Trauma and adversity:

Findings from the Mental Health Fellowships

Mental Health Foundation

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The Winston Churchill Memorial Trust runs the Churchill Fellowships, which support UK citizens to travel the world in search of innovative solutions for today's most pressing problems. Any UK adult citizen can apply, regardless of qualifications, age or background. They are chosen not for their past achievements, but for the power of their ideas and their potential to be change-makers. Applications can be made annually from May-September at www.wcmt.org.uk.

Mental Health Foundation

The vision of the Mental Health Foundation is good mental health for all. We work to prevent mental health problems, to drive change towards a mentally healthy society for all, and to support communities, families and individuals to live mentally healthier lives, with a particular focus on those at greatest risk. The Foundation is the home of Mental Health Awareness Week.

To find the full body of research produced by all 59 Churchill Fellows, or to listen to the corresponding podcasts for **Trauma and adversity**, please visit the Mental Health Foundation and Winston Churchill Memorial Trust websites.

To get in touch with a Fellow included in this briefing, or for more details on any of the case studies featured, please contact the Winston Churchill Memorial Trust at office@wcmt.org.uk

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Introduction

From 2016 to 2019 the Winston Churchill Memorial Trust ran the Mental Health Fellowships programme, funding individuals to travel abroad to learn more about how community-based solutions are being created in response to some of today's most pressing mental health challenges.

The Mental Health Foundation was the expert partner in this programme, helping to shape its aims, select the successful candidates from hundreds of applicants and provide mentoring to the successful Churchill Fellows. In total, 59 Fellows were chosen to investigate best practice in 17 countries and bring back new evidence and ideas to create positive change in their profession, practice and communities in the UK.

This is one of four briefings that distil the key findings from this rich body of learning, and make recommendations for policy and practice in the UK. Each briefing focuses on an aspect of the Mental Health Fellowships' overarching theme **'community-based solutions'**, and an overview of the learning from this Fellowship can be found in the programme's summative briefing.

Scope

This briefing on Trauma and Adversity brings together learning from six Fellows' research in the USA, Norway, Sweden, Bosnia & Herzegovina, Australia, New Zealand and Canada, that focuses on how community-based approaches are being used to effectively support people affected by trauma.

The learning from this category is grouped into two main sections:

Section 1: Trauma-informed approaches introduces the emerging field of trauma-informed care, provides a number of case studies and findings from two Fellows' research, and details good practice in trauma-informed approaches for a range of public organisations, institutions and services.

Section 2: Supporting veterans living with trauma focuses on the mental health needs of military veterans, provides a number of case studies and key findings from four Fellows' research, and introduces a range of non-traditional and more holistic approaches for supporting veterans' mental health.

Fellows' recommendations

Trauma-informed care

Public services, organisations and institutions should:

- Recognise that effective trauma-informed care cannot be done piecemeal, and ensure that there is a whole organisational approach and commitment to promoting a culture of care, safety and healing, with effective governance and leadership in place to ensure this happens.
- Make use of the guidance, resources and tools from a range of trauma-informed approaches, adopting the most useful and appropriate elements of these for their own service(s).
- Adopt a set of core trauma-informed values and principles to act as a framework for organising procedures and practice. This framework should be embedded in the organisation, to provide appropriate structures within which service-appropriate approaches to delivering trauma-informed care can be developed.

Mental health support for veterans

The Office for Veterans' Affairs and NHS England (and its equivalent for the devolved nations) should:

- Consider the evidence on 'Moral Injury', particularly from Canada, and ensure it is appropriately integrated into understanding veterans' mental health and shaping rehabilitation programmes in the UK.
- Promote the inclusion of the arts and creative arts therapies in national health and military strategic plans and initiatives. The arts should be formally recognised as a credible and transformative mechanism for veterans, families and communities affected by trauma and moral injury, with arts routinely offered as an intervention, alongside clinical options.
- Establish a holistic therapeutic retreat programme in the UK, to provide psychological support for military and veteran families who are caring for someone suffering from one or more of the following: mild Post Traumatic Stress Disorder (PTSD), mild Traumatic Brain Injury (TBI) and chronic pain.

The Office for Veterans' Affairs should:

- Work with NHS England to end the conceptualisation of veterans as victims and integrate the concept of post-traumatic growth into all mental health interventions and as a value adopted by all providers of services to veterans.
- Consider replicating George W Bush's Stand-To Veteran Leadership initiative in the UK to harness the leadership qualities of veterans to broaden their skills, knowledge and influence across the country.

Why trauma and adversity?

