Shoulder to shoulder: Moving forward

Led by: Sandy Row Community Forum
Funded by: Public Health Agency

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A little part of Belfast

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1.0 Introduction

Sandy Row Community Forum [SRCF] is a lead partner in the on-going design and development of a community well-being action plan based on identified need in the South Belfast area. The plan and actions are intended to improve positive emotional health and well-being for all adults. Through their previous work through the Healthy Minds project SRCF carried out a series of activities to inform the development of a Community Emotional Well Being Action Plan for the Sandy Row area.

At one of the planning and facilitation events generic issues affecting the health and well-being of individuals and families were identified. In addition, representatives' from diverse communities of interest expressed their concerns in regard to the health and well-being needs of a specific community of interest i.e. South Belfast Protestant Unionist Loyalist [PUL] ex-combatants.

Consequently the Forum funded by the Public Health Agency [PHA] commissioned a scoping study and development plan to address the specific issues raised by representatives of the PUL ex-combatant community who had been present at the consultation day.

The report that follows includes the information and results from the scoping study and the development plan.

1.1 The Scoping Study Framework

The primary purpose of this scoping study, commissioned by SRCF and funded through the PHA, is to identify the emotional health needs of South Belfast PUL Ex-Combatant Community.

Study Objectives:

- Understand the context of emotional well-being for the community of PUL ex-combatants in South Belfast.
- Assess the range and approach to emotional health and well-being needs for that community.
- Utilise peer researchers to carry out in-depth interviews and build their capacity to do so
- Document the learning from the project, including participant feedback or distinctive features.
- Provide suggestions for future planning.

An essential element of the scoping study is its integration with social policy recommendations in general and specifically with the key features integral to the Sandy Row and South Belfast community well-being development work. The purpose and outcomes of this work include to:

- Strengthen individuals.
- Strengthen the community, in this specific case, the PUL ex-combatant community of interest in South Belfast.
- Reduce structural barriers to mental health.
- Reduce discrimination and inequality in society and promote access to support for people who are vulnerable.

This scoping study has integrated this purpose and outcomes into the research methodology and in setting out the findings, conclusions and recommendations.

1.2 Methodology

The methodology for the scoping study focused on several elements.

- Mapping the Literature: providing an indication of the literature already produced relating to the health and well-being needs of the ex-combatant community in Northern Ireland and specifically in the PUL community. This scoping study is intended to contribute to the findings in relation to ex-combatants in a cohesive way.

- Policy mapping: identifying the main documents and elements from government agencies and professional bodies that have a bearing on the nature of the practice in relation to the health and well-being of ex-combatants in Northern Ireland and using these to contribute to recommendations. Particular reference is made to the discussion on the social determinants of health as well as current strategic health initiatives. It sought to utilise and integrate rather than duplicate existing information.

- Stakeholder consultations and research to provide an informed stakeholder centred approach to the study, the analysis of the findings and the final recommendations. The consultation and research comprised two specific elements; a questionnaire available on Survey Monkey and a paper copy of the same questionnaire distributed to ex-combatants. 120 questionnaires were distributed and 63 were returned – a response rate of 53%. In addition the peer researchers carried out a total of 22 in-depth interviews with respondents to gather more qualitative data while the quantitative questionnaire responses were completed.

- These in-depth interviews were invaluable as they were often carried out in the respondents' home setting and were specifically targeting individuals who may not have engaged in the questionnaire response for diverse reasons. For many, [approx. 60%] of the individual respondents this was due to their disconnection from community activities, their current health limitations and/or their reluctance to engage with the process. This is explored further in the scoping study.

- In addition, in-depth interviews [7 in total] carried out by the project lead with PUL ex-combatants who were able physically and emotionally and willing to engage in discussion on aspects of their experience as ex-combatants and the impact on their health and well-being.

- In order to provide a safe and quality experience for the peer researchers and for the individual interview respondents, a series of training days were held to build the capacity of the peer researchers. The key learning aims and outcomes from the training programme which was accredited as an ILM Introduction to Peer Advocacy course is set out in Appendix One. The modules delivered were; Safeguarding Adults, Identifying Concern and Implementing Response, Understanding Advocacy and Peer Research, Understanding the Role, Skills and Practice of Peer Research including Ethical Considerations, Safeguarding, Data Protection Requirements, Safety For All and Recording Information.

- A Study Advisory Group was set up to provide advice and guidance on aspects of the work. The membership is outlined in more detail in Appendix Two.

1.3 Study Challenges and Opportunities

The scoping study process and methodology experienced some challenges and opportunities outlined below to assess potential limitation, strengths and environmental context that might impact upon the study findings, conclusions or recommendations.

Originally, it was intended that the study would involve ex-combatants from the former UDA and UVF communities of interest in South Belfast. Representation was made with individuals on a Belfast wide and local South Belfast network basis by the project team. Consequently, former UVF representatives indicated that they would not be able to engage in the project as they were intending to carry out research themselves. Therefore all information in the study questionnaires and in depth interviews has been conducted with representatives from the former UDA jurisdiction.

Conversely, wider interest was generated outside the project main stakeholders with additional meetings held with representatives from North Belfast and Greater Lisburn areas wanting to discuss the potential to replicate the work. One of the project advisor group representatives also spoke to ex-combatant representatives on a cross community basis who asked to be informed in regard to results and recommendations.

Among many respondents, there was initial and some on-going reservations in regard to participating in the questionnaire returns. There were different reasons for this:

- Requirements to complete any kind of written questionnaire in terms of unfamiliarity and/or wariness about the process and/or physical and emotional health challenges.
- Individuals were "put off" by the length of the questionnaire and in particular some of the questions relating to their financial and familial circumstances.
- Initial concerns about confidentiality boundaries, including the use of the information. Peer researchers were provided with guidelines on this aspect of the process and ensured that these were carefully explained prior to the commencement of the interview.
- Many ex-combatants didn't want to revisit this aspect of their past. For many of them, there is a tension between acknowledging the past and recognizing its impact upon their current lives and those of their families. This is particularly significant in terms of Post-Traumatic Stress Disorder and is explored further in the study.

The use of peer researchers proved to be a positive and essential factor that contributed to increasing accessibility to respondents, the high response rate and the level of qualitative data. Their comments on the impact of the experience have also a contribution to make in terms of the level of awareness of vulnerability and risk in relation to the health and well-being concerns for former UDA ex-combatants.

- *"It opened my eyes and I know there's a problem but I didn't notice how much until I opened my eyes and looked around me."*
- *"Total eye-opener but glad I took it on. Course itself was an education on its own. Will stop and look at the bigger picture. Everything might not be as clear as it seems."*
- *"I think this pilot is the tip of the iceberg and there is a lot more problems than we will ever know."*
- *"I didn't realise there were so many ex-combatants and ex-prisoners who need help in lots of ways because of the impact of the conflict on their lives."*

The peer researchers were able to complete the questionnaires and qualitative interviews in the homes of respondents, many of whom were disconnected for different reasons from diverse forms of support. For some, this reflected feelings of apathy and abandonment that were in marked contrast to their previous sense of camaraderie within their own community of interest. This in turn, reflected on their connection with others. Given its' significance for overall

health and well-being it is explored in more depth in the findings, analysis and recommendations for the scoping study.

However, the carrying out of interviews by peer researchers in itself, appeared to reduce the isolation of some of the interviewees and enabled some connections to be made for future benefit. An additional positive outcome from the study methodology was the provision of opportunities to identify health and well-being concerns on an individual as well as group basis along with signposting information.

Access to the primary stakeholder group has to be considered within the overall environmental context of the perceived levels of 'legitimacy'[1] of loyalist ex-combatant groups with statutory and other public agency representatives. Claire Mitchell in her work on the limits of legitimacy comments that 'loyalist former combatants' organisations are one of the few actors in a position to engage with loyalist paramilitaries. This is an issue that 'normal' statutory channels find difficult to deal with".[2] She goes on to state that "the former combatants' organisations are, for some statutory bodies, more a pragmatic necessity than recognition of the former combatants' organisations as legitimate grassroots organisations."[3] It is a situation that is not peculiar to the relationship between ex-combatants with statutory and other public agency representatives. It has implications for connections and support networks with mainstream unionism parties and a wider unionist population.

It would be naive for this scoping study not to recognise the context of the perceived levels of "legitimacy" of loyalist ex-combatant groups with diverse communities of interest and the subsequent influence upon the social and economic factors that impact upon the health and well- being of individuals and upon the response to their identified needs. This will be referenced later in the study, particularly in regard to determinants of health, access to services and the wider aspect of the strength of civil society to deal the reintegration of former combatants.

2.0 Scoping Study Findings

1 Mitchell, C. (2008). *The Limits of Legitimacy: Former Loyalist Combatants and Peace-Building* in Northern Ireland Irish Political Studies Vol. 23, No. 1, 1–19, February 2008

2 Ibid.

3 Ibid.

The scoping study sought to consider the health and well-being context for the former UDA ex-combatant community of interest in South Belfast at a number of levels;

- Generically in terms of the health and well-being issues that may impact upon any citizen living in disadvantaged areas in South Belfast. The study found inequities of social and economic injustice across neighbourhoods and communities that had a significant adverse impact upon health and well-being upon individuals and groups within the area. Particular communities of interest were identified as experiencing additional disadvantage including an aging population and men's health in general. The study discusses the similarities and differences on the impact of disadvantage and other risk factors in terms of resilience and its implications for the study recommendations.

- Generically in terms of the health and well-being concerns that may impact upon an ex-combatant from any community of interest. The range of health issues affecting ex-combatants is explored along with opportunities to begin to segregate some of the particular findings in regard to loyalist ex-combatants and the specific challenges they experienced. These relate specifically to the outcomes of the peace process for the PUL community as well as the challenges in terms of an emerging generation of "prisoners" within those communities.

