating actions that will be taken to meet these needs and ensure equality of opportunity and access to Regional Trauma Network services during all phases of implementation.
10. From Phase 2 onwards the Health and Social Care element of the Regional Trauma Network will be available to all children, young people, and adults in Northern Ireland with clinically significant levels of psychological trauma, irrespective of the origin of their trauma

## CONCLUSIONS

11. Due to the politically sensitive nature of Troubles/Conflict-related trauma, data on certain Section 75 groupings are not routinely collected among current service user populations, namely: religious and political affiliation. However, population level data and secondary sources indicate that people from all and any political and religious backgrounds and none may have a need for trauma care. Given the broader political and social context of Northern Ireland and the nature of the Conflict/Troubles, particular care will be taken to ensure individual choice and safety are priority concerns at the clinical assessment stage. The report details these and other mitigating actions that will be taken to meet these needs and ensure equality of opportunity and access to Regional Trauma Network services.
  
12. People from black and minority ethnic (BME) and migrant communities are noted to have particular needs associated with the provision of trauma care through the Regional Trauma Network. In general these needs relate to supporting help-seeking behaviour, supporting safety, cultural competence, addressing stigma/perceived stigma associated with mental health needs, and enabling access and engagement with therapy. In addition, those who do not speak English as a first language will have communication needs. Phase 1 of the Regional Trauma Network implementation will include a focus on developing a greater understanding of these needs, and on that basis, developing mitigating measures that facilitate and enable access for those who require the service. This report details this approach, as well as ongoing mitigating actions that will be taken to meet the needs of people from black and minority ethnic and migrant communities, to ensure equality of opportunity and access to Health and Social Care Regional Trauma Network services.

## CONCLUSIONS

13. Data shows that lesbian, gay, and bisexual people may have negative experiences of the health sector, associated with fear and stigmatisation, and increased levels of need for psychological support. Taking this into account, this report details mitigating actions that will be taken to meet these needs and ensure equality of opportunity and access to Health and Social Care Regional Trauma Network services throughout all phases of implementation.
14. The design, development, and implementation of the Health and Social Care element of the Regional Trauma Network are strongly informed and shaped by extensive stakeholder engagement, service user participation (co-production).

Based on the information collated, the proposed model of implementing and delivering the Regional Trauma Network constitutes positive action. The phased implementation of the Health and Social Care element of the Regional Trauma Network allows the Health and Social Care Board to understand and subsequently design Regional Trauma Network services that are accessible, acceptable and effective for children, young people and adults and individuals with significant levels of psychological trauma irrespective of the origin of the trauma who experience barriers to accessing mental health services.

Quantitative and qualitative data will be collected and analysed throughout Phases 1, 2, and 3, enabling the Health and Social Care Board to incorporate learning from this model into the business planning for the future design and development of the Regional Trauma Network, maximising the potential for engaging with hard to reach, traumatised individuals across different communities, irrespective of the cause or origin of their trauma. Monitoring the uptake of Health and Social Care Regional Trauma Network services of different Section 75 groups, as appropriate, will also help to identify and better understand barriers to access, and to develop more effective pathways.

## CONCLUSIONS

In this way, the Health and Social Care Board aims to reduce barriers to engagement in high quality, evidence-based trauma interventions, ensuring that individuals access both statutory and community-based social and practical supports as necessary, to maximise and sustain their recovery.

Given that an estimated 39% of the population have experienced a Conflict/Troubles-related traumatic event, it is reasonable to anticipate that the Phase 1 enhanced access pathway will include representation from most Section 75 groups within the population, where a clinical need for enhanced trauma services is identified. From Phase 2 onwards all individuals in clinical need of trauma care across all Section 75 groupings will have access to Regional Trauma Network services.

As noted above, during implementation Phase 1, and across the phased implementation of the full Regional Trauma Network service model, 100% of the Northern Ireland population will continue to have access to existing mental health and psychological trauma therapy services, irrespective of the origin of their trauma.

### **Proposed monitoring**

These points of information will be monitored on an ongoing basis throughout the incremental implementation of the Health and Social Care element of the Regional Trauma Network.

The monitoring arrangements will be established in line with current Health and Social Care statistical monitoring approaches and obligations, and kept under review through both the operational management and co-production process to ensure their effectiveness.

## CONCLUSIONS

### **Proposed next steps**

On the basis of the information discussed in this report, the Health and Social Care Board proposes to proceed with the phased implementation of the Health and Social Care element of the Regional Trauma Network as outlined above. The anticipated launch date of Autumn 2019 for Phase 1 will be kept under review, in line with progress against regional recruitment objectives.



## **Annex 1: Partnership Agreement (Department of Health and The Executive Office)**



### **Partnership Agreement For the Regional Trauma Network (RTN) Service**

**May 2019**

## **Partnership Agreement For the Regional Trauma Network (RTN) Service**

This agreement is made between the Department of Health ("DoH") and the Executive Office ("TEO"), who act with the respective delivery bodies outlined in this agreement, and shall come into operation on 22 May 2019. It shall continue indefinitely or until terminated by the Northern Ireland Executive.

### **1. Context**

The Stormont House Agreement (December 2014) made the following commitment:

*The Commission for Victims and Survivors' recommendation for a comprehensive Mental Trauma Service will be implemented. This will operate within the NHS but will work closely with the Victims and Survivors Service (VSS), and other organisations and groups who work directly with victims and survivors.*

As the "NHS" is not a legal entity in the North of Ireland, the title Health and Social Care service ("HSC") will be used throughout this Agreement.

The Stormont House Agreement commitment was followed by an announcement by the then Minister for Health, Social Services and Public Safety in September 2015, which tasked officials with creating an innovative service which will meet the needs of those suffering from psychological trauma.

It is well documented in a range of research and national benchmarks that people in this jurisdiction experience higher rates of mental ill health when compared with Britain and Ireland.

It is estimated that mental health problems here are 20–25% higher than in the rest of the UK. One in four adults (about 25%) will experience a diagnosable mental health problem at any given time. This makes mental ill health the largest cause of disability in the region, and there is a range of evidence to suggest this is directly related to the legacy of the Conflict/Troubles.

The Commission for Victims and Survivors "Troubled Consequences" report in 2011 highlighted that four out of 10 people in the region have experienced a traumatic event

## ANNEX 1: PARTNERSHIP AGREEMENT

related to the Troubles and that Northern Ireland has one of the highest recorded rates of Post-Traumatic Stress Disorder (PTSD) anywhere in the world. The report estimates that one third of those who develop PTSD will not recover unless they have access to evidence-based trauma-focused therapy. The research also highlighted that the Conflict/Troubles has resulted in higher levels of other mental health problems, such as depression, self-harm, complex grief anxiety, panic, and substance misuse.

The 2015 report, *"Towards A Better Future: The Trans-generational Impact of the Troubles on Mental Health"* found that over 213,000 people here are experiencing significant mental health problems as a result of the Conflict/Troubles. These figures are based on robust, internationally comparable data, adopting the same criteria for mental disorders as used by psychiatrists and point to the conflict as a significant and distinctive stressor in the life of the community here.

The Regional Trauma Network aims to deliver the following strategic outcomes

1. People have improved access to quality trauma care.
2. Improved partnership working with the people of Northern Ireland to deliver highest quality trauma care.
3. People receive world leading, effective, and evidence-based trauma care.
4. An international centre of excellence for training, research, and trauma care is developed.

These strategic outcomes align to the draft Programme for Government (PfG) (2016-2021), specifically:

- PfG Outcome 4: We enjoy long, healthy, active lives;
- PfG Outcome 8: We care for others and we help those in need; and
- PfG Outcome 14: We give our children and young people the best start in life.

### **2. Formation of the Service**

An Implementation Team (membership set out at **Annex A**), supported by an expert Advisory Panel (membership set out at **Annex B**), will ensure that development and implementation of the service reflect clinical evidence and best practice. The remit and duration of the Implementation Team and the expert Advisory Panel will be kept under review and decided by agreement between DoH and TEO.

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### 3. Stepped Care

The Regional Trauma Network Service ("the RTN") will allow for a range of interventions, meeting the spectrum of need across the community. It is based on the Psychological Therapies Stepped Care model (see Annex C), which focuses on the recovery of the individual from psychological trauma.

The model takes account of the clinical evidence that for people to recover, they may often need a combination of evidence-based social, family, psychological and psychiatric interventions: in short, a collaborative partnership across community, voluntary and statutory services.

The voluntary and community sector will therefore continue to play a crucial role in delivering essential low to moderate intensity psychological and psycho-social interventions for people presenting with mild to moderate mental health issues. (i.e. Steps 1 and 2 in the Stepped Care model).

Step 3 interventions will be provided either by suitably qualified therapists within the voluntary and community sector or by suitably qualified mental health professionals within the HSC. The decision as to who will provide these interventions will be subject to assessed clinical need and will depend on the nature and severity of an individual's condition.

A suitably qualified therapist within the voluntary and community sector for these purposes is:

*A professional who is registered with, and adheres to, the ethical framework of a recognised, appropriate professional body listed at Annex D, with the remit of helping individuals, couples, families or groups address a wide range of issues and alleviate their psychological and emotional distress.*

A suitably qualified mental health professional for these purposes is:

*A mental health professional who is registered with a recognised regulatory body listed at Annex D, and who by adherence to their standards of practice demonstrates the skills, knowledge and character to practise their profession safely and effectively.*

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The medium to high impact, high intensity interventions (Steps 4 and 5 of the Stepped Care model) must be provided in the HSC by a suitably qualified mental health professional.