In recent years, our understanding of trauma has grown exponentially in the UK, and there is both a greater awareness of its long-term effects on survivors and its prevalence in society[1]. It was recently estimated that 70% of the general population have been exposed, either directly or indirectly, to a traumatic event at some point in their lifetime[2].

Something that was once associated with particular groups (for example, veterans), is now a human experience that we consider to be far more widespread and affecting a much larger proportion of our society. It is becoming clear that trauma and adversity can, in fact, enter into our lives at any moment; whether it be through a broken early attachment to a primary caregiver, repeated peer bullying, or through bereavement or other types of loss (to name but a few).

This shift in understanding has been to an extent both led by and reflected in the redefining of 'traumatic experience' in clinical practice. The term Post Traumatic Stress Disorder (PTSD) - a diagnosis most closely associated with traumatic experience and associated with the lasting effects that trauma can cause (including flashbacks) - made its first appearance in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) published by the American Psychiatric Association in 1980, and was closely connected with the legacy of the Vietnam War. This was preceded by earlier conflicts, including the two World Wars, giving birth to other terms such as shell shock, and war neurosis[3]. More recently, however, subsequent editions of the DSM have seen the criteria for PTSD modified to include traumatic situations that are not "outside the field of usual human experiences," recognising that even everyday life events can create PTSD[4].

Similarly, The Substance Abuse and Mental Health Services Administration (SAMHSA), a branch of the US Department of Health and Human Services, adopts a broad definition of a traumatic experience as "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual

wellbeing."[5] What is certain, is that in thinking about trauma and adversity, it is no longer an "us and them" debate, but a conversation about something which can affect us all.

The work of these Fellows is therefore well-timed and comes at a moment when we are continuing to develop our understanding of 'trauma' and re-thinking our approaches to effectively supporting those it affects. As the radical revolution of mental health services progresses - with a community-based care model largely replacing the acute and long-term care provided in in-patient settings - the Fellows' findings provide innovative ideas for how we as individuals, families and communities can work together to look after one another, create an environment of safety, connection and healing, and ensure that everyone is able to enjoy their lives again following the trauma or adversity that life sometimes brings.

Section 1: Trauma-informed approaches

Context

What is trauma-informed care?

Trauma-informed care is focused on creating conditions within services and / or organisations that reduce harm and promote healing, especially for individuals who have already experienced trauma.[6] It recognises that past experience of trauma can affect how a person perceives and responds to their environment in the present. For example, aspects of a situation that may seem benign to someone with no history of trauma can trigger overwhelming feelings of distress in a trauma-survivor.

Trauma-informed care is actively mindful that, in these ways and others, service design and delivery have the potential to perpetuate distress and disengagement in traumatised people. Based on this awareness, it endeavours to bring about organisational changes that will, at a minimum, prevent services from reawakening individuals' old traumas, or causing them new traumas; and, at best, create an environment that is sufficiently understanding and safe for healing to take place.

Why is it important?

Our growing recognition of the prevalence of trauma within our society has led to an increased understanding of the role public organisations and institutions often play in perpetuating trauma, inadvertently causing further harm to some of the most vulnerable people they work with.

As a result, there have been attempts, both abroad and in the UK, to develop trauma-informed public services, including schools, workplaces, "blue-light" emergency services and the criminal justice system (to name a few), that acknowledge, understand and respond to people's trauma in appropriate ways. It has been argued with increasing strength that if public sector services are to end this cycle of traumatisation and retraumatisation, then trauma-informed care represents "a vital paradigm shift."[7]

Good practice from abroad

Two Churchill Fellows visited a number of leading trauma-informed organisations delivering services in a variety of community-based contexts. The Fellows were:

Dr Karen Treisman

Report title: Becoming a More Culturally, Adversity, and Trauma-informed, Infused and Responsive Organisation

In 2018, Karen, a clinical psychologist, trainer, and author, travelled to the USA to research international approaches to integrating adversity, culturally, and trauma-informed and responsive principles at a system-wide and organisational level.

Daniel Johnson

Report title: A Best Fit Model of Trauma-informed Care for Young People in Residential and Secure Services

In 2016, Daniel, a forensic psychologist and service manager at Kibble Education and Care Centre, a specialist provider of child and youth care services, travelled to the USA, Norway and Sweden to investigate how trauma-informed principles have been turned into tangible practice in young people's residential care services.

Key findings

There is no single model

Between them, the Fellows visited and reviewed a large number of international trauma-informed services, including child welfare services, homelessness services and HIV services, and whilst each of the different models demonstrated strong individual features, no single model provided an appropriate approach that could be effectively transferred to all UK public services and organisations.