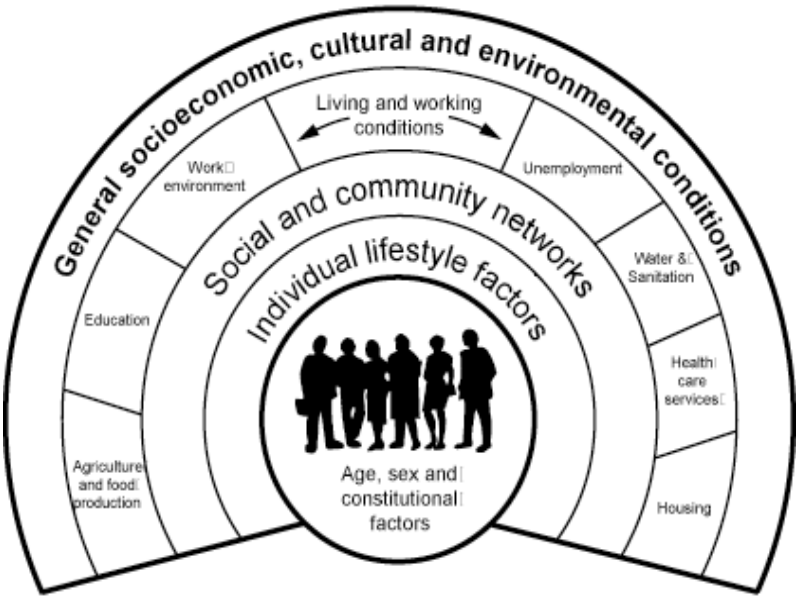
- Specifically the health and well-being concerns for PUL ex-combatants from the former UDA community of interest. The study identified particular concerns about the emotional and mental health of the respondents, particularly in regard to disconnection, isolation with feelings of abandonment that has resulted in high levels of depression and expressed suicidal thoughts.

The findings that follow integrate the information from the literature research as well as the specific information gathered from the questionnaires and interviews for the scoping study.

2.1 The Social and Economic Determinants of Health

There is no doubt that the social and economic conditions in which people live and work contributes to the level of their health and well-being and subsequent inequalities among and between diverse communities of interest.

Early work suggested that there are a myriad of influences that impact upon health and well-being.



While such conditions may be equally applicable to all citizens, the inequities in health caused by social and economic injustice and the structural violence that is expressed in poverty and multiple deprivation present what Jane Wilde describes as "*a steep social gradient in health whereby health tends to increase with wealth. This gradient runs across all social groups and is present for all the main causes of death*".[4]

Dahlgren, G and Whitehead M. (1991)

Wilde's paper suggests that three sets of factors are important when considering causes of health inequalities:

- socio-economic or material factors including the wider environmental context and the distribution of income and resources.
- psychosocial factors like stress, isolation, social exclusion and lack of social support.
- behavioural or lifestyle factors, such as smoking, poor diet and lack of exercise.

Wilde goes on to suggest that not only are these factors inter-related but represent an unacceptable social injustice and "contradict the basic Human Rights principle of achieving the highest standards of health and health care".[5]

This scoping study has sought through the review of literature to draw a picture of the accumulated disadvantage and subsequent health impact that may affect any citizen living in areas of multiple deprivations in South Belfast. In addition, it considers the generic context for former ex-combatants and specifically former members of the UDA and the legacy of the conflict upon their health and well-being.

4 Farrell, C., McAvoy, H., Wilde, J. and Combat Poverty Agency (2008) Tackling Health Inequalities – An All-Ireland Approach to Social Determinants. Dublin: Combat Poverty Agency/Institute of Public Health in Ireland.

5 Ibid.

2.2 Profile of South Belfast

Extensive work has already been carried out in mapping the social determinants of health in South Belfast. The sub-section that follows extracts information that is particularly relevant to the scoping study environmental scan.

South Belfast contains some of the most affluent areas in Northern Ireland alongside a number of inner-city communities suffering from significant deprivation and social and economic disadvantage. This is illustrated in the table[6] that follows that juxtaposes multiple deprivation and health domains across South Belfast. While the level of disadvantage has been recognised through the establishment of two Neighbourhood Renewal Areas in South West Belfast comprising of the Village, Donegall Road and Sandy Row and Inner south comprising of the Markets area, Donegall Pass and Lower Ormeau, others such as Ballynafeigh and Taughmonagh remain masked by the relative affluence of their neighbouring areas.

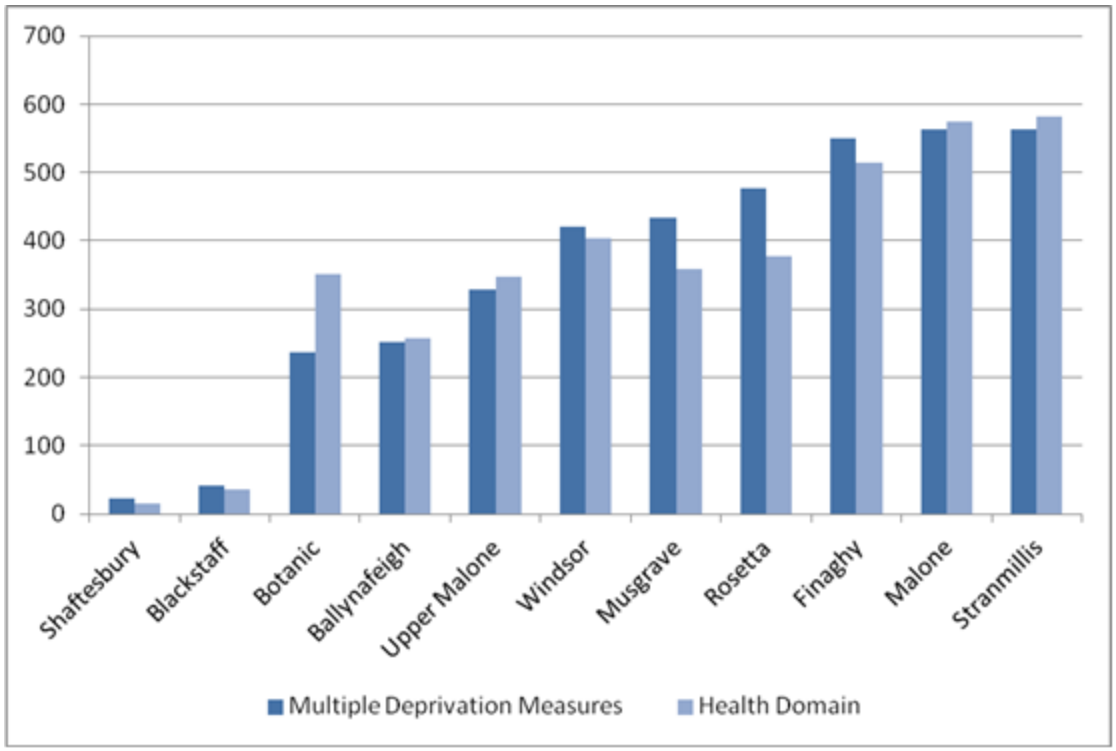


Table 1: Multiple Deprivation Measures (NIMDM) and Health Domain of the 11 South Belfast Wards 2010

The South Belfast Health Strategy produced in November 2011[7] provides a map of the multiple deprivation context as well as data on some significant health issues across the area which is

6 **Noble Rank Northern Ireland Multiple Deprivation Measures (NIMDM) and Health Domain of the 11 South Belfast Wards 2010 (Northern Ireland Statistics and Research Agency).**

summarised below. While the strategy provides excellent data on all aspects of health and deprivation, specifics in terms of adult health and well-being have been selected to inform this study.

- Botanic 5 (lower Ormeau) is within the most disadvantaged 10%, Upper Malone 2 (Taughmonagh) the worst 20% and Ballynafeigh 3 (including Annadale) in the worst 25% in terms of multiple deprivation in Northern Ireland.
- A high degree of health deprivation is to be found in the Shaftesbury ward with Super Output Area [SOA] Botanic 5 in the worst 10% in the Health Deprivation and Disability Domain.
- Life expectancy in Shaftesbury ward is consistently one of the worst in NI and the worst in south Belfast. Life expectancy in Blackstaff, Botanic and Ballynafeigh is below the Belfast and Eastern Health & Social Services Board (EHSSB) averages for both males and females.
- GP data for Shaftesbury, Blackstaff and Botanic wards demonstrates above EHSSB average of heart disease, in particular Cardiovascular Disease and Chronic Obstructive Pulmonary Disease (COPD) and related health behaviour issues, such as obesity; mental health; and cancer in a number of surgeries in or near the 3 ward.
- It is a well-known fact that the population in Belfast, as well as Northern Ireland and most of the Western world, is ageing (*Older People: Health, social and living conditions Belfast, 2006)*. According to the 2001 Census the average number of older people for the eleven wards in south Belfast is 18.6%, (6.2% to 26.3%).

In addition to the available statistics, a number of pieces of qualitative research have been undertaken to consider health issues in the South Belfast area. In summary, the research suggests that much of the population has a poor diet, including vitamin deficiencies and obesity, which has strong linkages to a number of medical issues.

As part of their Healthy Minds Project[8], Sandy Row Community Forum staff organised a one day workshop to listen to local concerns and to bring together cross sectoral partners and service users to facilitate collaborative working to address emotional health and well-being across the area.