The RTN partnership model is outlined in diagram form at **Annex E**.

### **4. Structure and Practice**

#### **4.1 Roles of the VSS and the HSCB**

The founding financial arrangements for the RTN are set out at **Annex F**.

The Victims and Survivors Service ("VSS") (an Arm's Length Body of TEO) shall arrange for the provision of services for the care, support and treatment of individuals who enter the Service at Steps 1 or 2, and who may progress to a Step 3 intervention, but without the need for specialist services or treatment provided by or within the HSC.

DoH, acting with the HSC, shall arrange for the provision of treatment services for individuals who require Step 4 or Step 5 care or treatment, and those individuals who require Step 3 care or treatment as delivered by suitably qualified mental health professionals within the HSC.

#### **4.2 Access to services provided by the VSS**

The Victims and Survivors Service (VSS) will provide services for the care, support and treatment of individuals who:

- self-refer;
- are referred by a voluntary or community sector organisation;
- are referred by a General Practitioner, or anyone within the HSC workforce; and/or
- are referred by a Regional Health & Wellbeing Case Manager.

#### **4.3 Access to RTN services provided by the HSC**

The HSC will provide treatment and services for the care and treatment of individuals who are referred via a VSS Health & Wellbeing Case Manager, a General Practitioner, or a relevant health professional in the HSC.

## ANNEX 1: PARTNERSHIP AGREEMENT

### 4.4 Role of VSS Health & Wellbeing Case Managers

The VSS will employ 5 regional mental health professionals to be known as Health & Wellbeing Case Managers. The VSS and the HSC have agreed the following in respect of the Health & Wellbeing Case Manager posts:

- the job specification, including grading and salary;
- the required qualifications;
- registration with a recognised professional body; and
- any other requirement for the post as may, by agreement between the VSS and the HSC be required.

The role of the Health & Wellbeing Case Manager will be to:

- act as a clinical management link between VSS-funded functions, and HSC-funded functions;
- advise and mentor Health & Wellbeing Caseworkers funded by the VSS and employed by the community & voluntary sector;
- assess, in accordance with service and clinical guidelines, the level of care, support and treatment needed by an individual who presents to VSS-funded services; and
- refer individuals who, in the opinion of the Health & Wellbeing Case Manager require treatment within the HSC, to that treatment.

### 4.5 Care provided by the HSC

The HSC shall establish a Managed Clinical Network within the RTN which will be responsible for providing treatment and care for cases assessed by the Health & Wellbeing Case Manager as requiring HSC treatment under Step 3, Step 4, and Step 5.

The founding structure of the Managed Clinical Network is set out at Annex E.

The HSC shall arrange for the appointment, employment, training and personal development of Managed Clinical Network staff.

Access to care provided by the HSC shall be equally available to anyone entitled to that care, on the basis of clinical need. Waiting standards shall be managed in accordance with usual clinical priority. Any individual who has been referred to HSC services and who is required to wait to access treatment shall, in the meantime, be able to access support from voluntary and community groups if required or preferred.

## ANNEX 1: PARTNERSHIP AGREEMENT

The HSC may commission such voluntary and community groups as it may consider qualified, to deliver services to individuals whose trauma is not inflicted as a result of the Conflict/Troubles, but who would benefit from treatment, support or care which does not need to be provided within the HSC.

### **4.6 Existing services to be subsumed within the Managed Clinical Network**

The following existing HSC services will be subsumed into the RTN and will align with the regionally agreed standards and service delivery protocols of the Network:

- (i) the regional service provided by the Family Trauma Centre;
- (ii) the trauma services provided by the Trauma Resource Centre, BHSCT; and
- (iii) that portion of specialist psychological therapies provided by the HSC that are related to the treatment of multi-factorial trauma.

The HSCB will work closely with all 5 Trusts to ensure there is parity of access to services across the region and that all existing staff have the same opportunities for training, education and contribution to research.

### **5. Principles for care within the RTN**

Treatment provided at Steps 3-5 within the RTN must either:

- (i) be based on and informed by appropriate clinical evidence as agreed by DoH; or
- (ii) be, or form part of, an emerging evidence base which in the opinion of DoH is appropriate for use within the RTN. This is intended to promote innovation in psychological trauma care.

All treatment and care within the RTN, at steps 3-5, shall be provided in accordance with established standards of care, as set down by relevant regulatory bodies listed at Annex D.

### **6. Outcome measures**

All services provided by the RTN shall be focused on improving people's psychological, social and economic outcomes, in line with the Programme for Government. TEO and

## ANNEX 1: PARTNERSHIP AGREEMENT

DoH shall, on an annual basis, agree the specific performance management measures to be applied.

### 7. Research

TEO and DoH shall agree, on an annual basis, a research agenda for the RTN. Potential priorities for this purpose will be recommended by a Research Collaborative, the membership of which shall be agreed by TEO and DoH.

Signed	Date
	22 <sup>nd</sup> May 2019
Gareth Johnston, Director of Equality, Victims, Human Rights and Delivering Social Change, The Executive Office	
Signed	Date
	22 <sup>nd</sup> May 2019
Jerome Dawson, Acting Director of Mental Health, Disability & Older People, Department of Health	



**Annex A**

**Implementation Team**

- HSCB Clinical Director
- HSCB Regional Trauma Network Manager
- HSCB Psychology Lead
- Victim and Survivors Service Head of Health & Wellbeing
- DoH representative
- TEO representative
- CVSNI Head of Policy and Research
- Service user representative

**Annex B**

**Clinical Advisory Team\***

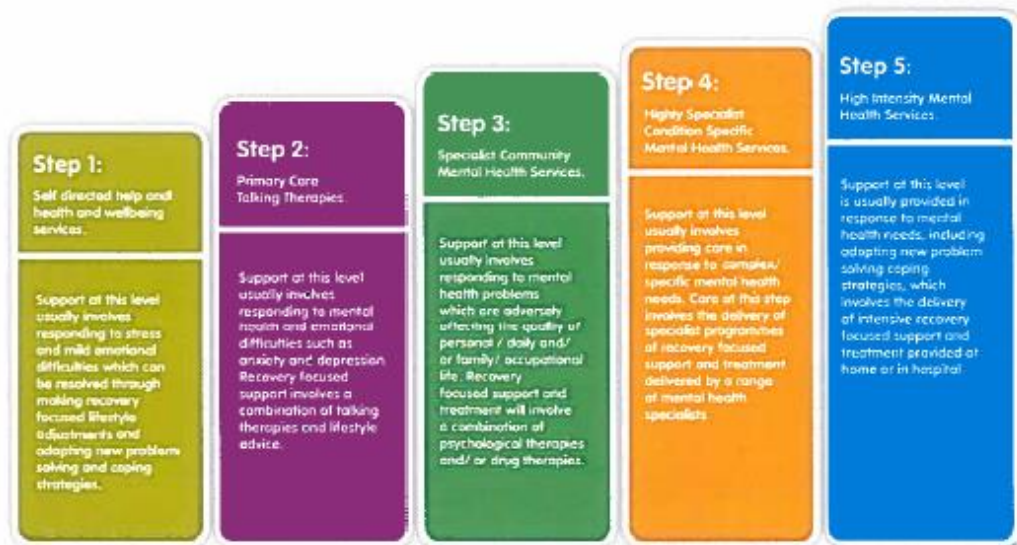
- Professor David Clark, University of Oxford
- Professor Anke Ehlers, University of Oxford
- Dr Patrick Smith, King's College London.
- Dr Brian Fitzmaurice, Trinity College Dublin

*\*Clinical Advisors can be co-opted onto this team as and when relevant expertise and advice is required throughout the design and delivery of the RTN with the agreement of the RTN Implementation Team.*

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## Annex C

### Psychological Therapies Stepped Care Model<sup>1</sup>



<sup>1</sup> Available at:  
[http://www.northerntrust.hscni.net/pdf/Care\\_pathway\\_for\\_people\\_who\\_require\\_mental\\_health\\_care\\_and\\_support.pdf](http://www.northerntrust.hscni.net/pdf/Care_pathway_for_people_who_require_mental_health_care_and_support.pdf)