This is because everyone's trauma is different, and what works for one individual might not work for another, and what might be appropriate and create an environment of safety and healing for one individual, may cause another to feel discomfort and anxiety. Similarly, changes that have worked for one organisation might not work for another. As a number of authors have noted, "Each individual has a unique history and specific triggers. There is no single profile."[8]

Instead, the Fellows found that each organisation had, to some extent, created a tailor-made trauma-informed approach best suited to their service, and the people accessing it. Daniel Johnson, for example, visited a number of different services in which trauma-informed models were being implemented, to review their effectiveness and identify good practice for the UK. These included the Sandhill Development Centre in New Mexico, USA, Jasper Mountain in Oregon, USA and the Ostbytunet Treatment Centre near Oslo in Norway. Jasper Mountain provides an interesting example of how a trauma-informed model was developed in order to support a specific group of people; in this case, children and young people from troubled backgrounds.

CASE STUDY

Jasper Mountain, Oregon, USA

Jasper Mountain is a large care, education and treatment centre in the Oregon forest, initially opened by a husband and wife who were practising therapists frustrated by the systems in which they worked. It provides a continuum of programmes that meets the needs of emotionally disturbed children and their families. Services include an intensive residential treatment programme with a therapeutic school, a short-term residential centre, treatment foster care programme, community-based wraparound programme and crisis response services. As it says on the website, its main ethos is "to support, not judge."

The design of the Jasper Mountain service demonstrates how an understanding of the children's experiences has influenced practice. For example, the main residential building is a castle, with a keep, large central hall and even a drawbridge. It has been built like this as children had said this was the structure they would prefer and in which they would feel most safe. The education building has no internal corridors and is instead linked by external walkways that are covered, but still open to the surrounding forest. This enables young people to quickly access sensory areas or walk among nature without concerning other young people.

In contrast to other services that have an isolated and sterile 'quiet room', Jasper Mountain has a walkway that leads from the school to a raised platform in the forest. Here, young people can express distress or dysregulation without distressing anyone else.

Challenges for UK implementation:

Jasper Mountain is able to offer a broad range of intensive and effective supports without prohibitive cost due in part to some operational differences to the UK. For example, instead of having their own bedroom, young people sleep in small dormitories of three beds. Young people are in their room immediately before and after sleep and spend the rest of their time in other communal areas. In the UK there are times that young people in care will share rooms, but dormitories do not fit national care standards and are at odds with principles of privacy.

Adopting a framework of approaches, values and principles

Instead of a one-size-fits-all approach, the Fellows identified that best practice in trauma-informed care is most usefully defined in terms of agreed and consistent approaches, values and principles, rather than fixed procedures. Such values and principles are being used by services abroad as a framework in which to organise their own service-appropriate approaches to delivering trauma-informed care.

The key values and principles identified by the Fellows varied to some degree; however, there were a number which were consistently held as being vital to delivering effective trauma-informed care. These included:

- Creating an environment of trust and safety for people accessing services
- Empowering individuals through co-production of services with those who use them
- Listening to the experiences of people accessing, and working for, the service
- Cultural humility and service-responsiveness to the needs of the individual
- Relationship-focused and relationship-centred care.

Based on the findings from her Fellowship, the following graphic reflects Dr Karen Treisman's understanding of the underlying values and principles that are vital for delivering effective trauma-informed care.

ASSUMPTIONS, PRINCIPLES, & VALUES OF A TRAUMA-INFORMED ORGANISATIONAL CULTURE

A PARADIGM TRANSFORMATION
A DIFFERENT LENS

DR. KAREN TREISMAN

CLINICAL PSYCHOLOGIST | TRAINER | AUTHOR

SafeHands ThinkingMinds .co.uk

Sketch by @wterral

THE FOUR R'S

A program, organisation, or system that is trauma-informed **realises** the widespread impact of trauma, stress, & adversity, & understands potential paths for healing & recovery. **Recognises** the signs & symptoms of trauma in staff, clients, & all others involved in the system. Actively **resists** re-traumatisation (Committed to being trauma-reducing instead of trauma-inducing). **Responds** by fully & meaningfully integrating, embedding, & infusing knowledge about trauma into policies, procedures, language, culture, practices, & settings (SAMHSA, 2014 - Adapted by Dr Karen Treisman).

There also needs to be respect, an expectation, & an acknowledgment that the journey to become & sustain being trauma-informed & trauma-responsive is complex, slow, dynamic, evolving, messy, & multi-layered.