Working in groups, participants prioritised concerns for individuals and groups in terms of socio-economic issues. These included;

- Redundancy and long term unemployment
- Changes in Welfare/Benefits – Universal tax credits
- Young people no worthwhile/tangible work experience

7 South Belfast Partnership Board. (2011). *South Belfast Health Strategy 2011 to 2013.* Belfast.

8 Project funded under the Big Lottery Fund - Healthy Minds Programme.

- Generational unemployment
- No role model – no male role models
- Troubles of last 30+ years/Fall out of past troubles on women and children
- Worklessness; low educational achievement; poverty of hope; apathy
- BEM gaps – compounding serious social issues
- Benefits reliance – incapacity

Participants went on to identify specific health and well-being concerns that impact upon the same community population including:

- Suicide – move away from overdoses to more final and violent methods
- Survivors guilt – coping mechanisms, emotional capacity at different stages
- Generational transfer of issues – fear; prejudice
- Use of anti-depressants – self-medication; diagnosis; parental substance misuse; learnt behaviour
- Social media – bullying, negative influences
- Drug and alcohol issues in all groups and particularly young adults
- People experiencing emotional breakdown
- Family breakdown
- Emotional and mental health issues passed on through generations
- Children's mental health – no services
- Domestic violence
- Drugs/alcohol misuse
- Pre-school and school children effects on their emotions not considered
- Lack of confidence and self-esteem in young people

As a result of the consultations the Sandy Row Community Forum developed an Emotional Health Plan to respond to some of the issues identified and to adopt a proactive response to prevention and earlier intervention initiatives. The outline of the plan, its objectives and actions are outlined in Appendix Three. Within the report internal and external factors were identified that may increase vulnerability to reduced emotional health.

Internal Factors that include:

- poor quality of relationships
- feelings of isolation
- experience of disharmony
- conflict or alienation
- physical illness, infirmity or disability
- a lack of self-esteem

External Factors that may compromise mental or emotional wellbeing include:

- poverty and unemployment
- social exclusion or discrimination
- poor physical environment
- negative peer pressures
- experience of abuse or violence
- family or community conflict or tension

In addition, participants from diverse communities of interest discussed some of the cultural beliefs that also impact upon the help seeking process for individuals, groups and communities including:

- Sensitive issues – not spoken about.
- Beliefs and acceptance of what you think is "normal" in society.
- Some groups of people served well in the community whilst other groups have fallen under the radar.

Emerging work on the health and well-being of men has sought to recognise the impact of cultural beliefs and the impact upon their help-seeking process i.e.

- Men self-stigmatise and many are embarrassed to admit to themselves or others that they have a mental health problem.
- This makes it much harder for them to ask for help for example from their GP or friends and family.
- Men often don't display the traditional symptoms of depression (sleepless nights, crying, feeling low) and are more likely to 'act out' (taking drugs, drinking, being aggressive) which means their problems can be overlooked or misdiagnosed.[9]

The relationship between masculinity, male culture and mental health is considered in an excellent document produced by Mind where a number of key observations are made for which there is some evidence or academic support, as follows:

- There are often significant tensions between conventional masculine behaviour and the idea of nurturing good mental health.
- Admitting the need for support with emotional and psychological problems may be a particular challenge for some [men] and may account for some of the more destructive behaviours seen more commonly in men.

During the Advisory Board meetings and during a number of the issues reference was made to the notion of combatants as "hard men". It may be possible that this description is not confined only to those "hard men" who would describe themselves as ex-combatants. The Mind report

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9 Wilkins, D and Kemple, M. (2011). *Delivering Male: Effective Practice in Male Mental Health.* London. The Men's Health Forum.

points out some of the characteristics that are often accepted as cultural characteristics of masculinity, for example (and among others): “the willingness to “soldier on” when under emotional stress; the consumption of large amounts of alcohol and the greater propensity to physical aggression”[10]. There is good evidence that, in general, men lead unhealthier lives than women. Men are more likely to drink alcohol to excess, more likely to misuse drugs, more likely to work, very long hours, more likely to be involved in accidents, less likely to take part in health improvement programmes, less likely to eat a healthy diet and more likely to be overweight.[11]

Within the scoping study several of the respondents referred to their perception of the gap in services in address the needs of men’s health and well-being in the area.

- *“For men in general, there’s not a lot in Sandy Row, little activities sometimes for male care.”*
- *“We should be developing services for men as well as women with access to our own space.”*
- *“We need something like a “men’s zone” where there is access to help for mental health, drugs and alcohol abuse, to deal with the impact of the conflict and being marginalised.”*
- *“We used to have a UB40 club open three times a week where people could come for drop in, play snooker and talk to others.”*

In summary, this scoping study recognises that ex-combatants may experience the same health challenges in identifying need and accessing specific supports as other men living with multiple deprivation in the South Belfast area. The need for a more strategic approach to the issue needs to be considered further within the neighbourhood as a whole.

Conversely little research and needs analysis has been directed towards female ex-combatants, particularly within loyalist communities. The implications in terms of their health and well-being may be as significant for female as for male ex-combatants. The PHA and other Government agencies and Departments may wish to consider this for future research and scoping study purposes.

Another specific subgroup identified within the scoping study is that of ex-combatants as part of an ageing population. The South Belfast Partnership Board Strategy cited previously also referred to the specific needs of older people. As evidenced later, it is important to recognise that the ex-combatant population involved in this study is also essentially an aging one.

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10 Ibid.

11 Ibid.

Therefore, it may be extrapolated that the health findings of the pilot project concerned with older people in the Belfast population might also be considered in terms of the ex-combatant population. These findings include;

- Living alone was a main issue as almost four fifths of older interviewees lived alone, approx. 82.8%.
- Social isolation was another key finding as less than half of the older people interviewed, 43%, reported no contact with friends.
- Older people with poorer health tend to report more feelings of loneliness.
- Respondents indicated that health and mobility was the biggest factor in restricting and preventing older people getting out and about.

The literature review undertaken for the study found that the challenges of ageing were rarely considered in terms of the ex-combatant population. It is suggested that: *"the problems facing them fit neatly into the analysis of the March 2005 consultation paper Ageing in an Inclusive Society (OFMDFM 2005). Yet, there is almost no recognition in this or other policy literature that this ageing population exists. To date there has only been one piece of research on this issue – Jamieson, Shirlow and Grounds (2010)[12]".*

Conversely during the face to face interviews for the scoping study some respondents expressed their concerns over an emerging "prisoner or offender" population in PUL communities as a result of the recent public disorder events.

Several commented on the situation and its potential impact;

- *"My concerns are flags, protests and the outcomes and what it does to next generations. There will be more prisoners or people with convictions because of recent public disorder."*
- *"We could have a new generation of prisoners and we don't want to get to that stage, not by punishment beatings but by showing that as ex-combatants we are here and can provide direction for loyalist aspirations. Younger people have a problem with their identity and we can help them see they have a worthwhile cause without going back to war."*
- *"So far we have prevented fragmentation and 'dissident' loyalism but we have to keep looking at it."*

12Rolston, Bill. (2011). *Review of Literature on Republican and Loyalist Ex-Prisoners.* Belfast. Transitional Justice Institute. University of Ulster.

The issues concerning identity and its impact on the emotional health and well-being of ex-combatants requires a holistic approach that integrates opportunities created by OFMDFM with an understanding of the potential preventative and earlier intervention aspects for health, well-being and community safety. These are also explored later in terms of building resilience.

In summary, this sub section of the scoping study acknowledges the similarity of the environmental circumstances that contribute to the differing levels of health and well-being for any member of the population living in areas of multiple deprivation in Northern Ireland and specifically in South Belfast.

In the next sub section, consideration is given to the specific context of social and economic factors and health determinants firstly within the context of any ex-combatant and then specifically for the research participants' respondents in this study.

2.3 Social, Economic and Health Conditions of Ex-Combatants

The review scan found a significant number of research reports outlining the social, economic and health conditions of ex-combatants. A recent paper by Bill Rolston[13] has completed a comprehensive review of the literature on the life circumstances of ex-prisoners. This is referenced here and recommended as essential background reading to the report.

It is clear that many ex-combatants across the various reports cited, experienced a combination of social and economic factors that has contributed adversely to the determinants of their health. These are presented under the same categories referred to previously in the Wilde report on the social determinants of health.

The literature review provided an opportunity to begin to segregate some of the particular findings in regard to loyalist ex-combatants and the specific challenges they experienced. In the information that follows data has been specifically selected in terms of Loyalist ex-combatants other than when it provides comparative analysis with the experience of Republican ex-combatants.

13 Ibid.

2.3.1 Socio-economic or Material Factors Including the Wider Environmental Context and The Distribution of Income and Resources

- The vast majority of the 300 ex-prisoners surveyed by Shirlow et al. (2005) had experienced financial difficulties when first released and 48% of loyalists and 64% of republicans continued to have such difficulties. Later work by Jamieson, Shirlow and Grounds (2010) found on-going challenges in terms of financial problems, not just the lack of money, but also problems in relation to handling money. Few ex-combatants had made financial preparations for retirement. Because of time spent in prison only 35% (29% of republicans and 44% of loyalists) will have made at least ten years of National Insurance Contributions by retirement age. Less than 1 in 10 were paying into a private pension fund. The review information concluded that the risk of poverty in old age is almost certain. They will be between two and four times as likely as other pensionable age people to be entirely dependent on state benefits.

- Opportunities to generate income through employment opportunities that are maximised by capacity and skills building to gain employment are limited for the ex-combatant population. A series of reports indicated that former prisoners who are employed tend to be in lower paid jobs and within their own communities, which often were areas of highest unemployment and employment opportunities. Some had found employment in the community sector as a result of their contribution to peace building.

- Shirlow's (2001) found that employment was a major problem for ex-prisoners because of their lack of, or lack of relevant, skills. Negative attitudes, political vetting and state policies all worked against them finding a job.