**Annex D**

**Professional Bodies**

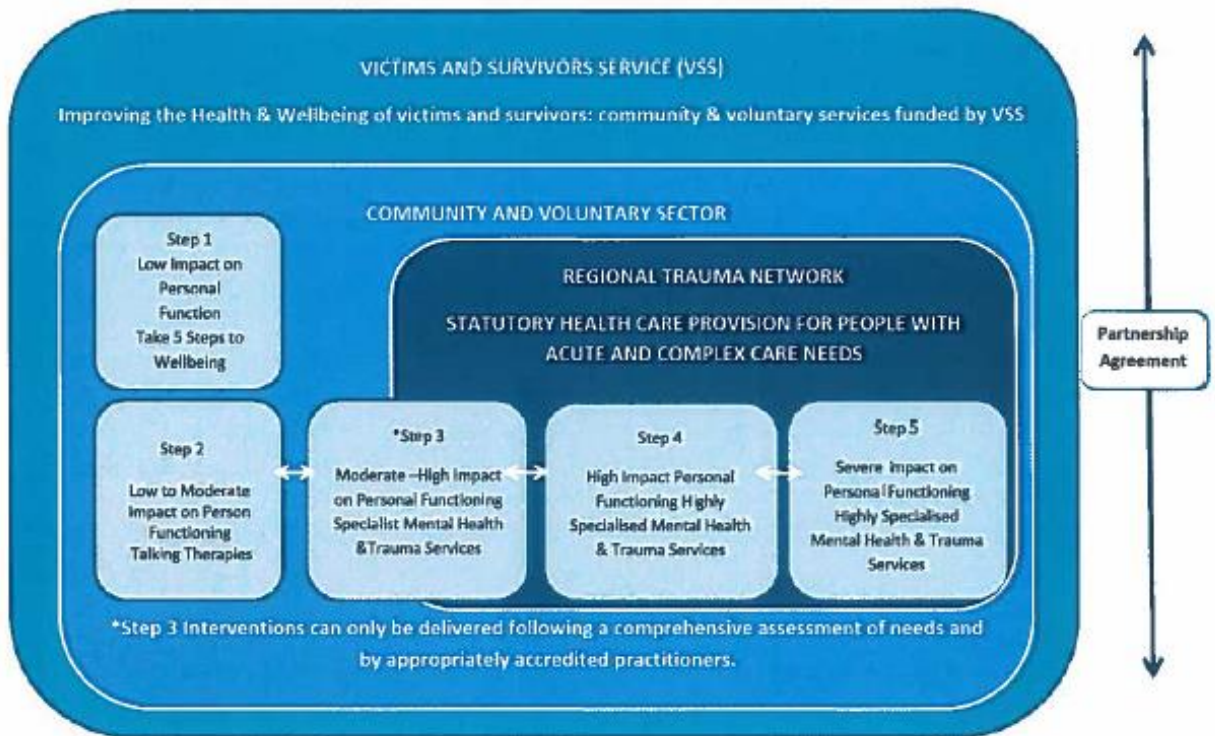
BACP:	British Association for Counselling and Psychotherapy.
IACP:	Irish Association for Counselling and Psychotherapy
IACT:	International Association of Counsellors and Therapists
UKCP:	United Kingdom Council for Psychotherapy
BPS:	British Psychological Society
BABCP:	British Association for Behavioural & Cognitive Psychotherapies
IABCP:	Irish Association of Behavioural and Cognitive Psychotherapy

**Regulatory Bodies**

NISCC:	Northern Ireland Social Care Council
HCPC:	Health and Care Professions Council
NMC:	Nursing and Midwifery Council
GMC:	General Medical Council

Annex E

Regional Trauma Network Service Model



## ANNEX 1: PARTNERSHIP AGREEMENT

### Annex F

#### Founding Financial Arrangements

##### HSC

Recurrent Funding of £0.895m has already been secured (£0.175m in 2016/17 and £0.720m in 2017/18). A total of £0.560m of this recurrent funding has already been allocated to Trusts leaving a balance of £0.338m available recurrent funding in 2018/19 (including pay and price uplifts).

An additional amount of £0.500m non-recurrent funding was allocated in 2018/19 as part of a £10m funding package for Mental Health services provided through the Confidence and Supply Transformation funding arrangement. This gives a total of £1.398m funding available for 2018/19 (£0.560m of which is at Trusts and £0.838m at HSCB).

It should be noted that the £0.500m Confidence and Supply Transformation funding is time limited and cannot be guaranteed as being available for 2019/20.

Further bids have been put forward for additional funding in 2019/20.

##### VSS

In the 2015 the PEACE IV EU Programme for Peace and Reconciliation<sup>2</sup> named the VSS as Lead Partner to deliver a *Victims and Survivors Programme*. This Programme aims to improve the health and wellbeing of victims and survivors, and to build capacity within the sector to deliver high quality services. It complements existing TEO funding for health and wellbeing services delivered by community and voluntary organisations for victims and survivors across the region.

The VSS PEACE IV application was approved in November 2016. It secured funding of £13,372,519 over the period November 2016 to July 2021. This budget includes, among other commitments: provision for a network of Health & Wellbeing Case Managers and Caseworkers, and resources for training and capacity building. On this basis, the community and voluntary sector element of the RTN for victims and survivors was established in April 2017.

<sup>2</sup> For information on the PEACE IV Programme, see: <https://www.seupb.eu/piv-overview> - Citizens' Summary Document available at: <https://seupb.eu/sites/default/files/styles/PEACEIV/PEACE%20IV%20-%20%20Draft%203.pdf>

## Annex 2: Stakeholder Engagement

The key stakeholders of the Regional Trauma Network (RTN) include but are not limited to:

- Minister (when appointed) and Department of Health (DoH)
- Northern Ireland Assembly Health Committee (when appointed)
- The Executive Office (TEO)
- Health and Social Care Trusts
- Health and Social Care Board (HSCB)
- Service users / carers / families
- Commission for Victims and Survivors (CVS)
- Victims and Survivors Service (VSS)
- Victims and Survivors Service-funded organisations in the community and voluntary sector
- Other Government Departments and statutory agencies
- The wider community and voluntary sector, including both advocacy and service providers
- Public Representatives
- Local populations across Northern Ireland

Stakeholder and wider public awareness of all Phases of the Regional Trauma Network has been raised prior to this Consultation over the period 2014 to the present, through the following key actions:

1. The Stormont House Agreement (2014) (see above).
2. On 10 September 2015 the Health Minister announced the establishment of the new 'Regional Trauma Mental Health Network.'<sup>128</sup>
3. In September 2016 the Health Minister re-affirmed commitment to the development of the network and pledged

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<sup>128</sup> See: <https://www.health-ni.gov.uk/news/health-minister-moves-transform-major-trauma-services>

a further non-recurrent £180K to enable its design, development and implementation.<sup>129</sup>

4. In November 2015 the European Union Programme for Peace and Reconciliation (PEACE IV)<sup>130</sup> named the Victims and Survivors Service as the Lead Partner delivering a *Provision of Services for Victims and Survivors Programme*, with a specific focus on improving the health and wellbeing of victims and survivors of the Conflict/Troubles and building capacity within the sector to deliver high quality services.
5. The Victims and Survivors Service application for PEACE IV funding was approved in November 2016, securing funding for five Health and Wellbeing Case Managers (Registered Practitioners), 25 Health and Wellbeing Caseworkers and significant resources to increase training and build capacity and expertise within the sector. On this basis, the community and voluntary sector element of the Regional Trauma Network for victims and survivors was established in April 2017.
6. In December 2016 a Partnership Agreement was drawn up between the Department of Health and the Executive Office, which set out the mechanisms via which the Victims and Survivors Service would interface with Health and Social Care to ensure relevant, timely, accessible, and comprehensive trauma care for those whose mental health has been impacted by the Troubles/Conflict.
7. The Health Minister committed recurrent funding of £0.175M in 2016/2017 to establish the Health and Social Care element of the Regional Trauma Network.

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<sup>129</sup> See: <https://www.health-ni.gov.uk/news/hamilton-announces-start-funding-new-world-leading-mental-trauma-service>

<sup>130</sup> For information on the PEACE IV Programme, see: <https://www.seupb.eu/piv-overview> - Citizens' Summary Document available at: <https://seupb.eu/sites/default/files/styles/PEACEIV/PEACE%20IV%20-%20%20Draft%203.pdf>



8. In 2016/2017 the Regional Trauma Network Implementation Team and Partnership Board were established with representatives from Health and Social Care Board, Victims and Survivors Service, Health and Social Care Trusts, Commission for Victims and Survivors, Department of Health, The Executive Office, and service users.
9. A further £0.720M was committed to the Health and Social Care element of the Regional Trauma Network by the Department of Health in 2017/2018.
10. From 2017/2018 and 2018/2019 a total of £0.560M has been allocated to Trusts.
11. In September 2018 a Regional Trauma Network Manager was appointed to the Health and Social Care Board.
12. Engagement with the All Party Group on Suicide Prevention (October 2018).
13. Active involvement with the Northern Ireland Adverse Childhood Experiences (ACEs) Reference Forum.
14. Active involvement with the Safeguarding Board Northern Ireland.
15. Ongoing engagement with the Rural Community Network.
16. The Department of Health allocated a further £0.500M to the Health and Social Care element of the Regional Trauma Network in 2018/2019.
17. Ongoing engagement with the Victims and Survivors Practitioners' Working Groups, the key platform for Victims and Survivors Service-funded community and voluntary organisations.

18. Ongoing engagement with the Victims and Survivors Service, the Commission for Victims and Survivors, and the Forum for Victims and Survivors.
19. Ongoing engagement with the Health and Social Care Trusts.
20. In January 2019, the Regional Trauma Network established a bespoke Co-production forum, in line with the Health and Social Care Co-production principles and ethos.<sup>131</sup> This forum is known as the Partnership Alliance for Learning from Lived Experience (see **Annex 3**).
21. Stakeholder engagement events lead by the Health and Social Care Board in February 2018 and February 2019, enabling communication with wider stakeholders. This included, for example, representatives from organisations that deliver services and support to Black and Minority Ethnic (BME) communities, Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) individuals and groups, refugees and asylum seekers, veterans, police and prison personnel, children and young people, families, and people living with Human Immunodeficiency Virus (HIV). More detail is provided below.\*  
Follow-up engagement with these stakeholders is ongoing.
22. December 2018 onwards presentations in relation to the development of the Regional Trauma Network have been delivered to:
  - Royal College of Psychiatrists International Congress, London.