Therefore, it requires work, skill, time, shared vision, investment, sensitivity, adaptability, commitment, hope, & so much more (Treisman, 2018).

The principles & values are relevant to all people in all roles; & should also be reflected in all aspects of the organisation from the mission statement, to team meetings, to recruitment (See Weaving & Infusing Worksheet).

TRUST & MULTI-LAYERED SAFETY

RELATIONSHIP-FOCUSED

RELATIONAL TRAUMA REQUIRES RELATIONAL REPAIR (TREISMAN, 2016)

CURIOSITY, REFLECTIVENESS, EMPATHY, COMPASSION, & UNDERSTANDING

ACKNOWLEDGING, HOLDING, & CELEBRATING RESILIENCE

BEHAVIOUR IS COMMUNICATION

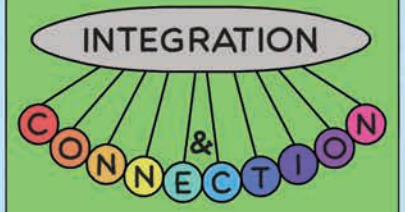
CULTURAL HUMILITY & RESPONSIVENESS

COMMUNICATION, COLLABORATION, & TRANSPARENCY

AGENCY CHOICE MASTERY VOICE

(AT MULTIPLE LEVELS)

INTEGRATION & CONNECTION



There are no shortcuts

A key finding identified within both Fellows' work was that for trauma-informed care to be effective, it cannot be done piecemeal, and instead requires continuous persistence, determination and reflection on the part of each service or organisation. It means developing and moving towards system-wide cultural transformation in relation to understanding, skills, values, attitudes, policies and cultures, and is a commitment by an organisation to engage meaningfully, in each of these areas, in a continuous process of adaptation.[9]

As Dr Karen Treisman points out, being trauma-informed does not, for example, mean putting a fruit bowl in reception, or training staff in trauma-informed approaches in a one-off session. It instead requires a whole organisational approach and commitment to promoting a culture of care, safety and healing, with effective governance and leadership in place to ensure this happens. The values and principles of trauma-informed care detailed above need to be hard-wired into the very essence of the organisation, informing every decision and every action taken by the service, and those working for it. In other words, there are no shortcuts.

The following infographic was developed by Dr Karen Treisman, and illustrates the wide breadth of areas that organisations must focus on if they are to become "trauma-informed."

WEAVING & INFUSING TRAUMA-INFUSED & TRAUMA-RESPONSIVE VALUES & PRINCIPLES

THROUGHOUT THE WHOLE SYSTEM: A CULTURAL & PARADIGM TRANSFORMATION

DR. KAREN TREISMAN

CLINICAL PSYCHOLOGIST | TRAINER | AUTHOR

SafeHands ThinkingMinds .co.uk

Sketch by @wterral

THE PHYSICAL ENVIRONMENT

Design, Building, Space

SUPERVISION

Performance Reviews & Appraisals

TEAM Meetings, Working Group, Feedback, & Communication Forums

Meaningful CONSULTATION & Decision-Making in ALL Aspects

by those with lived experience & multiple different voices

THE RECRUITMENT PROCESS

Job Description
Communication
Interview
Feedback
Induction

LEADERSHIP & MANAGEMENT

POSITIVE ROLE MODEL

- EMPATHETIC
- COMPASSIONATE
- SUPPORTIVE
- CURIOUS
- COMMITED
- COLLABORATIVE

EVERY INTERACTION is IMPORTANT

TYPE & CHOICE OF LANGUAGE

The Organisation's VISION, MISSION, VALUES

POLICIES & PROCEDURES LEGISLATION

EVALUATION & MONITORING

STAFF WELLNESS, WELL-BEING & SELF-CARE

TRAINING & CONTINUING WORKFORCE DEVELOPMENT

MATERIALS

SIGNS | Brochures | LETTERS

ASSESSMENT

SCREENING & Tools

TYPES OF SERVICES AND APPROACHES OFFERED & AVAILABLE

MENU
- SERVICE
- APPROACH
- SERVICE
- APPROACH

Applying the learning in the UK

Dr. Karen Treisman

During her Fellowship, Dr Karen Treisman, identified a series of nine principles and values (as seen in the infographic above) essential for any organisation aiming to integrate appropriate trauma-informed care into their organisational culture.