- More recently, Jamieson, Shirlow and Grounds' (2010) research survey of 190 ex-prisoners found that 51% were in paid employment, 30% working full-time – 36% of loyalists and 27% of republicans. Political ex-prisoners were four times as likely to be unemployed as others in Northern Ireland. 26% were unemployed and 16% in receipt of sickness or disability benefit – loyalists 21% and republicans 13%.
    - Both groups of ex-prisoners were more likely than others in Northern Ireland to be on Disability Living Allowance (DLA). Mental ill health was correlated with being unemployed and on DLA.
    - Those interviewed list a series of factors which in their view militate against employment: the general economic situation, the refusal of employers to employ, security concerns, restricted access to training and ageism.

- Loyalist ex-prisoners point to an additional number of blockages which are particularly if not uniquely relevant to them (Kelly 2011). They have found difficulty in engaging in security-related employment because of the operations of the Security Industry Authority (SIA) (Northern Ireland Office 2006), and cite instances of their children being

discriminated against in terms of joining the armed forces because of their parent's criminal record.

The particular impact of the combination of status as an ex-combatant and the impact upon aspects of day to day living were articulated by one respondent.

"Am classed as an ex-combatant. Call a spade, a spade. A definition was never made. If convicted it's harder to get a job. Others from my community are engaged in peace building, yet can't get into America. Why? It's hard for Protestants, especially when they see and hear Irish Republicans in America."

One respondent commented *"…with employability there is a sense of responsibility, there is more pride in self."*

While employment remains an area where the practical and legal barriers to full reintegration remain, there is a need for those concerned with the health and well-being to consider the impact on ex-combatants. This may include reduced levels of economic autonomy or the accumulated effect of prejudice by employers or the overall impact upon levels of resilience to deal with the prejudice and lack of re-integration on a day to day basis. It may also impact adversely upon social mobility and the subsequent lack of opportunities for individuals and their children to be no longer identified wholly in terms of identity as an "ex-combatant".

2.3.2 Psychosocial Factors like Stress, Isolation, Social Exclusion and Lack of Social Support

Diverse reports cited in the literature review, consider aspects that influence upon psycho-social factors such as isolation, social exclusion and lack of social support. These impact upon ex-combatants stress, resilience levels as well as their emotional health and well-being and include:

- Breakdown of relationship with partner/wife. Shirlow's study (2001) out the divorce rate for ex-combatants as 17% higher than the Belfast average.
- Return to the community can be a mixed experience particularly for Loyalist ex-prisoners cited within a number of research reports. (Crothers 1998; Kelly 2011; Shirlow et al. 2010). Jamieson, Shirlow and Grounds (2010) surveyed 73 loyalist ex-prisoners and 113 republicans and found that loyalists were more likely than republicans (18% versus 8%) to feel isolated in their own community. Loyalist ex-prisoners found themselves facing rejection by mainstream unionism. The Orange Order, for example, saw the early release of politically motivated prisoners, loyalists as well as republicans, as part of a 'long train of concessions' (McAuley et al. 2010). Consequently, loyalists

have less acceptance in their communities than republicans have in theirs, and republicans have had an easier time establishing their legitimacy in the wider nationalist community (Mitchell 2008)[14].

The loss of the community or camaraderie of other ex-prisoners is a factor that will be referenced further in the section that follows. Several research reports acknowledge the contrast between the prison experience where people shared, in general, a common ideology, in comparison with the experience of a return to a community and society with diverse attitudes and behaviours to ex-combatants. This was explored initially in the introductory section on "legitimacy" and will be referenced further in the sections that follow.

2.3.3 Behavioural or Lifestyle Factors, Such as Smoking, Poor Diet, and Lack of Exercise

The review of the literature review provided examples of some of the behavioural or lifestyle factors that impact upon the lives of ex-combatants.

The unemployed are five times as likely as others in NI to be on sedatives and tranquillisers or ant-depressants[15]. Sections of this study provide a profile of the ex-combatant population who are who are not in paid work and are on Disability Living Allowance. Research has shown that those in receipt of DLA are more likely than others in Northern Ireland to be suffering from mental ill health. Conversely many find it difficult to access or use the mental health services they need. This is discussed in more detail in later sections of the study.

The literature review cited previously states:

"In this regard the health behaviour and symptomatology of these former politically motivated prisoners is very similar to that of analogous groups such as army veterans, or police or emergency service personnel, who have been required to deal with violent scenes in the course of their work. Former politically motivated prisoners' mental health problems are also similar to those of other detainees suffering more long term forms trauma, such as prisoners of war. While self-medication through excessive alcohol use may provide short term relief from distressing feelings, this behaviour is likely to have damaging long term effects on their mental

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14 Rolston, Bill. (2011). *Review of Literature on Republican and Loyalist Ex-Prisoners.* Belfast. Transitional Justice Institute. University of Ulster.

15 NACD/PHIRB (2009) *Drug Use in Ireland and Northern Ireland, 2006/2007, Bulletin 6 Drug Prevalence Survey: Sedatives or Tranquillisers, and Anti-Depressants* Dublin and Belfast: National Advisory Council on Drugs and Public Health Information and Research

and physical health, their personal, familial and social relationships and their capacity to work."[16]

Jamieson and Grounds (2002) found 56% of their sample of former prisoners reported alcohol problems. Later work by Jamieson, Shirlow and Grounds (2010) used specific tools FAST and CAGE to measure alcohol dependency. The former showed 72% of republicans and 64% of loyalists over the threshold for hazardous drinking; the latter showed 53% or republicans and 55% of loyalists over the alcohol dependence threshold. These scores are twice the Northern Ireland average. Even with lower scores, women ex-prisoners were two and a half times more likely to be alcohol dependent than women in the rest of the population.

In the same report, reference is made to the "guilt" and trauma associated with encounters with death may give rise to depression and anxiety, preoccupation with death and related co-morbidity in the form of alcohol or drug dependency. Issues of self-medication with drink and drugs were also examined and in particular in the context of maladaptive coping mechanisms to deal with stress and distress.

The scoping study has sought to date to provide a mapping of the social determinants of health and their impact upon generic communities experiencing multiple deprivations and specific communities of interest including residents in Sandy Row and the wider South Belfast Neighbourhood Partnership area, as well as ex–combatants both republican and loyalist across the region.

It has confirmed that the ex-combatant population, as with the population of others living in areas of multiple deprivations experience a cause and effect that affects their physical and emotional health and well-being. It has also reiterated the particular challenges and barriers faced by ex-combatants to address these issues. These include reduced opportunities and active discrimination in gaining employment, a notable absence from enterprise, education and training with a knock on effect on economic autonomy and financial security. They experience many of the same concerns as an ageing population, living with disadvantage with added isolation for some, from their own communities, families and traditional support networks.

The loss of camaraderie for some who become disconnected from support networks can have a significant adverse impact upon all aspects of their health and well-being.

The section of the scoping study that follows outlines the same factors and impact specifically in terms of the former UDA ex-combatant population that participated in the scoping study activities.

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16 Rolston, Bill. (2011). *Review of Literature on Republican and Loyalist Ex-Prisoners.* Belfast. Transitional Justice Institute. University of Ulster.

3.0 Former UDA Ex-Combatants in South Belfast

3.1 Respondents Profile

63 respondents participated in the research. This included the 22 individuals who participated in more in-depth interviews with the peer researchers and the 7 with the lead researcher.

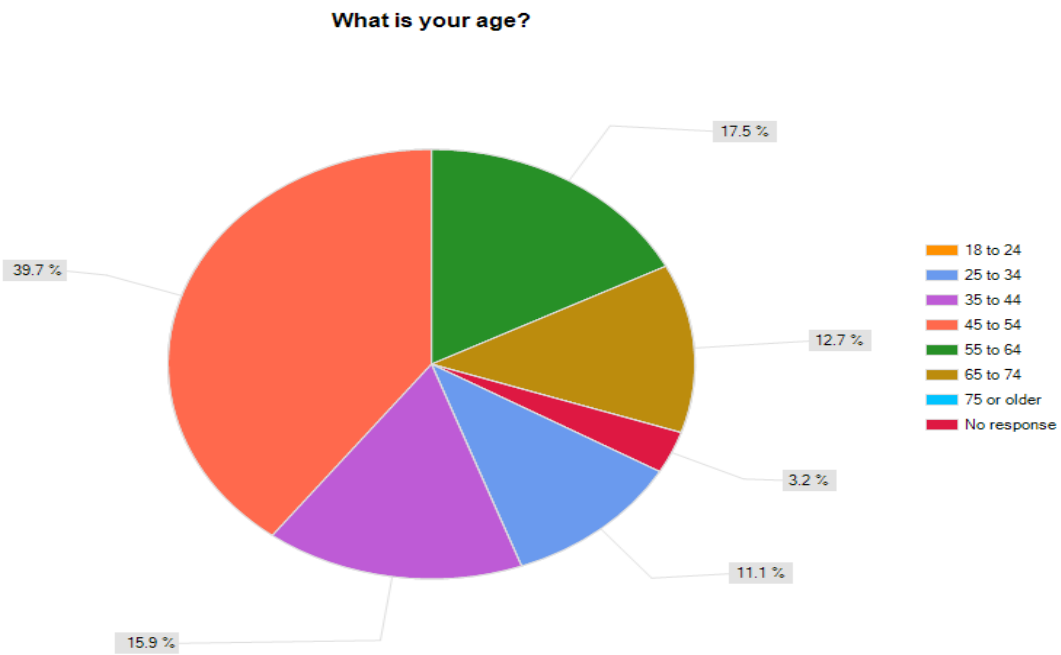

Table 2: Age Profile of Research Participants

The largest ratio of respondents [almost 40%] in the 45-54 age range while over half were in the higher age bands from 55 years to 75 years or older as illustrated in Table 2. 17% were receiving a state pension. One respondent commented "*We are older men now living in poverty".*

The year of release for those who had been imprisoned ranged from 1983 -1999 [the year of the Belfast Agreement.] Of those respondents who had been imprisoned for political offences 86% were not involved in any form of repeat crime for non–political offences since 1998. 22% of respondents chose not to answer this question.