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<sup>131</sup> To access the Department of Health (DoH) *Co-production Guide*, see: <https://www.health-ni.gov.uk/publications/co-production-guide-northern-ireland-connecting-and-realising-value-through-people>

## ANNEX 2: STAKEHOLDER ENGAGEMENT

- British Association of Counselling and Psychotherapy (BACP) Annual Conference, Belfast.
- Northern Ireland Eye Movement Desensitization and Reprocessing (EMDR) Annual Conference, Belfast.
- Royal College of Psychiatrists Northern Ireland Spring Conference, Belfast.
- 'Five Nations' Adverse Childhood Experiences Forum, London (including members from Health, Education, Police and Justice).
- Queens University Medical Students in partnership with WAVE Trauma Centre.
- Health and Social Care Trust staff across the region.
- National Health Service Confederation.
- Queens University Belfast Trauma-Focused Cognitive Behavioural Therapy Master students.
- Northern Ireland British Psychological Society (BPS) Annual Conference, Antrim.

\* The stakeholder event held on 21 February 2019 invited the following organisations to review and comment on this draft document:

- Action Mental Health
- Aisling Centre
- Aware Defeat Depression
- Barnardo's
- Beyond the Battlefield
- Birth Mothers for Justice
- Bryson Group
- Carers NI
- Cause
- Chinese Welfare Association
- Combat Stress
- Contact NI
- Counselling All Nations
- Cruse Bereavement Care

## ANNEX 2: STAKEHOLDER ENGAGEMENT

- Decorum NI
- Embrace NI
- Extern
- Health & Social Care Board
- Health & Social Care Trusts
- Horn of Africa People's Aid NI (HAPANI)
- Inspire Wellbeing
- Interethnic Forum
- MACS NI
- Men's Advisory Project NI (MAP NI)
- Migrant Centre NI
- Migrant Help UK
- Mind Yourself
- Mindwise NI
- Ministry of Defence
- National Society for the Prevention of Cruelty to Children (NSPCC)
- New Life Counselling
- Nexus
- Northern Ireland Association for the Care and Resettlement of Offenders (NIACRO)
- Northern Ireland Commissioner for Children and Young People (NICCY)
- Northern Ireland Council for Ethnic Minorities (NICEM)
- Northern Ireland Council for Refugees and Asylum Seekers (NICRAS)
- Northern Ireland Council for Voluntary Action (NICVA)
- Northern Ireland Gay Rights
- Northern Ireland Human Rights Commission
- Northern Ireland Local Government Association (NILGA)
- Omagh Ethnic Minority Group
- Police Rehabilitation and Retraining Trust (PRRT)
- Praxis Care
- Public Health Agency (PHA)
- Queer Space
- Rainbow Project
- Relate

## ANNEX 2: STAKEHOLDER ENGAGEMENT

- Rural Community Network
- SAIL
- Simon Community
- South Belfast Roundtable
- Survivors and Victims of Institutional Abuse
- Start 360
- The Law Centre
- The Red Cross
- UDR and Royal Irish Regiment Aftercare Service
- Victim Support NI
- Voices of Young People in Care (VOYPIC)
- Women's Aid

## **Annex 3: Partnership Alliance for Learning from Lived Experience (PALLE)**

### **Rationale for the Establishment of a Regional Trauma Network Partnership Alliance**

#### **REGIONAL TRAUMA NETWORK MISSION STATEMENT:**

*We work collaboratively and in partnership with people in our society to improve access to the highest quality psychological trauma care*

## **1 Introduction**

- 1.1 This paper outlines how the Regional Trauma Network will support and enable individuals with lived experience of accessing mental health and trauma services to participate in and inform the design, development, and delivery of improved, person-centred psychological trauma care in Northern Ireland.
- 1.2 This approach is underpinned by the Health and Social Care commitment to the ethos and principles of Co-Production.<sup>132</sup> It is also informed by the extensive stakeholder engagement undertaken by the Regional Trauma Network Management Team with delivery partners across the community and voluntary sector over the period 2016 to the present via:
- The Victims and Survivors Service and Victims and Survivors Practitioners Working Groups;
  - The Victims and Survivors Forum and Commission for Victims and Survivors;

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<sup>132</sup> To access the Department of Health (DoH) *Co-production Guide*, see: <https://www.health-ni.gov.uk/publications/co-production-guide-northern-ireland-connecting-and-realising-value-through-people>

- The wider community and voluntary organisations that support people who experience psychological trauma that is not related to the Troubles/Conflict (including for example refugees, victims of domestic and sexual violence, etc.); and
- Preliminary discussions with Health and Social Care service user consultants and co-production specialists.

## **2 Background: the Regional Trauma Network**

- 2.1 As part of the **Stormont House Agreement (2014)**, the Northern Ireland Executive made a commitment to establish a comprehensive Mental Health Trauma Service. This commitment refers to recommendations in a Comprehensive Needs Assessment published by the Commission for Victims and Survivors (CVS) in 2012, which identified mental health as the number one priority for victims and survivors of the Conflict/Troubles, and recommended the development of a trauma-focused coordinated service network lead by the Department of Health in partnership with the Executive Office. This network would deliver a comprehensive regional trauma service drawing and building on existing resources and expertise in the statutory and community and voluntary sector.
- 2.2 The Health and Social Care element of the **Regional Trauma Network** is an enhancement to existing provision of mental health services for children and adults. It aims to improve access to the highest quality trauma services to the population of Northern Ireland by the creation of a specialised local trauma team in each Health and Social Care Trust. It involves the design, co-production, and implementation of an integrated service model to respond to the needs of adults and children with trauma-related psychological and psychosocial difficulties.
- 2.3 When fully implemented, the Health and Social Care element of the Regional Trauma Network is for anyone who needs psychological trauma care, regardless of the origin of their trauma.

ANNEX 3:  
PARTNERSHIP ALLIANCE FOR LEARNING FROM LIVED EXPERIENCE

- 2.4 The Regional Trauma Network will be implemented on an incremental basis involving systematic stakeholder engagement and consultation; the development of referral and service-user pathways; continuous learning and analysis of evidence; better understanding of needs; and formulation of recommendations for ongoing service improvement.
- 2.5 The **strategic outcomes** that the Regional Trauma Network aims to deliver are as follows:
1. People have improved access to quality trauma care.
  2. Improved partnership working with the people of Northern Ireland to deliver highest quality trauma care.
  3. People receive world leading, effective, and evidence-based trauma care.
  4. An international centre of excellence for training, research, and trauma care is developed.
- 2.6 The Regional Trauma Network strategic outcomes align to the **‘three pillars’ approach** to clinical outcomes in mental health (McCusker, 2014),<sup>133</sup> a regional protocol that provides guidance on designing **accessible**, **acceptable**, and **effective** care.
- 2.7 Key constraints affecting the implementation of the Regional Trauma Network include:
1. **Resources:** the Health and Social Care element of the Regional Trauma Network is currently based on a mainly non-recurrent budget, as per all mental health inescapable funding in the current political climate.
  2. **Timescales:** the phased delivery schedule is streamlined as follows:<sup>134</sup>

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<sup>133</sup> McCusker, C. (2014). *An Outcomes Framework for Psychological Services in Northern Ireland*. Belfast: HSC Board.

<sup>134</sup> **Note:** these timescales may change, subject to recruitment and staff capacity.



- **PHASE 1 (Autumn 2019 – March 2020):** Working in partnership with the Victims and Survivors Service and its funded organisations, the Pathway Development Working Group will establish a system of pathways and an assessment protocol to create increased access to community, voluntary, and statutory services. This will be enabled via a network of 25 Health and Wellbeing Caseworkers (Northern Ireland Social Care Council Registered) and 5 Health and Wellbeing Case Managers (Registered Practitioners aligned to each Health and Social Care Trust) funded via the Victims and Survivors Service. A Child Pathway subgroup of the Pathway Development Working Group will be established in 2019 and a pathway will be developed for individuals with significant trauma symptoms that are not associated with Conflict/Troubles-related incident/s who experience barriers to accessing mental health services.
- **PHASE 2 (April 2020 – March 2021):** Recruitment of full Regional Trauma Network Local Trauma Teams and **implementation of the full model**, i.e. referral pathways open to all relevant statutory and non-statutory referral agents for both child and adult service users based on learning and experience from Phase 1.
- **PHASE 3 (April 2021 – September 2021):** Development of **future Regional Trauma Network strategy and action planning** based on: performance information and learning from Phases 1 and 2; evidence of need, demand, and planning to engage and meet needs of hard to reach groups; and recommendations for service development and additional resources.

2.8 Given these constraints, the Regional Trauma Network Management Team has a responsibility to ensure timely, quality delivery against all of its objectives. This includes maximising the opportunities for and effectiveness of engagement with

stakeholders, in particular people with lived experience of trauma and accessing mental health services.