Since returning to the UK, Karen has worked with more than 90 organisations to support and enable them to adopt principles that are adversity, culturally and trauma-informed. This includes local authorities, NHS teams, nurseries, schools, prisons, police services, residential homes, fostering services, and many more. The largest ongoing initiative is with Barnardo's, where several thousand leaders, volunteers and employers are being trained in trauma-informed approaches. This involves Karen consulting to all parts of the organisation, such as retail, fundraising, front-line service provision, corporate, inspection, and communications, as well as supporting the design of an in-house training package and e-learning modules.

Karen has also delivered leadership training to more than 500 leaders in Barnardo's and used the infographics made during the Fellowship to create plaques, screen savers, mugs, and stress balls to make the message more visible. There is an evaluation team assessing the impact of this training and these resources.

Karen is writing a book on this topic due to be published by Jessica Kingsley, with contributors from all around the world.

Section 2: Supporting veterans living with trauma

Context

What do we mean by the term 'veteran'?

The term "veteran", as defined by the UK Government, applies to anyone who has served for at least a day in HM Armed Forces, whether as a regular or as a reservist.[10] In 2016, it was estimated that there were approximately 2.5 million veterans residing in the UK, with that figure expecting to drop to 1.6 million by 2028.[11]

What are mental health risks for veterans?

Only around 0.1% of regular service personnel are discharged annually for mental health reasons. However, some veterans develop mental health problems after leaving service, and of these, 20-25% will be experiencing PTSD.[12]

Many veterans will have had their lives enriched by their service, and transition into civilian life, together with their families, without significant difficulty. For some, however, this transition is brought to the point of failure by mental health issues which range in complexity and severity, and due to factors affecting them before, during and after military service. Their experiences of war can, unfortunately, leave them with trauma that is often bound up in deep suffering, which is sometimes difficult to articulate, often accompanied by a loss of identity and purpose.[13]

Veterans' mental health problems may be made worse or caused by post-service factors, such as the difficulty in making the transition to civilian life, marital problems, and loss of family and social support networks. Younger veterans (aged under 24) are at high risk of suicide, being three times higher than their civilian counterparts,[14] and ex-service personnel are also vulnerable to social exclusion and homelessness,[15] both of which are risk factors for mental ill health. Alcohol misuse is also high.[16]

What is happening nationally?

The UK's involvement in conflicts in Iraq and Afghanistan re-ignited interest in the welfare and health of Service personnel on their return from duty, in particular their mental health problems, such as PTSD.[17] This led to successive Governments committing to improving the health and wellbeing of veterans, and, building on preceding efforts, in 2017, the Ministry of Defence (MOD) launched a new strategy 'Defence people mental health and wellbeing strategy 2017-2022' to improve the mental health

and wellbeing of the Armed Forces, their families and defence civilians. This included a commitment to support NHS England (NHSE) in the completion of Mental Health Taskforce objectives, ensuring that the mental health of veterans and their families is embedded in the pathway from Service discharge and for on-going healthcare requirements

Then, in 2019, the UK Government created the Office for Veterans' Affairs, which (for the first time) ensures that veterans' affairs will be overseen by a minister in the Cabinet Office; namely, the Minister for Defence, People and Veterans. The Office for Veterans' Affairs has a unique remit as an employer to fulfil the principles of the Armed Forces Covenant. This is a pledge, on behalf of the nation, that serving personnel, their families and veterans will not be disadvantaged in comparison with other citizens.

What support is currently available?

The statutory responsibility for mental health care of veterans falls to NHS England and its equivalents in the devolved administrations[18] and available treatments are usually limited to talking therapies and medication.

A number of special mental health projects have been set up by the Ministry of Defence with the NHS, in recognition of the difficulties veterans face accessing help. The Medical Assessment Programme (MAP), based at Guy's and St Thomas' NHS Foundation Trust in London, offers help and treatment to any veteran of any conflict, no matter how long ago, and to their carers. There is also a Reserves' Mental Health Programme (RMHP) open to anyone who has seen active service as a volunteer or reservist since 1 January 2003 and has mental health problems that might be linked to service on operations.

More recently, the devolved nations have acknowledged the need for more community-based care. NHS England offers veteran-specific out-patient services through its Veterans' Mental Health Transition, Intervention and Liaison Service, launched in April 2017, and its Complex Treatment Service, launched in April 2018. With the creation of the latter, NHS England moved away from residential care treatment. Both the Welsh and Scottish Governments also either fund or co-fund veteran-specific out-patient services.[19]

Still more work to do?