Throughout this report the term ex-combatant, rather than ex-prisoner is used more generally. This acknowledges that the term ex-combatant can have a wider definition than those who experienced a period in confinement through internment, remand or sentencing.

Dr Kenneth Bush in his work Aid for Peace defines the term militarized violence as, in his conflict sensitive analysis considers “ex-combatants” in terms of all those who carried “military weapons in or out of uniform” and is not limited to those who experienced a period of confinement. While the questionnaire returns indicate the year of release of individuals, the number of returns also suggest that there are a number of those who returned responses who may not in fact ever been imprisoned but who would regard themselves as former UDA members but who did not experience imprisonment.

Given the prevalence of others in the population of Northern Ireland who might within Bush’s definition also be considered “ex-combatants” who experience health and well-being challenges because of their experiences in the conflict, the Public Health Agency, who commissioned this study may wish to consider an adapted version of the scoping study to gather evidence of the health and well-being needs of ex-security service personnel including police and members of the Ulster Defence Regiment [UDR]. As referenced previously, expressions of interest in the questionnaire and in the outcomes have already been received by republican and loyalist ex-combatant support groups wishing to access the information.

3.2 Respondents Self-Assessment of Health Status

Respondents were invited to self-assess the current state of their physical and emotional health and the subsequent impact upon a series of activities. The full range of responses is set out in tables in Appendix Four.

Over a quarter thought that their physical health or emotional problems interfered with their social activities in the 4 weeks prior to answering the questionnaire. Table 3 below illustrates their response to question on the extent to which physical health problems were the source of the “interference”.

Not at all	Slightly	Moderately	Quite a bit	Extremely
30%	8%	22%	30%	10%

Table 3: Interference with Social Activities

Slight variances were found in those respondents who reported the duration and length of time where their lives had been affected by their health status. 27% of respondents reported this as being some of the time and 22% none of the time. Almost equal numbers of respondents felt that their health was approximately the same or somewhat worse than it had been a year ago. 34 % described their bodily pain as severe to very severe levels and 33% as moderate.

The impact in the previous 4 weeks of the status of their physical health on work or other regular daily activity was also reported and is illustrated in table 4 below.

	Yes	No
Cut down on the amount of time spent on work or other activities	**35%**	**65%**
Accomplished less that you would like	**44%**	**56%**
Were limited in the kind of work or other activities	**44%**	**56%**
Had difficulty performing the work or other activities (for example, if it took extra effort)	**43%**	**57%**

Table 4: Impact on Work and Other Activities

Overall respondents did not have a positive perspective on their current or future health status as illustrated in table 5 below.

	Definitely True	Mostly true	Don't know	Mostly false	Definitely false
I seem to get sick a little easier than other people	**14%**	**22%**	**39%**	**11%**	**14%**
I am as healthy as anybody I know	**9%**	**16%**	**24%**	**27%**	**24%**
I expect my health to get worse	**28%**	**25%**	**40%**	**2%**	**5%**
My health is excellent	**2%**	**18%**	**9%**	**22%**	**49%**

Table 5: Current and Future Health Status

A larger research study would allow for a comparison of responses from the scoping study group with a profile of individuals living in similar environment, with a similar age and socio-economic profile etc. However, based on an analysis of the responses from the scoping study participants it is clear that their assessment and experience of their physical health and the subsequent impact upon their lives is adverse.

Having gathered the information from the respondents self–assessment of aspects of their current and projected future health status, attention is given in the following sub sections to gauging some of the determinants of that health status utilising two of the three categories set out previously in the scoping study.

3.3 Socio-Economic or Material Factors Including the Wider Environmental Context and the Distribution of Income and Resources

The socio-economic factors examined in the study included type of accommodation, economic status including the receipt of benefits.

Approximately three quarters of the respondents [75.8%] lived in rented accommodation, 7% lived in the home of family or friends and only 18% owned their own homes.

31% of respondents were unemployed. In a later question 68% of respondents agreed that they “have been refused employment due to my background”.

Approximately 18% of respondents were employed full time; 3% employed part-time. None were self–employed, in training schemes or students which may indicate the absence of ex-combatants from any form of enterprise creation, education and training.

Table 6 below illustrates the number and type of receipt of benefits. It is of note that almost a third are in receipt of disability living allowance and 29 % are in receipt of incapacity benefits.

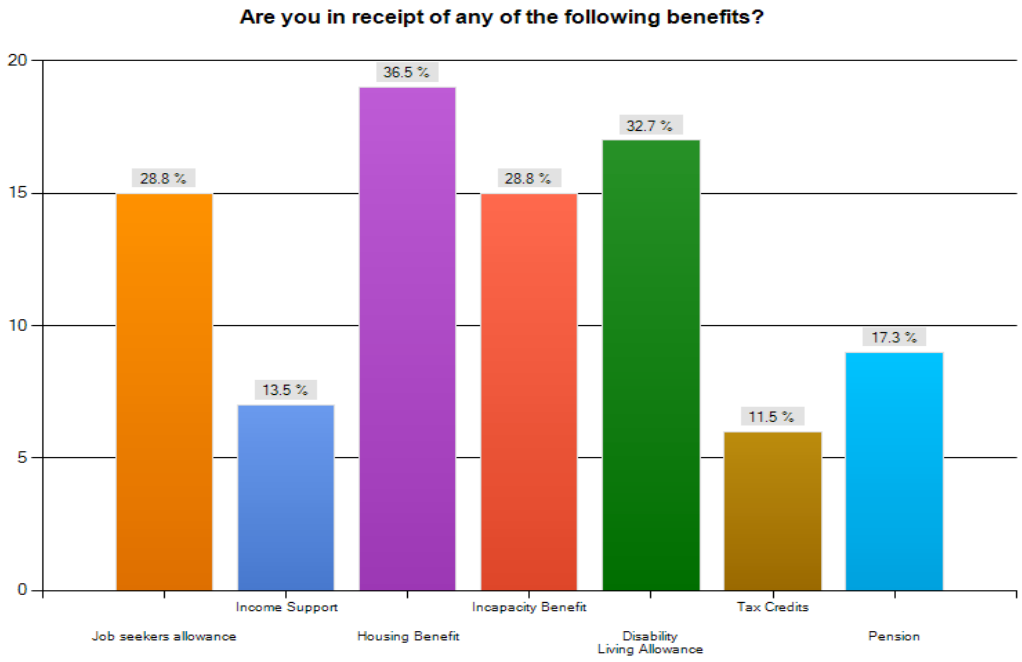

Table 6: Benefits Profile of Respondents

The face to face interviews and the feedback from the peer researchers confirmed the concerns that individuals had specifically in relation to financial matters. These included;

- Concerns in relation to their housing
- Lack of information about benefits
- Worrying about their future financial circumstances, particularly in older age
- Worry about changes in benefits.

One respondent commented *"if I lose benefits it will have a terrible knock on effect".*

While these concerns may be shared with other populations of residents and older people, the added barrier for the respondents in the scoping study was the self-imposed isolation from access to support needs to be considered. Peer researchers carrying out the face to face interviews were reminded often by the respondents of their concerns about the information they were being asked to share in terms of their socio-economic conditions and how their experience as ex-combatants had contributed to that situation.

"What I learnt was just how bad some of the boys are in terms of money and health and their worries about what's going to happen to them at the end of the day."

These worries are explored further in the section that follows, focusing in particular on health and well-being.

3.4 Behavioural or Lifestyle Factors

Undoubtedly, some of the biggest concerns expressed by the peer researchers who visited respondents at home or were aware of others within their community was concern about the lifestyle factors that were adversely impacting upon the health and well-being of former UDA ex-combatants. This was validated by the quantitative data returned in the questionnaires as well as the qualitative data gathered for the scoping study.

The quantitative data is presented in the series of tables that follow in relation to alcohol consumption and the impact upon lifestyle and well-being. It is important to state that while many of the respondents reported levels of alcohol consumption and impact that indicate significant concern, that there were also respondents who did not drink at all or only in moderation.

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often do you have EIGHT or more drinks on one occasion?	**16%**	**14%**	**11%**	**41%**	**18%**
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	**41%**	**16%**	**14%**	**21%**	**8%**
How often during the last year have you failed to do what was normally expected of you because of drinking?	**43%**	**14%**	**13%**	**22%**	**8%**

Table 7: Profile of Alcohol Use

Concerns are raised when just over 40% of respondents agree that they have eight drinks or more on one occasion on a weekly basis with 18% doing the same on a daily basis. While the nature of the drinks as beer or spirits was not identified, in either instance, it is above the recommended alcohol unit consumption. Similarly 60% of respondents reported that they had had a drink first thing in the morning to steady nerves or get rid of a hangover.

While it would be easy to recommend that preventative health initiatives and awareness raising of the adverse impact of excessive alcohol drinking, the reality is that many of the same respondents had already received “messages” from others about their alcohol consumption and even had some concerns themselves. Their responses are indicated in the tables below.