### **3 Co-Production: a Framework for Engaging People with Lived Experience**

- 3.1 Service users are at the heart of the Regional Trauma Network commitment to working *collaboratively and in partnership* with those who have a stake in the successful delivery of accessible, acceptable, and effective trauma services. While the outcomes based accountability (OBA) requirements of the draft Programme for Government provide a framework for monitoring and measuring the *effectiveness* of Regional Trauma Network services,<sup>135</sup> to deliver an *accessible* and *acceptable* model, we need to listen to those with lived experience of mental health services and psychological trauma care.
- 3.2 The learning and good practice consolidated in the Department of Health *Co-production Guide* provides a robust framework for engaging with service users and people with lived experience of ill health, need, and access to services, and enabling and facilitating positive change and on that basis.
- 3.3 In the *Guide*, 'co-production' is defined as follows:

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<sup>135</sup> Please refer to the *Regional Trauma Network Phase 1 Outcomes Delivery Plan (September 2018-March 2020)*.

**Co-production:** *A highly person centred approach which enables partnership working between people in order to achieve positive and agreed change in the design, delivery, and experience of health and social care. It is deeply rooted in connecting and empowering people and is predicated on valuing and utilising the contribution of all involved. It seeks to combine people's strengths, knowledge, expertise and resources in order to collaboratively improve personal, family and community health and wellbeing outcomes. Co-production is not just a word, it is not just a concept, it is a genuine partnership approach which brings people together to find shared solutions. In practice co-production involves partnering with people from the start to the end of any change that affects them. It works best when people are empowered to influence decision making and care delivery processes.*

- 3.4 Decision making in Health and Social Care is governed by a wide range of legal, professional, and policy mandates. With the introduction of Personal and Public Involvement (PPI) Legislation, co-production creates the opportunity for people to work in genuine partnership and to take shared responsibility for improving health and social care outcomes.
- 3.5 Whilst recognising that shared decision making does not mean everyone has the same authority, co-production seeks to empower partners to take shared ownership for the delivery of health and social care outcomes. Inevitably, within this context, the extent to which decisions and solutions can reflect the diversity of interests and expectations of all partners will be limited by Health and Social Care responsibilities to adhere to legal and regulatory requirements, financial accountabilities, and Executive and Ministerial priorities. Clear and ongoing communication between partners is, therefore, an essential aspect of effective co-production.

3.6 The **six principles of co-production**, summarised below, are key reference points for understanding the ethos of this approach:

1. **Valuing People:** Co-production is a person centred process which is dependent on building reciprocal relationships between people.
2. **Building Representative Networks:** A core principle of co-production is to move towards balanced meaningful participation, engagement and shared ownership.
3. **Building People's Capacity:** Co-production is dependent on creating the circumstances for shared decision making and power from boardroom to point of care services. This requires investment in building people's knowledge; training people in PPI, co-production, quality improvement, population health, and community development approaches; and harnessing the efforts and work of existing organisations, networks, and teams.
4. **Reciprocal Recognition:** Co-production requires the contribution of all participants to be valued and a commitment to learn together, and resolve different perspectives with respect.
5. **Cross-Boundary Working:** Co-production creates the conditions for a multi-agency approach to improving outcomes for local communities.
6. **Enabling and Facilitating:** Co-production requires staff, leaders and managers to become facilitators and enablers of change. Effective facilitation is established by empowering all involved to have solution focused approaches and promotes joint responsibility for achieving positive outcomes.

3.7 The second principle, ***Building Representative Networks*** is directly relevant to the Regional Trauma Network mission to work collaboratively and in partnership with service users and people with lived experience of trauma. The *Guide* provides the following additional detail in relation to this principle:

### **Building Representative Networks**

*A core principle of co-production is to move towards balanced meaningful participation, engagement and shared ownership. It is about developing effective collaborative partnerships in order to co-design and co-deliver services. It is dependent on developing representative and sustainable networks, with people from all sectors including individuals with significant trauma symptoms who experience barriers to accessing mental health services. The principle of representative means that co-design and co-delivery groups should reflect a balance of people who use services, staff who provide services and as appropriate other external partners.*

*This requires detailed **stakeholder mapping** using the ‘**ARE IN**’ principles:*

- **Authority:** *People with the ability to act to influence change and enable it to happen when a solution has been developed by the group.*
- **Resources:** *People who know what we have capacity to do/not do (e.g. finance/HR/access/influence).*
- **Expertise:** *In the topic (social, economic, technical, professional etc.).*
- **Information:** *That others need (data etc.).*
- **Need:** *Service users, carers, staff and others who will be affected by the outcome.*

*Mapping stakeholders in this way will help strengthen existing networks; enable the development of new networks; and to bridge networks where gaps exist. It also creates a real opportunity to maximise social capital through the development of peer led/community networks.*

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- 3.8 Together, the six principles of co-production and the recommended ARE IN stakeholder mapping approach will guide the Regional Trauma Network strategy for building a Partnership Alliance for Learning from Lived Experience.
- 3.9 In doing so, the Regional Trauma Network is cognizant of both the importance of building participants' – and potential new participants' – capacity to contribute to such a forum, and the critical need to operate efficiently and effectively within the resource and timescale constraints highlighted above. For this reason, the Regional Trauma Network will initially aim to convene a Partnership Alliance of individuals with existing capacity and experience in relation to co-production and co-design processes. Engaging with this forum and adjusting its scope, focus, and membership over the phased implementation of the Regional Trauma Network will create the opportunities to build upon and diversify this existing capacity.

#### **4 Next Steps**

In keeping with the ethos of co-production, the Regional Trauma Network Management Team has been working with individuals with lived experience of trauma and mental health services from the very start of the planning process, to identify and achieve an end result that is collaboratively agreed. On the basis of that engagement, the following next steps have been identified:

- 4.1 **In February 2019**, the Regional Trauma Network Management Team, working with a small number of existing service users and people with relevant lived experience, will conduct an ARE IN stakeholder mapping exercise.
- 4.2 In order to build a representative network of people with lived experience of trauma and access to mental health services, and recognising that trauma affects people from all backgrounds, this process will specifically aim to identify service users or

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representatives from hard to reach communities and groups across society.

- 4.2 On that basis, the Regional Trauma Network Management Team seek expressions of interest from individuals within identified stakeholder groups, and invite them to engage in the new Partnership Alliance for a period of up to two calendar years.
- 4.3 To ensure the Partnership Alliance can function as a participatory mechanism, the membership will initially be limited to a maximum of 12 individuals. If the number of people expressing an interest and with capacity to participate exceeds 12, the Regional Trauma Network will offer the additional individuals the opportunity to assist with related developments (e.g. training and induction support, championing the Regional Trauma Network in their respective networks, etc.).
- 4.4 The Regional Trauma Network Management Team will aim to convene the first Partnership Alliance meeting in April 2019. At that meeting, the members will agree ground rules and a Terms of Reference. Arrangements will also be made for training and capacity building, commencing with the Health and Social Care Board 'Finding Your Voice' programme.
- 4.5 The meeting and process will be kept under review, and additional representatives may be co-opted as necessary.
- 4.6 In this way, we aim to build a Partnership Alliance that is effective, inclusive, and reflects the diversity of backgrounds and circumstances of the people who may need to access the Regional Trauma Network.

## Annex 4: Regional Trauma Network Trauma Measures

Table A4 below shows the key evidence-based measures that will guide the Regional Trauma Network assessment, monitoring, and evaluation protocols.

This framework be kept under review over the implementation period and adjusted in line with learning and emerging evidence as required.

For further information, please refer to the **Regional Trauma Network Operations Manual**.

**Table A4: Regional Trauma Network Trauma Measures**

Measure		Description	Psychometric Properties
1	Impact of Event Scale-Revised	22 item scale measuring distress levels on a range of difficulties related to trauma symptoms.	$\alpha = 0.95$ (SD 0.90, Mean 1.59). Also good concurrent and discriminative validity. RTC sample (1)
2	Trauma Symptom Inventory-2	120 item measure across 13 clinical scales (Anxiety, Intrusions, Defensive avoidance, Dissociation, Sleep Disturbance, Insecure attachment, Impaired self-reference, Depression, Suicidality, Sexual disturbance, Tension reduction behaviour, Anger, Somatic preoccupation).	$\alpha = 0.80$ (2) Convergent validity for TSI-1 (3)



ANNEX 4: TRAUMA MEASURES

Measure		Description	Psychometric Properties
3	PCL-5	20-item self-report measure that assesses the presence and severity of PTSD symptoms. Items on the PCL-5 correspond with DSM-5 criteria for PTSD.	$\alpha = .96$ Convergent and discriminative validity. Veteran sample (4)
4	Post-Traumatic Stress Disorder Checklist	17-item self-report scale for PTSD is based on DSM-IV criteria and takes 5-7 mins to complete. There are slightly different versions for use with military (M) or civilian (C) populations, as well as a version focused on a "specific stressful experience" (S).	$\alpha = .97$ with good convergent validity (5)
5	Post-Traumatic Symptom Scale-Interview Version.	Semi-structured interview for PTSD assessment and diagnosis. It consists of 17 items corresponding to the DSM-IV PTSD symptoms, assessing re-experiencing, avoidance and hyperarousal symptoms. Items are rated on 0-3 scales for combined frequency and severity, yielding one score per item. 25 mins to complete.	Inter-rater reliability for PTSD diagnosis ( $k = .91$ ) and overall severity ( $r = .97$ ) (6)

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Measure		Description	Psychometric Properties
6	Clinician Administered PTSD Scale	Structured interview designed to make a categorical PTSD diagnosis, as well as to provide a measure of PTSD symptom severity. 30-60 minutes.	$\alpha = .94$ and strong convergent validity (7)
7	Structured Interview for Disorder of Extreme Stress – Self Report	Self-report instrument and consists of 45 items divided into 6 subscales according to symptoms of DESNOS, with answers on a five-point Likert scale.	$\alpha = .96$ and divergent validity found (8)
8	International Trauma Questionnaire	12 item self-report diagnostic measure for PTSD and Complex PTSD	Awaiting correspondence from developer
9	Complex Trauma Questionnaire	Measure of early relational trauma	Good convergent validity and internal consistency of factors (9)
10	Dissociative Experiences Scale-II	28 item self-report measure designed to assess trait dissociation.	$\alpha = .96$ and convergent validity found (10)

**References:**

- 1) Beck, J. G., Grant, D. M., Read, J. P., Clapp, J. D., Coffey, S. F., Miller, L. M., & Palyo, S. A. (2008). The Impact of Event Scale-Revised: Psychometric properties in a sample of motor vehicle accident survivors. *Journal of Anxiety Disorders*, 22(2), 187-198.