Until recently, little was known about veterans' mental health, due to a lack of recording in the national census, and in NHS records. What is known is that only half of those experiencing mental health problems sought help from the NHS, and those who did were rarely referred to specialist mental health services.[20] Many of these are due to stigma, and it being viewed by veterans as a weakness to seek help.[21]

For those who do seek help, there is growing evidence to suggest that their needs are not being met. In 2018 a House of Commons Defence Committee inquiry

found that the Covenant's pledge is not always adhered to, as it conflicts with a fundamental principle of the NHS that "no one is given favour over anyone else"[22] and that there is a perceived lack of coherence between different local bodies and how they implement the Covenant's health commitments.

Good practice from abroad

Four Churchill Fellows visited a range of international programmes providing holistic, community-based approaches to supporting the mental health of veterans. The Fellows were:

Simon Edwards

Report title: An International Perspective of PTSD: Root Causes and Treatment

Simon is the founder and trustee of Serve On, a charitable organisation providing help and support to UK international and local communities in times of crisis. In 2016, he travelled to the USA, Australia and New Zealand to draw lessons for the UK on supporting the transition of servicemen back into civilian life.

Dr Amanda Wood

Report title: Improving Psychological Support for Military Families, in particular Children

In 2016, Amanda, a chartered psychologist from Bishop Auckland, travelled to the USA to explore ways of improving psychological support for military families, particularly children.

Charlie Morley

Report title: Beyond Mindfulness: Best Practice for Veterans with PTSD

In 2018, Charlie, an author and mindfulness teacher from Bermondsey, travelled to Canada and the USA to study mindfulness-based treatments for veterans with PTSD.

Alison O'Connor

Report title: Transforming Trauma: Moral Injury and Arts with Military Veterans, Families and Communities

Alison is a psychotherapist, trainer and Co-Founder of Cardiff based Arts in Health organisation, Re-Live. Alison travelled to Bosnia & Herzegovina and America in 2016 to investigate the impact of the creative arts on families and veterans affected by trauma and moral injury.

Key findings

Are traditional methods working?

Whilst traditional treatment approaches (such as medication and talking therapies) are well-evidenced and have the potential to be effective for many, a number of the Fellows drew attention to a rich variety of alternative approaches being used internationally to effectively support the mental health needs of veterans. These include a wide range of programmes involving mindfulness, yoga, performing arts, holistic retreats and equine learning, amongst others.

Such programmes are more difficult to find in the UK, and gaps in this type of provision are generally filled on a small-scale basis by the voluntary and community sector. A 2017 report by the Directory of Social Change and the Forces in Mind Trust identified 76 such charities, with a third having such provision as their sole remit.[23]

Combat Stress, for example, provides holistic approaches, such as retreats offering psychological support for veterans and their families. Treatment is offered in line with the National Institute for Health and Care Excellence (NICE) treatment guidelines, and depending upon the treatment package, can include: psychoeducation, trauma-focused Cognitive Behavioural Therapy (tfCBT), Eye Movement Desensitisation and Reprocessing (EMDR), mindfulness, anger management and anxiety management. In some cases, art therapy is offered.

As pointed out by a number of Fellows, the rationale for such interventions (as opposed to more traditional approaches) is rooted in an understanding of trauma as something that exists not only in our minds, but also in our bodies. It has therefore been argued that holistic treatments, which provide healing for both 'mind and body', have the potential to be more effective than talking therapies and medication alone. As Fellow and mindfulness teacher Charlie Morley says, mindfulness meditation and yoga were found to help veterans with pain reduction, sleep and emotional regulation, as they focus on the breath and the body which helps to regulate the nervous system following trauma.[24]

One programme adopting a more holistic 'mind and body' approach is the Lone Survivor Foundation's Veteran Retreat, visited by Amanda Wood.

CASE STUDY

The Lone Survivor Foundation (LSF), Salt Lake City, USA

T he non-profit LSF was founded in 2010 by Marcus Luttrell, a US Navy SEAL who was the only survivor of Operation Red Wings in Afghanistan in 2005. Upon his return, and based on his own personal experiences, Marcus identified the need for a holistic treatment programme offering elements beyond standard government programmes.

Services provided by LSF include support for service members/veterans and their families from all military branches who suffer from the following injuries: mild PTSD, mild TBI, chronic pain and military sexual trauma (MST).

LSF aims to support both the individual and the family by providing psycho-education on the injuries sustained in combat, reducing symptoms of stress and therapeutic support. Five-day retreats are conducted all year round in natural environments conducive to healing and include the following: individual, couple and family retreats, as well as for MST survivors and caregivers. Treatments include: yoga, individual therapy, group sessions, psycho-education, swimming in therapy pools, and equine-assisted learning.