	Yes	No
Have you ever felt you should cut down on your drinking?	**52%**	**48%**
Have people annoyed you by criticising your drinking?	**59%**	**41%**
Have you ever felt bad or guilty about your drinking?	**48%**	**52%**

Table 8: Feelings on Alcohol Use

	No	Yes, on one occasion	Yes, on more than one occasion
In the last year has a relative or friend, or a doctor or other health worker, been concerned about your drinking or suggested you cut down?	**43%**	**18%**	**39%**

Table 9: Feelings of Others on Alcohol Use

The peer researchers expressed particular concern in regard to the denial of the problem stated by some and how in some cases the alcohol consumption further disconnected ex-combatants from “safer” drinking situations where they were less vulnerable and at risk. The peer researchers reported:

- *“Concerned that some of the men I talk to don’t realise that they need some kind of help. They also seem to think that drinking every day is the norm and that it won’t do any harm to them in years to come.”*
- *“He drinks when there’s a crisis, drinks when there’s a celebration, takes drink to sleep.”*
- *“He’s drinking himself into an early grave - it’s like a form of suicide.”*

In terms of the increased vulnerability, one peer researcher reported on the “paradise club” drinking that was occurring when individuals drank all day in a flat or house with others, most of whom were not ex-combatants.

“It’s a paradise club situation - same people all in the same boat do they really want help to change their life?] They are not all ex-combatants but they have managed to identify some things in common. It’s happening to ex-combatants who have distanced themselves from anything but it - the paradise club.”

Similarly the interviews and the contact with others to complete the questionnaire identified some of the factors that had precipitated the abuse of drugs for some individuals.

- *“Lack of partner, been involved in combat, been victims of attacks [republican and loyalist]. Now their biggest worry is where the next hit on drugs will come from. They have no one to talk to.”*
- *“They told me that they need to talk together about their problems with others like themselves but there is nowhere for them to go.”*
- *“Some of these people are in denial. On the other hand some is receiving help about drug addiction and trying to move on. Some of the people have moved on, but had problems with relationships with wives and girlfriends in the past as well as alcohol problems.”*
- *“This guy is now experiencing withdrawal of sleeping tablets. They need services that people can be involved with. Problem is they’re getting them elsewhere – fabricated ones - that’s my fear.”*

The “fear” of this peer researcher needs also to be viewed within the wider context that 54% of the respondents had been described medication by their GP for anxiety or sleeping difficulties during the last year and 48% prescribed medication for depression during the same period.

While this sub section of this report has referred specifically to a sub group of the respondents who are particularly vulnerable and at risk because of their abuse of alcohol and drugs this also has to be seen within the wider context of the increasing reliance and misuse of medicated drugs and alcohol consumption among the wider population.

The Sandy Row Emotional Health and Wellbeing Report 2012-2013 stated that;

Research raises concerns about sexual health and abuse and shows a higher than average numbers of people within the area are on prescription drugs for mental health problems, such as anxiety, depression, self-harm, suicide and alcohol/drug abuse.

Anecdotally, overprescribing has begun to lead to the development of a black market for prescription drug abuse, in addition to on-going abuse of illegal drugs. There are also concerns about the level of alcohol consumption and dependency. In many ways connected to these issues are growing concerns about levels of domestic violence, isolation of older people and an increasing suicide rate in the area.

In summary this scoping study has found that many ex-combatants share the same concerns about money, housing, their physical health and well-being and the prospects for their future lives as other citizens living in similar situations. In the same way, the use of unhealthy and maladaptive coping mechanisms' such as abuse of alcohol and drugs [medicated and illegal] results in particular individuals having increased levels of vulnerability and risk in terms of their safety, health and well-being. The impact of these issues and concerns is exacerbated by a combination of isolation, and lack of access to support they trust.

In the section of the study that follows, the psycho-social determinants identified previously are used as a preliminary focus for the findings and discussion on emotional health, well-being and mental health concerns that are at the core of the rationale for this study.

4.0 Emotional Well-Being and Ex-Combatants in South Belfast

Previous sections of this scoping study have sought to provide a holistic approach to understanding the context of emotional well-being for the community of PUL former UDA ex-combatants in South Belfast.

The study to date has considered the socio economic determinants that impact upon physical and emotional health and well-being of diverse communities, particularly those living within areas of multiple deprivations.

This section of the study focuses specifically on the emotional health needs of former UDA members in South Belfast and considers the ranges and approaches necessary to meet those needs. For the purposes of the study emotional health and well-being is understood as *"a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment."*[17] The sub sections that follow address these "well-being" factors within the context of the lives of the scoping study respondents.

4.1 A Positive State of Mind and Body

The tables that follow record the self-assessment of the positivity of mind and body by the respondents. It is important to note that there were a number of the respondents who appear to have successfully re-integrated back into communities and are coping, as many individuals do, with the "ups and downs" of day to day living. The degrees of positivity and the resulting levels of energy and positivity were assessed by respondents within a specific timeframe of the previous four weeks. Results are recorded in the tables that follow.

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Did you feel full of pep?	**2%**	**9%**	**3%**	**21%**	**25%**	**40%**
Have you felt so down in the dumps that nothing could cheer you up?	**6%**	**21%**	**14%**	**24%**	**24%**	**11%**
Have felt calm and peaceful?	**2%**	**5%**	**8%**	**22%**	**35%**	**28%**
Did you have a lot of energy?	**3%**	**8%**	**6%**	**19%**	**19%**	**45%**

Table 10: Self-Assessment of Positivity

Levels of calm and peacefulness are particularly low with 28% experiencing these positive states of being none of the time and 35 % only a little of the time with similar low levels in terms of energy and feeling "full of pep".

17 Gateshead Emotional Health and Well-being Action Plan 2010 – 2013, NHS South of Tyne and Wear, Gateshead Council

In the same time frame, respondents were asked to consider their levels of concentration, anxiety, confidence and happiness. These are recorded in the table below.

	Much less than usual	Same as usual	More than usual	Much more than usual
Been able to concentrate on whatever you are doing?	**38%**	**60%**	**-**	**2%**
Lost much sleep over worry?	**10%**	**49%**	**30%**	**11%**
Felt like you were playing a useful part in things?	**32%**	**62%**	**3%**	**3%**
Felt capable of making decisions about things?	**22%**	**73%**	**5%**	**-**
Felt constantly under strain?	**13%**	**51%**	**23%**	**13%**
Felt that you could not overcome your difficulties?	**16%**	**52%**	**21%**	**11%**
Been able to enjoy your normal every day activities?	**40%**	**54%**	**3%**	**3%**
Been able to face up to your problems?	**37%**	**60%**	**-**	**3%**
Been feeling unhappy and depressed?	**17%**	**48%**	**21%**	**14%**
Been losing self-confidence in yourself?	**23%**	**49%**	**14%**	**14%**
Been thinking of yourself as a worthless person?	**19%**	**48%**	**22%**	**11%**
Been feeling reasonably happy, all things considered?	**49%**	**49%**	**-**	**2%**

Table 11: Self-Assessment of Anxiety and Happiness

In considering the table as a whole a clear picture emerges of a significant percentage of the respondents from the ex-combatant community struggling to cope with day to day situations such as decision making and concentrating on whatever they were doing. Similarly high percentages report being unable to face up to their problems, feeling unhappy and depressed, lacking self–confidence and thinking of themselves as a worthless person.

What has not been ascertained in this scoping study is the degree to which the degree of unhappiness, low self-confidence and self-worth and challenges in coping with day to day living are specific to the ex-combatant community and which are shared and to what degree among the wider population in which they live and socialise. The cause and effect of the overall interference of “emotional problem” with day to day social activities was also identified by respondents as recorded in the table below.

During the past 4 weeks, to what extent has your emotional problems interfered with your normal social activities with family, friends, neighbours or groups?

Not at all	Slightly	Moderately	Quite a bit	Extremely
29%	11%	11%	43%	6%

Table 12: Interference with Social Activities

However where a differentiation can be made between ex-combatants is their specific response to the assessment of the personal costs they experienced as a result of the conflict. This is explored further in the sub–section that follows.

4.2 Feeling Safe and Able to Cope

Respondents were asked to consider the personal costs of their experience as a result of the conflict. The table that follows records their responses.

	No harm	Mild harm	Moderate harm	Severe harm
Physical injury	43%	24%	18%	15%
Psychological harm	18%	25%	43%	14%
Ability to form a successful, close relationship with a partner	30%	10%	33%	27%
Ability to express affection	23%	29%	29%	19%
Ability to express worry and unhappiness	13%	33%	40%	14%
Ability to confide about personal problems	11%	23%	45%	21%
Estrangement from family members	25%	25%	29%	21%
Suffering caused to family members	8%	27%	35%	30%

Table 13: Personal Cost of the Conflict

Just over half [57%] considered that they had experienced moderate to severe psychological harm which is high in comparison with the harm form physical injury [33%]. Similar high levels of harm are also expressed in terms of the ability to express worry and unhappiness [54%] with 66 % recognizing the impact on their ability to confide about personal problems. There is no doubt that the lack of ability to speak about the challenges and problems they are experiencing will also have an adverse impact upon their help–seeking process and the access to available support mechanisms where these are available. Estrangement from family members [50%], awareness of the suffering caused to family members by the situation [65%] and ability to express affection [48%] may be likely to further exacerbate isolation and limit use of available support from family networks.

The level and degree of impact experienced by a combatant is often experienced in a post conflict context rather than during the actual time of the violence. Similarly, the type, level and degree of support interventions need to match individual need and to be based on a robust framework of assessment of need, vulnerability and risk. Barriers and challenges to access the same interventions need also to be considered.