- 2) Runtz, M., Godbout, N., Eadie, E., & Briere, J. (2008). Validation of the revised Trauma Symptom Inventory (TSI-2). *In Annual Meeting of the American Psychological Association*, Boston, MA.
- 3) Snyder, J. J., Elhai, J. D., North, T. C., & Heaney, C. J. (2009). Reliability and validity of the Trauma Symptom Inventory with veterans evaluated for posttraumatic stress disorder. *Psychiatry Research*, 170(2-3), 256-261.
- 4) Bovin, M. J., Marx, B. P., Weathers, F. W., Gallagher, M. W., Rodriguez, P., Schnurr, P. P., & Keane, T. M. (2016). Psychometric properties of the PTSD checklist for diagnostic and statistical manual of mental disorders–fifth edition (PCL-5) in veterans. *Psychological Assessment*, 28(11), 1379.
- 5) Weathers, F. W., Litz, B. T., Herman, D. S., Huska, J. A., & Keane, T. M. (1993). *The PTSD Checklist (PCL): Reliability, Validity, and Diagnostic Utility*. Paper presented at the 9th Annual Conference of the ISTSS, San Antonio, TX.
- 6) Foa, E. B., Riggs, D. S., Dancu, C. V., & Rothbaum, B. O. (1993). Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *Journal of Traumatic Stress*, 6, 459-473.
- 7) Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Gusman, F. D., Charney, D. S., & Keane, T. M. (1995). The development of a clinician-administered PTSD scale. *Journal of Traumatic Stress*, 8, 75-90.
- 8) Zlotnick, C., & Pearlstein, T. (1997). Validation of the structured interview for disorders of extreme stress. *Comprehensive Psychiatry*, 38(4), 243-247.
- 9) Maggiora Vergano, C., Lauriola, M., & Speranza, A. M. (2015). The Complex Trauma Questionnaire (ComplexTQ): development and preliminary psychometric properties of an instrument for measuring early relational trauma. *Frontiers in Psychology*, 6, 1323.
- 10) Zingrone, N. L., & Alvarado, C. S. (2001). The Dissociative Experiences Scale-II: Descriptive statistics, factor analysis, and frequency of experiences. *Imagination, Cognition and Personality*, 21(2), 145-157.

## Annex 5: Reference List

Belfast Health & Social Care Trust (BHSCT) & Aware Defeat Depression. (2014). *Ethnic Minorities: Mental Health Toolkit – A Guide for Practitioners*. Available at: [http://www.belfasttrust.hscni.net/pdf/BME\\_Cultural\\_Awareness\\_Document\\_sml.pdf](http://www.belfasttrust.hscni.net/pdf/BME_Cultural_Awareness_Document_sml.pdf)

Breen-Smyth, M. (2012). *The needs of individuals and their families injured as a result of the Troubles in Northern Ireland*. Belfast: WAVE Trauma Centre. Available at: <http://www.wavetraumacentre.org.uk/campaigns/the-injured-campaign-recognition-for-all>

Bunting, B., Murphy, S., O'Neill, S., & Ferry, F. (2013). Prevalence and treatment of 12-month DSM-IV disorders in the Northern Ireland study of health and stress. *Social Psychiatry and Psychiatric Epidemiology*, 48 (1), 81-93.

Carmel, T. C. & Erickson-Schroth, L. (2016). 'Mental Health and the Transgender Population', *Journal of Psychosocial Nursing & Mental Health Services*, 54 (12): 44–48.

Commission for Victims & Survivors (CVS). (2011). *Troubled consequences: A report on the mental health impact of the civil conflict in Northern Ireland*. (Prepared for the Commission for Victims and Survivors by the Bamford Centre for Mental Health and Wellbeing at the University of Ulster in Partnership with the Northern Ireland Centre for Trauma and Transformation and Compass.) Available at: <https://www.cvsni.org/media/1435/troubled-consequences-october-2011.pdf>

Commission for Victims and Survivors (CVS). (2012). *Comprehensive Needs Assessment - Final Report*. Available at: <https://www.cvsni.org/resources/research/>

## ANNEX 5: REFERENCE LIST

- Commission for Victims and Survivors (CVS). (2014). *Pension for the Severely Injured Project - Final Report*. (Prepared for the Commission by RSM McClure Watters.) Available at: <https://www.cvsni.org/resources/research/>
- Commission for Victims and Survivors (CVS). (2015). *Towards a Better Future: The Trans-generational Impact of the Troubles on Mental Health*. [Prepared for CVS by Ulster University – 2015]. Available at: <https://www.cvsni.org/resources/research/>
- Conciliation Resources. (2014). *Gender in Peacebuilding*. Available at: [http://www.cr.org/downloads/CR\\_Gender\\_peacebuilding.pdf](http://www.cr.org/downloads/CR_Gender_peacebuilding.pdf)
- Department of Health, Social Services & Public Safety (DHSSPS). (2011). *Transforming Your Care: A Review of Health and Social Care in Northern Ireland*. Available at: <https://www.health-ni.gov.uk/topics/health-policy/transforming-your-care>
- Department of Health, Social Services & Public Safety (DHSSPS). (2012). *Delivering the Bamford Vision: The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability - Action Plan 2012-2015*. Available at: <http://www.niassembly.gov.uk/globalassets/documents/employment-and-learning/inquiries/post-sen/government--academic-papers/delivering-the-bamford-vision---action-plan-2012---2015.pdf>
- Department of Health, Social Services and Public Safety Northern Ireland (DHSSPS). (2014a). *Northern Ireland Health and Social Care Inequalities Monitoring System Regional Report*. Available at: <http://www.dhsspsni.gov.uk/hscims-2014-bulletin.pdf>

- Department of Health, Social Services and Public Safety (DHSSPS). (2014b). *Making Life Better: A Whole System Strategic Framework for Public Health 2013-2023*. Available at: [https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/making-life-better-strategic-framework-2013-2023\\_0.pdf](https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/making-life-better-strategic-framework-2013-2023_0.pdf)
- Department of Health. (2018). *Co-Production Guide for Northern Ireland - Connecting and Realising Value Through People*. Available at: <https://www.health-ni.gov.uk/publications/co-production-guide-northern-ireland-connecting-and-realising-value-through-people>
- Disability Discrimination (Northern Ireland) Order 2006. Available at: <http://www.legislation.gov.uk/nisi/2006/312/contents/made>
- Doyle, J.L. & McWilliams, M. (2018). *Intimate Partner Violence in Conflict and Post-Conflict Societies: Insights and Lessons from Northern Ireland*. Belfast: Ulster University. Available at: <https://www.ulster.ac.uk/news/2018/september/study-shows-how-victims-of-domestic-violencebenefitted-from-the-peace-process-in-northern-ireland/>
- Elliot, M. et al. (2015). Sexual Minorities in England Have Poorer Health and Worse Health Care Experiences: A National Survey. *Journal of General Internal Medicine*, 30 (1): 9-16
- Eoin Rooney, NHSCT and Ballymena Inter-Ethnic Forum, 2013 – cited in Belfast Health & Social Care Trust (BHSCT) & Aware Defeat Depression. (2014). *Ethnic Minorities Mental Health Toolkit: A Guide for Practitioners*. (p. 3). Available at: [http://www.belfasttrust.hscni.net/pdf/BME\\_Cultural\\_Awareness\\_Document\\_sml.pdf](http://www.belfasttrust.hscni.net/pdf/BME_Cultural_Awareness_Document_sml.pdf)
- Fay, M., Morrissey, M., Smyth, M. & Wong, T. (1999). *The Cost of the Troubles Study: Report on the Northern Ireland Survey*. Derry-Londonderry: INCORE.