One unpublished paper has evaluated the LSF retreat model for veterans and family members with symptoms of psychological trauma.25 As part of a routine programme evaluation from 2012 to 2015, 167 veterans/family members provided self-reported data on symptoms of PTSD, anxiety and pain prior to and after the three-day intensive retreat programme. Results showed that at the beginning of the retreat, 90% of participants screened positive for PTSD and 66% for depression. Post retreat, 77% of participants reported a clinically meaningful reduction in symptoms of 10 points or more.

Clinical benefits were evident for global measures of psychopathology, anxiety and pain across all types of retreat including: individual, group and military sexual trauma (MST). Limitations of this research include the outcome data being collected as overall programme evaluation and therefore not addressing individual groups of participants. To date, three non-profit organisations utilise this programme model for wounded soldiers and their families, including: LSF, Warrior Mission At EASE, and The Brian Bill Foundation.

A new perspective on trauma

While lesser known in the UK, Moral Injury (MI) is increasingly being acknowledged internationally as an important factor in understanding veteran mental health, and occurs when an individual is involved in, fails to prevent or witnesses a serious act that transgresses deeply held moral beliefs.[26]

Given the nature of war, servicemen and women are often involved in acts of combat where the risk of transgressing moral beliefs is high. These include being involved in direct acts of killing or harming others, or indirect acts such as witnessing death or dying, failing to prevent the immoral acts of others, or giving or receiving orders that are perceived as gross moral violations.[27]

A common example of MI among veterans is the notion of "survivor guilt". This may be experienced by an individual who has avoided death or injury when, for example, someone else has taken their place on patrol and then has been killed or injured, causing the individual to be heavily burdened by their perception that they are responsible.

Unlike PTSD, which has become an all-encompassing term for acknowledging the psychological hardship experienced by some veterans, MI acknowledges a deeper, spiritual condition, a "soul wound"[28] encompassing shame, guilt and loss of identity.

Although MI is certainly not a new phenomenon, research and treatment development are in their early stages. Alison O'Connor was introduced to the pioneering work Rita Nakashima Brock and Gabriella Lettini are developing at The Soul Repair Center at Brite Divinity School, addressing MI from a spiritual perspective. She also learnt about Brett Litz and colleagues, who are piloting a treatment called Adaptive Disclosure which centres on incremental sharing of morally injurious experiences in group work settings for veterans, with an emphasis on self-forgiveness and compassion-building.

Alison details how the theory of MI resonated with her work with Veterans in Wales, and the stories she had heard of the murkiness of the long "dirty war" fought just across the water in Northern Ireland. Her report identifies a number of case studies that use the performing arts, such as ballet and storytelling, to investigate some of the moral questions facing veterans following service. In addition to MI, Simon also found that the term post-traumatic stress disorder can, to an extent, be unhelpful for military veterans. His preference would be that we talk simply about post-traumatic stress or post-traumatic injury, arguing that 'disorder' suggests permanence, while 'injury' implies something that can be healed.

Life after service: re-establishing connection and empowerment

Trauma is at its core a disempowering feeling, and devastates the social systems

of care, protection, and meaning that support human life. In returning from service, veterans can find it difficult to "carry on" as they had before: re-integrating themselves back into civilian life, reconnecting with past relationships, and finding new purpose and meaning can be incredibly challenging.[29]

With this in mind, a number of Fellows suggested that an integral part of their recovery should be focused on re-empowerment, re-establishing safety, and re-building connections and relationships to people and communities. Some of the Fellows visited a range of different programmes being used to empower and reconnect veterans with their communities following service, such as the George W Bush Stand-To Veteran Leadership initiative.

Empowering veterans: Post-traumatic Growth

The term post-traumatic growth was developed in the 1990s by Dr Richard Tedeschi and Dr Lawrence Calhoun at the University of North Carolina. Post-traumatic growth (PTG) is a theoretical and scientific model exploring the relationship between major life adversity and resulting positive growth.

The concept is central to a number of international initiatives aimed at empowering veterans, supporting them to regain confidence and to build a new life following service. For example, the Stand-To Veteran Leadership programme develops the leadership skills of US veterans to enable them to increase their contribution and impact within society following service.

Simon Edwards, Fellow and the founder of Serve On, met with Professor Richard Tedeschi to discuss the five-element framework of PTG developed by Tedeschi and Calhoun in 1996.[30]

1. Through trauma we discover that we are stronger and more resilient than we thought.

2. Because of what we have overcome we have a deeper appreciation of and gratitude for life.

3. Confrontation with aspects of our true nature creates a humility that allows us to have

better relationships with others.
We become less egotistic and more compassionate and empathetic towards others.