The degree and duration of Post-Traumatic Stress Disorder [PTSD][18] is a concern for all those concerned with the emotional and mental health legacy of the conflict. Post-traumatic stress disorder (PTSD) is a condition which develops after involvement in or witnessing a serious trauma. Signs include:

- Recurring thoughts, memories, images, dreams, or flashbacks of the trauma which are distressing.
- Trying to avoid thoughts, conversations, places, people, activities or anything which may trigger memories of the trauma, as these increase distress or anxiety
- Feeling emotionally numb and feeling detached from others.
- Outlook for the future is often pessimistic and find include finding it difficult to plan for the future. There may also be a loss of interest in activities previously enjoyed.
- Increased arousal not experienced before the trauma. This may include:
    - Difficulty in getting off to sleep or staying asleep.
    - Being irritable which may include outbursts of anger.
    - Difficulty concentrating.
    - Increased vigilance.
    - Being more easily startled than previously

Respondents identified specifically their experience of different aspects of the PTSD condition in the study.

	Strongly Agree	Agree	Neither Agree or disagree	Disagree	Strongly Disagree
I directly witnessed terrible scenes during the conflict that I do not want to think about, but I am still bothered by memories or upsetting dreams about them	**21%**	**40%**	**19%**	**17%**	**3%**
I directly witnessed terrible scenes during the conflict that I do not want to think about, and I try to avoid situations that remind me of them	**18%**	**43%**	**22%**	**14%**	**3%**

18 http://www.patient.co.uk/health/post-traumatic-stress-disorder

I directly witnessed terrible scenes during the conflict that I do not want to think about, and if something reminds me of them I feel anxious and panicky	**14%**	**43%**	**24%**	**17%**	**2%**

Table 14: Experience of PTSD Conditions

One respondent told the peer researcher interviewing him how he had to turn off the news coverage of the bombings at the Boston Marathon and another reported how he read no newspapers and switched off all news coverage because of the anxiety they generated.

This juxtaposition of PTSD and those directly involved in conflict and war has long been recognised. De Jong argues that thirty to forty five years after a war, a large proportion of "veterans" he examined were still suffering from PTSD and were at an increased mortality risk from tuberculosis, accidents, or coronary heart disease. Time *per se* does not necessarily heal wounds for a considerable amount of people.' (De Jong, 2002: 42).

The symptoms of anxiety, depression and nightmares associated with PTSD will often continue many years after the original stressful situation and be re-triggered by similar or new stressful situations and experiences.

The "new situation" for many of the ex-combatants in this study has not necessarily proved to be positive. While fifteen years has passed since the Belfast Agreement and the decommissioning of paramilitary weapons, new fears and concerns relating to the conflict are emerging for the respondents in this study. During the interviews a number of the respondents referred to the anxiety created by the Historical Enquiries Team and the Supergrass Trials. The recent public disorder events and the political crisis in the PUL community were also a source of anxiety and concern for some.

The impact of the HET upon health and well-being was noted by a number of individuals;

"Nobody gets anyone to open up about anything because of HET – confidentiality goes right out of it. On the other hand people need to talk, not necessarily about what they've done about what they're feeling and thinking now about those times. They need to understand the clear boundaries about how others can help them."

"I know someone who is starving themselves to repent for what they've done."

"People need a chance to talk, not about what they've done abut about what they're thinking and why they are thinking it at this time. Is it drink? Is it drugs? What is affecting them that day that addresses that thinking?"

The provision of the input from a representative from the Trauma Centre in the Everton Complex was positive and extremely useful in the training session for the peer researchers. Clear boundaries were described in relation to confidentiality and ways in which to talk about current mental and emotional health challenges without necessarily having to revisit events in the past. The representative also agreed as to the lack of similar provision on a community basis in South Belfast but promoted the services in the Trauma Centre as accessible on a Belfast wide basis.

Other specific issues impacting upon emotional health and well-being were highlighted during the study. The sense of abandonment and the negative thinking expressed by some respondents in regard to the political situation for ex-combatants from the PUL community was also apparent both in the quantitative data and the qualitative comments. 73 % of respondents disagreed with the statement that "the peace process has made it easier for ex-combatants to cope financially, emotionally and socially."

One interviewee commented "*The political change drives negative thinking for me"*. The impact upon their sense of identity and self-value was also referenced. "*We were the reactive Prods – the patsies for the politicians while for republicans they went from gunmen to government".* Another stated *"there are no mechanisms in how to deal with the conflict generation".*

The words abandonment and betrayal was used by a number of the respondents, particularly in the face to face interviews. As referenced previously in the study that sense of abandonment

was also expressed in terms of the former UDA as an organisation and particularly when contrasted with the strength and impact of the camaraderie discussed previously in the study.

"Health issues arise because things weren't put in place at the time, including mental health. It's the biggest let down and fall down in my opinion."

The adverse impact upon individual's sense of purpose for the future was also apparent. This is reflected in the table that follows in their responses to statements about their current state of thinking.

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
As I get older my capacity to deal with the past gets easier	**2%**	**24%**	**24%**	**34%**	**16%**
I have been able to find a sense of purpose for the future from a personal point of view	**7%**	**26%**	**22%**	**29%**	**16%**
I have been able to find a sense of purpose for the future from a political	**8%**	**14%**	**14%**	**42%**	**22%**

point of view					
There is not a distance between me and those in my age group who did not engage in the conflict	**6%**	**27%**	**20%**	**25%**	**22%**

Table 15: Current State of Thinking

The lack of sense of purpose for the future has also to be viewed in contrast to the previous experience of ex-combatants during the conflict.

- *"There is a big loss of purpose. Before when they got up in the morning they were a UDA member who felt they were doing something for their community. There is also a loss of identity. Community doesn't respect them now."*

- *"Some fellas have mental health problems because they haven't that focus in their lives anymore. When you were in the organization you had to stay alert, now some just stay in the house and drink."*

The stage at which the "tipping point" of negative thinking escalates into a form of clinical depression and suicidal thinking or actions is not the remit of this scoping study.

However, there is clear evidence from the respondents that depression and suicidal thinking is a reality for many.

	Strongly Agree	Agree	Neither Agree or disagree	Disagree	Strongly Disagree
I have not had times of feeling seriously depressed	**6%**	**18%**	**14%**	**32%**	**30%**
There have been times when I have not wanted to go on living	**13%**	**27%**	**22%**	**21%**	**17%**
I think I will be happy in the future	**2%**	**22%**	**41%**	**22%**	**13%**

Table 16: Depression and Suicidal

As recorded in the table above almost 62% had experienced feeling seriously depressed at some time and 38% experienced times when they have not wanted to go on living. This situation is exacerbated by the sense of lack of fulfilment within different aspects of their lives. Only a quarter of respondents thought that in their old age they will look back on their lives with a sense of achievement, a quarter neither agreed or disagreed with the statement and almost half of the respondents stating they felt no sense of achievement with their lives.

An excellent article by Michael Tomlinson on Northern Ireland's suicide rate [July 2012] [19] explains that *"the toxic mix of greater political stability and increasing social isolation is putting those born into the Troubles at much greater risk of suicide than their British or Irish counterparts."* Tomlison goes on to report that *"What the data show is that men in their late thirties up to their early fifties are the group contributing most strongly to the upward suicide trend since 1998. In other words, those born into the conflict or who were children during the worst years of violence are the cohort which now has the highest suicide rates and the most rapidly increasing rates of all age groups."*

Given the profile of the respondents in this study, the expression of despair and abandonment there are clear indications of heightened risk of suicidal thoughts and tendencies factors for a number of ex-combatants participating in this study. This is further exacerbated by the experience of physical and emotional isolation and the added factors of social and economic injustices referenced previously in the study.

4.3 Sense of Connection with People, Communities and Wider Society

Isolation proved to be a distinctive feature that impacted upon the lives of many of the respondents. For some it was physical isolation. 41% of the respondents are living alone. 46% lived with their partner. For others it was the isolation from family, friends and the wider community because of the context of the conflict and their role as ex-combatants.

	Strongly Agree	Agree	Neither Agree or disagree	Disagree	Strongly Disagree
I feel isolated within my community due to my background	**9%**	**43%**	**21%**	**24%**	**3%**

Table 17: Isolation and Impact

Looking to the future, a third of respondents agreed with the statement that "I have no-one close to me who is likely to look after me in old age".

The sense of current and future isolation was reinforced by the information gathered in the interviews by the peer researchers.

- *"For some, their families disowned them; their children didn't understand what they did. They wanted to know why the network of former UDA ex-combatants didn't do*

19 http://blogs.lse.ac.uk/politicsandpolicy/archives/25613

something earlier. Now they think they have only a few years left and they feel it's too late. They put on a good face because you're supposed to be a hard man."

- *"Others don't want us. It's [referring to a local facility in south Belfast] for the community but not for our community."*

The sense of disconnection extends to non- involvement in community or social activities.

- *"They said things like they're burnt out. Take a back seat. Don't get involved in current community activities or get engaged in anything."*

Of greater significance is the impact of the disconnection from other ex-combatants. Its impact has to be understood in contrast to the camaraderie experienced by the same individuals when imprisoned or living through the conflict as UDA members in their own communities.

- *"The basis is camaraderie. It's our family and we have to do something about it."*
- *"Need confidence built on camaraderie to be ourselves again."*
- *"Because 15 years have passed some people are now disconnected even from the people they knew as comrades in the past."*
- *"As men we're not good at talking face to face but we can do it when we're shoulder to shoulder."*

The nature of camaraderie has been described as a "*sense of trust, loyalty and goodwill that has developed between people who have known each other for a significant period of time"*[20].

This scoping study suggests that it is more than goodwill and friendship. The elements of trust and loyalty built in conflict situations brings an added connection that is often not recognised nor fully understood by those who have not experienced the same conditions. On a more positive note 54% respondents thought their family and friends had a good understanding of their experiences during the conflict and certainly more so now than 10 tens ago.

The ending of a conflict situation brings benefits but also a loss of what has existed before.