- Fay, M.T., Morrissey, M. & Smyth, M. (1998). *Mapping Troubles-Related Deaths in Northern Ireland 1969-1998*. Derry/Londonderry: INCORE. (For information available online, see: <http://cain.ulst.ac.uk/issues/violence/cts/fay98.htm>.)
- Ferry, F., Bolton, D., Bunting, B., Devine, B., McCann, S. & Murphy, S. (2008). *Trauma, Health and Conflict in Northern Ireland: A Study of the epidemiology of trauma related disorders and qualitative investigation of the impact of trauma on the individual*. Londonderry & Omagh: The Northern Ireland Centre for Trauma and Transformation & The Psychology Research Institute, University of Ulster.
- Ferry, F., Bolton, D., Bunting, B., O'Neill, S., Murphy, S. & Devine, B. (2011). *The Economic Impact of Post-Traumatic Stress Disorder in Northern Ireland: A report on the direct and indirect health economic cost of post-traumatic stress disorder and the specific impact of conflict in Northern Ireland*. Londonderry & Omagh: The Northern Ireland Centre for Trauma and Transformation & The Psychology Research Institute, University of Ulster.
- Gray, A. M., Hamilton, J., Kelly, G., Lynn, B., Melaugh, M. & Robinson, G. (2018). *Northern Ireland Peace Monitoring Report Number 5*. Belfast: Community Relations Council. Available at: <https://www.community-relations.org.uk/publications/northern-ireland-peace-monitoring-report>
- Gray, A.M., Horgan, G., & Leighton, A. (2013). Moving towards a Sexual Orientation Strategy for Northern Ireland. Available at: <http://www.ark.ac.uk/pdfs/policybriefs/PBso.pdf>

ANNEX 5: REFERENCE LIST

- Health & Social Care Board (HSCB). (2015). *Accessible Formats Policy for the Provision of Information* (v 0.2). Available at: [http://www.hscbusiness.hscni.net/pdf/Accessible\\_Formats\\_Policy\\_Version\\_0.2\\_Jan\\_2015.pdf](http://www.hscbusiness.hscni.net/pdf/Accessible_Formats_Policy_Version_0.2_Jan_2015.pdf)
- Health & Social Care Board (HSCB). (2018). *Disability Action Plan 2015-2019 (Updated April 2018)*. Available at: <http://www.hscboard.hscni.net/download/PUBLICATIONS/EQUALITY/HSCB-Disability-Action-Plan-April-2018.pdf>
- Health & Social Care Board. (2018). *Working Together: A Pathway for Children and Young People through Child and Adolescent Mental Health Services (CAMHS)*. Available at: [http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you\\_in\\_mind/21122018-HSCB-CAMHS-Pathway-Document.pdf](http://www.hscboard.hscni.net/download/PUBLICATIONS/MENTAL%20HEALTH%20AND%20LEARNING%20DISABILITY/you_in_mind/21122018-HSCB-CAMHS-Pathway-Document.pdf)
- Hughes, J., Campbell, A., Hewstone, M., & Cairns, E. (2007). 'Segregation in Northern Ireland: Implications for Community Relations Policy,' *Policy Studies*, 28 (1): 33-53.
- Kelly, G. (2012). *Progressing Good Relations and Reconciliation in Post-Agreement Northern Ireland*. Derry/Londonderry: INCORE. Available at: [http://uir.ulster.ac.uk/21681/1/Reconciliation\\_Research\\_Report\\_Kelly.pdf](http://uir.ulster.ac.uk/21681/1/Reconciliation_Research_Report_Kelly.pdf)
- Legacy Gender Integration Group. (2015). *Gender Principles for Dealing with the Legacy of the Past*. Available at: [https://www.ulster.ac.uk/\\_data/assets/pdf\\_file/0009/66285/Gender-Principle-Report-Sept-2015\\_Final-Version.pdf](https://www.ulster.ac.uk/_data/assets/pdf_file/0009/66285/Gender-Principle-Report-Sept-2015_Final-Version.pdf)



- Light, B. et al. (2011). *Lesbian, Gay & Bisexual Women in the North West: A Multi-Method Study of Cervical Screening Attitudes, Experiences and Uptake*. The Lesbian & Gay Foundation and University of Salford. Available at: [http://usir.salford.ac.uk/id/eprint/16596/5/LGF\\_Final\\_Report3.pdf](http://usir.salford.ac.uk/id/eprint/16596/5/LGF_Final_Report3.pdf)
- McBride, R. (2011). *Healthcare issues for transgender people living in Northern Ireland*. Available at: <http://conflictresearch.org.uk/reports/equality-diversity/Healthcare-issues-for-transgender-individuals.pdf>
- McCusker, C. (2014). *An Outcomes Framework for Psychological Services in Northern Ireland*. Belfast: Health & Social Care Board.
- McNeil, J., Bailey, L., Ellis, S., Morton, J., & Regan, M. (2012) *Trans Mental Health Study 2012*. Available at [https://www.gires.org.uk/wp-content/uploads/2014/08/trans\\_mh\\_study.pdf](https://www.gires.org.uk/wp-content/uploads/2014/08/trans_mh_study.pdf)
- Mental Health Foundation. (2016). *Mental Health in Northern Ireland: Fundamental Facts 2016*. Available at: <https://www.mentalhealth.org.uk/publications/mental-health-northern-ireland-fundamental-facts>
- National Institute for Health and Care Excellence (NICE). (2018). *Post-traumatic stress disorder: NICE guideline [NG116]*. Available at: <https://www.nice.org.uk/guidance/ng116>
- National Institute for Mental Health in England. (2012). *Mental disorders, suicide, and deliberate self-harm in lesbian, gay and bisexual people a systematic review*. Available at: <https://www.mindout.org.uk/wp-content/uploads/2012/06/self-harm-in-lesbian-gay-and-bisexual-people.pdf>
- Northern Ireland Census. (2011). Available at: <http://www.nisra.gov.uk/census.html>

ANNEX 5: REFERENCE LIST

Northern Ireland Commission for Children and Young People (NICCY). (2017). *Child and Adolescent Mental Health in NI: A Scoping Paper which includes the human rights basis of mental health, a review of evidence regarding prevalence and need, an overview of the CAMHS system, and an outline of key policy implications*. Available at: <https://www.niccy.org/media/2810/niccy-scoping-paper-mental-health-review-apr-2017.pdf>

Northern Ireland Health Survey (2017) Available at: <https://www.health-ni.gov.uk/publications/tables-health-survey-northern-ireland>

Northern Ireland Office. (2014). *The Stormont House Agreement*. Available at: <https://www.gov.uk/government/publications/the-stormont-house-agreement>

Northern Ireland Policing Board (NIPB). (2017). *Thematic Review of Policing Race Hate Crime*. Available at: <https://www.nipolicingboard.org.uk/sites/nipb/files/media-files/race-hate-crime-thematic-review.PDF>

Northern Ireland Statistics & Research Agency (NISRA). (2018). *Suicide Deaths 2017*. Available at: <http://www.nisra.gov.uk/demography/default.asp31.htm>

O'Doherty, J. (2016). *OUTstanding in your field. Exploring the needs of LGB&T people in rural Northern Ireland*. Available at: <https://www.rainbow-project.org/Handlers/Download.ashx?IDMF=75981d9c-f647-46bf-86e2-a27b566cfe63>

- O'Hara, M. (2013). *Through Our Minds: Exploring the Emotional Health and Wellbeing of Lesbian, Gay, Bisexual and Transgender People in Northern Ireland*. Available at: <https://www.rainbow-project.org/Handlers/Download.ashx?IDMF=fce626f4-de30-40d4-bf4f-43dd4afc39ea>
- O'Neill S, Ferry F, Murphy S, Corry C, Bolton D, et al. (2014). 'Patterns of Suicidal Ideation and Behaviour in Northern Ireland and Associations with Conflict Related Trauma', *PLoS ONE* 9(3): e91532. Available at: <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0091532>
- Police Service of Northern Ireland. (2017) *Annual Report and Accounts for the year ended 31 March 2017*. Available at: <https://www.psni.police.uk/globalassets/inside-the-psni/our-departments/finance-and-support-services/documents/main-report.pdf>
- Quiery, M. (2007). *Invisible Women. A review of the Impact of Discrimination and Social Exclusion on Lesbian and Bisexual women's health in Northern Ireland*. Lesbian Advocacy Services Initiative, Ballymena. Available at: [http://hereni.org/wp-content/uploads/2012/09/invisible\\_women.pdf](http://hereni.org/wp-content/uploads/2012/09/invisible_women.pdf)
- Regional Trauma Network (RTN). (2018). *Regional Managed Care Network for the Treatment of Psychological Trauma (the Regional Trauma Network) Operations Manual [Working Document – version 1.0]*. Belfast: Health & Social Care Board (HSCB).
- Rural Needs Act (Northern Ireland) 2016. Available at: <https://www.legislation.gov.uk/nia/2016/19/contents> (See also: <https://www.daera-ni.gov.uk/articles/rural-needs>)

- Russell, R. (2016). *International Migration in Northern Ireland: an Update – Research and Information Service Research Paper*. Belfast: Northern Ireland Assembly. Available at: <http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2016-2021/2016/general/3916.pdf>
- Schubotz, D. & O’Hara, M. (2011). ‘Shared Future? Exclusion, Stigmatization, and Mental Health of Same-Sex-Attracted Young People in Northern Ireland’, *Youth and Society*, 43 (2): 488-508.
- Sneddon, H. (2018). *Mental Health and Wellbeing of Asylum Seekers and Refugees: Evidence Review and Scoping*. Belfast: Public Health Agency.
- Special EU Programmes Body (SEUPB). (2015). *Citizens’ Summary: PEACE IV Programme (2014-2020)*. Available at: <https://seupb.eu/sites/default/files/styles/PEACEIV/PEACE%20IV%20-%20%20Draft%203.pdf>
- Victims and Survivors (Northern Ireland) Order 2006. Available at: <http://www.legislation.gov.uk/nisi/2006/2953/contents>
- Victims and Survivors Service (VSS). (2018). *Estimation of Needs and Demand for Statutory Services (as at 23 October 2018)*. Belfast: VSS.
- Wendt, D. & Shafer, K. (2016). Gender and Attitudes about Mental Health Help Seeking: Results from National Data. *Health & Social Work*, 41:1 (e20-e28).
- Women’s Aid Federation Northern Ireland. (2018a). *A response to Service Framework for Mental Health & Wellbeing 2018-2021*. Available at: <https://www.womensaidni.org/resources/>

ANNEX 5: REFERENCE LIST

Women's Aid Federation Northern Ireland. (2018b). *Violence against Women Consultation with Victims, Survivors and Service Users*. Available at:  
<https://www.womensaidni.org/resources/>

## **Annex 6: The Steps of an Equality Impact Assessment**

### **1. What is it we are actually looking at? ('Aims of policy')**

The first part of an EQIA involves thoroughly understanding the policy to be assessed; what context it is set in; who is responsible for what; what links there are with other organisations or individuals in implementing the policy etc.