4. Because we have lost something that we took for granted, new possibilities emerge with

new priorities and goals. Often, we find a purpose beyond ourselves.

5. A discovery or confirmation of a spiritual connection and change which provides us with a more profound understanding of life, including the discovery that meaning in life is key.

In contrast to the more familiar depiction of post-war veterans struggling with PTSD and other mental health problems, PTG embraces the idea that positive

transformation can arise in the days, months and years following devastating adversity. This has led to an increased awareness and understanding of how we can change the paradigm within which we treat veterans (and others) who have endured trauma: not as victims, but as individuals with the potential (with appropriate support in place where needed) to acknowledge and embrace their present situation, setting new priorities and goals and becoming leaders in their communities.

Reconnecting to communities: sharing our stories

Journalist and author Matthew Green recently carried out extensive research with veterans and families in the UK. His book, 'Aftershock: The Untold Story of Surviving Peace' (2015) expresses the complexity of the difficulties facing those struggling with the repercussions of service. He writes of the "futureless isolation" many veterans are living with, and of the difficulty that some veterans face in reconnecting to their past relationships and communities.

A number of the Fellows visited international programmes aimed at re-integrating veterans into their communities, and building bridges between veterans and civilians – something which has traditionally been more of an 'us and them' relationship. Below is a case study from Alison O'Connor's visit to The Telling Project in Milwaukee, a programme focused on connecting veterans and communities through storytelling theatre, which is now being implemented on a national scale.

CASE STUDY

The Telling Project, Milwaukee, USA

The Telling Project's mission is summarised in their words: "It's time to speak, it's time to listen."

Process

The writer/director meets with participants for an in-depth interview about their military experience. S/he then goes away and writes a script, weaving together the stories of each veteran or family member into a cohesive, poetic narrative. Each veteran or family member reads the script for approval before the group comes together for a short, intensive period of rehearsal and performance training.

The play is performed at a professional theatre in the local community, supported by a full-scale publicity campaign to build interest and audience. Each performance is followed by a discussion between audience and performers, veterans and their community with the aim of deepening their understanding and bridging the military/civilian divide.

Reach

Since 2008, The Telling Project has produced 40+ original performances.

180 veterans and family members have shared their stories on stage.

Veterans have performed in 16 states across the nation.

Decision makers and policy experts are reached through targeted performances and discussions through The Telling Project institute.

The Telling Project's success is challenging the much-stated belief that only veterans will be able to hear and understand veterans' experiences. Their plays do not apologise for their content; audiences listen to veterans reflecting on experiences such as the pain of seeing children die, or the helplessness of not being able to save civilians. Across America, audiences at The Telling Project events are bearing witness and sharing the weight of moral injury and the consequences of warfare.

Conclusion

Drawing on good practice overseas for supporting people living with trauma, the Fellows' findings have made one thing clear: as our understanding of trauma evolves, so must the way we respond to it.

Whilst traditional approaches (such as medication and talking therapies) are well-evidenced and have the potential to be effective for many, a number of the Fellows drew attention to a rich variety of more holistic approaches (based upon a mind-body understanding of trauma) being used internationally to effectively support the mental health needs of veterans.

Similarly, in relation to trauma-informed care, our growing recognition of the prevalence of trauma in our society, has led to an increased understanding of the role public organisations and institutions often play in perpetuating trauma, and highlighted the need to develop trauma-responsive public services. With this in mind, there is an opportunity (and a need) to embed a trauma-informed system across all settings, including schools, workplaces, "blue-light" emergency services and the criminal justice system (to name a few), that acknowledges, understands and responds to people's trauma in appropriate ways. If this opportunity is taken, we will begin to develop a society that recognises the deep suffering often associated with trauma, and create an environment that is sufficiently understanding and safe for individual healing to take place.

Both approaches - more holistic programmes for veterans, and trauma-informed care - are in their infancy in the UK, and there is scope for them to be adopted much more widely, and championed by health care providers, public services and decision makers. To this end, the Fellows' findings make a valuable contribution to this work, providing important evidence on how these approaches are being used effectively abroad, and making a strong argument for their implementation in the UK.

To find the full body of research produced by all 59 Churchill Fellows, or to listen to the corresponding podcasts for **Trauma and Adversity**, please visit the Mental Health Foundation and Winston Churchill Memorial Trust websites.

To get in touch with a Fellow included in this briefing, or for more details on any of the case studies featured, please contact the Winston Churchill Memorial Trust at office@wcmt.org.uk.

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