### **2. How can we tell what is happening on the ground? ('Consideration of data')**

This involves reviewing what data is available in-house or elsewhere and identifying what data needs to be newly collected. 'Data' means both statistics and the views, experiences and suggestions of those affected by the policy. 'Collecting new data' means going out and doing a survey and also talking to people who are affected by a policy or those who are involved in implementing the policy, for example in delivering a service.

### **3. So are there any problems for any of the groups? ('Assessment of impacts')**

All relevant data that has been identified (whether collected from available sources or newly gathered) is brought together and analysed. Conclusions are drawn as to the impact of the policy on the nine groups.

### **4. What can be done to make things fairer? ('Consideration of measures')**

Now the findings are related back to action: proposals are what can be done to address any inequalities/ unfairness that the analysis of the data has revealed.

### **5. Are we getting the right picture and are we thinking of doing the right thing? ('Formal consultation')**

The findings and the proposed actions are brought back to the public at this stage, usually on the basis of a draft report. Now

it's time to find out what people think about the analysis and proposals!

**6. With what people have told us – what are we going to do? ('Decision by public authority')**

After the wider public has had a chance to comment on the analysis and proposals it's time for the organisation to take final decisions and commit themselves to action points.

**7. This is what we have found out and this is what we will do ('Publication of results of EQIA')**

These decisions and commitments are published in a final report alongside the findings from the analysis of collected data and the comments raised by the wider public during formal consultation.

**8. Keeping a close eye on what is happening ('Monitoring of adverse impacts')**

An EQIA is not a one off. It's important to keep a close eye on what difference the changes to the policy actually make.

## Annex 7: Glossary

**Child and Adolescent Mental Health Services (CAMHS)**

CAMHS are the services within Health and Social Care that assess and treat young people with emotional, behavioural, and/or mental health difficulties.

**Commission for Victims and Survivors (CVS)**

The Commission is a Non-Departmental Public Body (NDPB) of The Executive Office.

Within *the Strategy for Victims and Survivors 2009*, the Commission is identified as:

- Being the primary source of advice to government on victims and survivors issues;
- Having responsibility for the strategic assessment of need; and
- Being responsible for ensuring that the correct structures are in place to meet those needs and identify gaps in provision.

‘Victims and survivors’ refer to victims and survivors of the Northern Ireland Conflict/Troubles, as defined in the Victims and Survivors (NI) Order 2006.

For more information, see: [www.cvsni.org](http://www.cvsni.org)



**Community  
Mental Health  
Teams (CMHTs)**

Community Mental Health Teams (CMHTs) within Health and Social Care support people living in the community who have complex or serious mental health problems. Different mental health professionals work in a CMHT.

**Complex Post-  
traumatic Stress  
Disorder  
(CPTSD)**

Complex PTSD is a clinically-diagnosed condition listed in the WHO International Classification of Diseases, 11th version (ICD-11). It is defined by the presence of elevated PTSD symptoms as well as disturbances in three domains of self-organization: affective dysregulation, negative self-concept, and interpersonal problems.

CPTSD is associated with chronic sexual, psychological and physical abuse and neglect, chronic intimate partner violence, victims of kidnapping and hostage situations, indentured servants, victims of slavery and human trafficking, sweatshop workers, prisoners of war, concentration camp survivors, residential school abuse survivors, and defectors from cults or cult-like organizations. Situations involving captivity/entrapment can lead to CPTSD-like symptoms, which can include prolonged feelings of terror, worthlessness, helplessness, and deformation of one's identity and sense of self.

**Diagnostic and Statistical Manual of Mental Disorders (DSM–5)**

The Diagnostic and Statistical Manual of Mental Disorders (DSM–5) is the product of more than 10 years of effort by hundreds of international experts in all aspects of mental health. It is an authoritative volume that defines and classifies mental disorders in order to improve diagnoses, treatment, and research.

**Health and Social Care (HSC)**

Health and Social Care in Northern Ireland is the name of the publicly funded service which provides public health and other social care services.

The Northern Ireland Executive is responsible for funding the HSC through the Department of Health.

HSC is free of charge to all residents of Northern Ireland and the rest of the United Kingdom.

**Health & Social Care Board (HSCB)**

The Health & Social Care Board is a regional Arms-Length Body (ALB) of the Department of Health, and responsible for the commissioning and coordination of health and social care services across Northern Ireland.

**Health and Social Care Trust (HSCT)**

Five Health and Social Care Trusts provide integrated health and social care services across Northern Ireland: Belfast HSC Trust, South Eastern HSC Trust, Western HSC Trust, Southern HSC Trust and Northern HSC Trust.

HSC Trusts manage and administer hospitals, health centres, residential homes, day centres, and other health and social care facilities, and they provide a wide range of health and social care services to the community.

*Note: There is a sixth Trust, the Northern Ireland Ambulance Service. This EQIA does not refer to this service.*

**International Classification of Disease, Eleventh Revision (ICD-11)**

The International Classification of Disease, Eleventh Revision (**ICD-11**) is a system of medical coding created by the World Health Organization (WHO) for documenting diagnoses, diseases, signs and symptoms, and social circumstances.

ICD is the foundation for the identification of global health trends and statistics, and the international standard for reporting diseases and health conditions. It is the diagnostic classification standard for all clinical and research purposes. ICD defines the universe of diseases, disorders, injuries, and other related health conditions. These are listed in a comprehensive, hierarchical fashion that allows for:

- Easy storage, retrieval and analysis of health information for evidenced-based decision-making;
- Sharing and comparing health information between hospitals, regions, settings and countries; and
- Data comparisons in the same location across different time periods.

**Post-traumatic  
Stress Disorder  
(PTSD)**

PTSD is a clinically-diagnosed condition listed in the Diagnostic and Statistical Manual of Mental Disorders, (DSM-5) the recognized authority on mental illness diagnoses. Common symptoms of PTSD include reliving a traumatic event through nightmares, flashbacks, or constantly thinking about it. Avoidance of situations or people that trigger the memory of the traumatic event, having only negative thoughts or emotions, and constantly feeling jittery, nervous, or “on edge” are also symptoms of PTSD. Diagnosing PTSD takes account of the duration, intensity, and severity of symptoms and the level to which they interfere with daily functioning.

**Public Health  
Agency (PHA)**

The Public Health Agency is Arms-Length Body (ALB) reporting to the Department of Health and responsible for health improvement, prevention of disease and illness, and patient safety.

**Regional  
Trauma Network  
(RTN)**

The Regional Trauma Network (RTN) is a new service. It involves the design, development, and implementation of an integrated service model for the treatment of trauma and aims to:

- Improve individual, family, and community experience of mental health trauma care;
- Increase the overall capacity of mental health services in the region;
- Improve the psychological and social outcomes for service-users, their

- families, and communities; and
- Improve governance and accountability of trauma care provided by statutory Health and Social Care (HSC) services, and the voluntary and community sector.

***Mission statement***

*We work collaboratively and in partnership with people in our society to improve access to the highest quality psychological trauma care.*

**The Department of Health (DoH)**

The Department of Health is a devolved Northern Ireland government department in the Northern Ireland Executive. The minister with responsibility for the department is the Minister of Health.

For more information, see:

<https://www.health-ni.gov.uk>

**The Executive Office (TEO)**

The Executive Office is a devolved Northern Ireland government department in the Northern Ireland Executive with overall responsibility for the running of the Executive. The Ministers with overall responsibility for the department are the First Minister and deputy First Minister.

For more information, see:

<https://www.executiveoffice-ni.gov.uk>

**Victims and  
Survivors  
Service (VSS)**

The VSS is an Arms-Length Body (ALB) of The Executive Office. It delivers government funding and support to victims and survivors of the Conflict/Troubles. This funding is directed both towards individuals in certain circumstances, and to organisations that deliver services and support for victims and survivors across the region.

***Vision statement***

*To improve the health and wellbeing of victims and survivors.*

‘Victims and survivors’ refer to victims and survivors of the Northern Ireland Conflict/Troubles, as defined in the Victims and Survivors (NI) Order 2006.

For more information, see: [www.vssni.org](http://www.vssni.org)