- *"With comradeship you had your security within your own group. It's all gone now. People go out as individuals not as a mass of people together."*
- *"They may be friends but they are not previous "comrades in arms" and there is a big difference. When they are, you can talk about specific issues and shared experiences that not everyone has had."*

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20 www.businessdictionary.com/definition/camaraderie.html

Previous sections of this study have referred to the sense of loss of identity and purpose experienced by many of the ex-combatants participating in the research. This "loss" is also linked to a sense of unease at the outcomes of the peace process for their particular community of interest.

- *"It's harder for a loyalist community to accept the peace process. Promises were made and not upheld. There were not money benefits, no looking after the people involved and looking after their mental health."*
- *"Ex-combatants have been lift in limbo."*

The losses described by many of the respondents in this research include loss of identity and of purpose, a transition from a position of strength experienced during the conflict to *"not quite certain who I/we are now"*.

Work on transition management suggests that this shift of "hearts and minds" requires the same attention as the changes brought about by decommissioning and the structures of combatant groups. There are also opportunities presented by the work of the Fellowship of Messines in terms of transition and identity that could be accessed by some of the individuals and ex-combatant groups in South Belfast. Similarly there is a need to connect the same individuals and groups to opportunities to consider shared history, identity and experience. Some of this work has begun through the South Belfast Cultural Network but they would benefit from the opportunities to develop a more robust and developmental approach to this work based on the experience, best practice and opportunities provided by others.

The sense of disconnection for ex-combatants in this study also exists in terms of access to services to address some of the physical and emotional health issues indicated in this scoping study to date.

Individuals recorded their isolation in access to and use of services to support them and provided a rationale for their choice.

	Strongly Agree	Agree	Neither Agree or disagree	Disagree	Strongly Disagree
I have problems for which I need psychological help but I am not getting it	**14%**	**29%**	**27%**	**22%**	**8%**
I find it easier to talk now about what I went through during the conflict than I did ten years ago	**-**	**22%**	**48%**	**21%**	**9%**
My fellow loyalists have more physical and emotional problems than others of their age	**38%**	**47%**	**13%**	**2%**	**-**

My fellow loyalists are good at hiding the problems that they face	**35%**	**49%**	**11%**	**5%**	**-**
The peace process has made it easier for ex-combatants to cope financially, emotionally and socially	**5%**	**5%**	**17%**	**30%**	**43%**

Table 18: Isolation and Services

A significant number of respondents 85% believed that their "comrades" had more physical and emotional problems than others of their age. Conversely almost the same number 84% agreed that fellow loyalists are good at hiding the problems they face while only 10% agreed with the statement that the peace process has made it easier for ex-combatants to cope financially, emotionally and socially.

There was overwhelming recognition [91%] positive response rate that there are forms of support lacking but that ought to be put in place for "older" loyalists who were ex-combatants. Some respondents commented:

- *"What help is there going to be for these men?"*
- *"There is a lack of counselling for ex-combatants."*

The evidence from this study suggests however, that the challenge lies, not only in the lack of support but also in the reluctance of ex-combatants from the study group to use the support when it is available. This is reflected in the qualitative research responses:

- *"There is a need for some kind of support but we don't want it or don't have any trust in those who offer it."*
- *"Not prepared to go somewhere unless they were ex-combatants and empathetic."*
- *"Big trust issues. Won't go because they don't know them."*
- *"Some have tried places like AA and FASA but it doesn't work if they can't talk freely or think that people are judging them because of their identity as an ex-combatant."*
- *"Any who tried just got fed up and stopped seeking support because they seemed to think nobody was worried about them enough."*
- *"It's like a taboo. There are no mechanisms in place to deal with the conflict generation of loyalist ex-combatants."*

This section of the scoping study has sought to provide a framework to understand the health and well-being concerns, particularly the emotional and mental health challenges experienced by former UDA members in South Belfast.

In the following section of the study an understanding of the characteristics and process of resilience is explored to consider why particular individuals adapt more positively to some of the challenges outlined throughout this study to date. It goes on to suggest a framework for building resilience within the ex-combatant community and within South West Belfast as a whole, drawing upon new and existing work undertaken by SRCF and others.

The final section of the study then goes on to outline some of the interventions suggested by participants' in the study as well as some examples of best practice from the literature review and the implications for the recommendations from the study.

5.0 Resilience and a Framework for Action

5.1 Understanding Similarities and Differences in Impact

This report to date has outlined the factors that impact upon the health and well-being outcomes for individuals living in generic and specific disadvantaged communities. It is recognised that there are two types of communities referred to in this report. One is based on geographical location i.e. South West Belfast and specifically the Sandy Row area. The other is referred to throughout this document as a "community of interest", i.e. individuals who experience specific shared factors regardless of where they're living. In this report this refers specifically to former UDA ex-combatant members in South Belfast.

Reference is made at different stages of the report for the need to consider where and how outcomes can be attributed to the factors experienced by any individuals within those communities e.g. poverty, unemployment and ill-health and where they the same factors may appear to affect some but not all individuals. This section of the report seeks to explore why the experience of similar factors may result in different outcomes for specific individuals and suggests ways in which to optimise the opportunities for positive outcomes in the future for specific and generic communities of interest affected by this report.

The report places this exploration within an understanding of the process and characteristics of resilience, its impact upon individuals and considers the implications for the conclusions and recommendations for this report.

5.2 Understanding Resilience

At its simplest, resilience is understood as the *"ability to overcome adversity, achieving good outcomes regardless of life events or circumstances"*.[21] It is understood more fully as the ability to:

21 Oxford English Dictionary definition.

- bounce back and cope effectively in the face of difficulties
- bend, but not break under extreme stress
- rebound from adversities
- handle setbacks, persevere and adapt even when things go awry
- maintain equilibrium following highly aversive events[22]

The concept of resilience acknowledges that any individual, family group and even communities can experience distressing, stressful and traumatic experiences. However, it suggests that there are characteristics' and a process that enable some individuals, families and communities to be better able to adapt and manage challenging situations with outcomes that result in lesser degrees of incapacitation, harm and hindrance than for others in similar environments. The process that increases resilience among individuals, families and communities is most often referenced in terms of the degree of the absence or presence of protective resource factors that increase or lessen risk of harm and/or promote well-being. Some of these factors are influenced by specific actions and thinking that can increase resilience at different levels. These are outlined in the sub section that follows in terms of community, family and individuals.

5.2.1 Community Resilience Protective Factors

Community resilience is about communities and individuals harnessing local resources and expertise to help themselves in an emergency, in a way that complements the response of the emergency services.[23]

The work on building community resilience suggests that its' beneficial outcomes include local people prepared and able to respond effectively to emergency situations who use local resources and expertise in an appropriate self-help way to deal with crisis.

While many individuals within communities already informally help each other, planning and preparing in a formal way creates an environment that means that individuals and groups within the community are better able to cope with challenging situations. A resilient community will not only be better prepared to respond at the time of an emergency, but will be better equipped to recover in the long-term, and to do so more quickly.

22 http://www.robertsoncooper.com/iresilience/#.UeWs8LZwaM8

23 **http://www.surreycc.gov.uk/people-and-community/emergency-planning-and- community-safety/emergency-planning/community-resilience**

It is crucial to understand that building community resilience does not mean the absence of public and statutory support. Rather it is about developing a better working relationship between those agencies and the communities with which and for whom they work. It creates an environment where individuals and groups within the community are better able to access and use available resources and support. This is also applicable at a family and individual level as indicated in the sub–sections below.

It is of note that the Sandy Row Community Forum Development Manager alongside the BSCR Community Confidence Officer are in the process of developing a community crisis response plan under the Safer Sandy Row Initiative that will help to integrate and consolidate resilience skills at all levels. Anticipated outcomes include practical arrangements in place to address different forms of challenging situations within the area as well as the strengthening of strong social networks. It is hoped that this will build connectedness and community cohesion with an increase in individuals willing to intervene if they witness challenging behaviours.

5.2.2 Family Resilience Protective Factors

In 2012, the Sandy Row Community Forum, in collaboration with SureStart and other social partners, commissioned a report[24] to inform the design and development of a support programme for children aged 4-7 years and their families within the South West Belfast Neighbourhood Renewal Area. The report and the resulting model presented “My Life Counts” offered a distinctive framework and design for integrated programmes and development opportunities for parents and children separately and together.

The My Life Counts framework and design outlined in the report and illustrated in Appendix Five of this report sought to develop many of the characteristics identified as integral to building resilient families. Dr. Froma Walsh[25] identifies nine characteristics that resilient families share. They are outlined in summary here and in detail in Appendix Six.

- **Finding meaning in adversity.** Crises are viewed as shared challenges where there is understanding learning and a moving forward from the experiences.
- **Positive outlook.** Resilient families have an optimistic rather than pessimistic view of life encouraging each other in the challenges to be faced.

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24 Briefing Paper on the ‘Design and Develop a support programme for children aged 4-7 and their families within South West Belfast Neighbourhood Renewal Area. SRCF 2012

25 Walsh, Dr F. (2006). *Strengthening Family Resilience.* London. Guilford Press.

- **Transcendence and spirituality.** Resilient families have beliefs and values from which they find strength and comfort in a variety of ways beyond the challenges of their personal lives.
- **Flexibility.** Resilient families adapt to change and are able to adjust to new experiences and challenges while maintaining the best of what has provided stability in the past.
- **Connectedness.** Resilient families pull together and support each other as individuals and as a family group during times of crisis.

- **Social and economic resources.** When they don't have the resources they need resilient families know how to access the help they need and do so.
- **Open emotional sharing.** Resilient families accept and encourage a wide range of the expression of emotions and feelings with individuals taking responsibility for their own feelings and accepting others who have different feelings.
- **Clarity.** Resilient families practice clear, consistent and honest communication.
- **Collaborative problem solving.** Resilient families work together to understand a problem and identify ways to solve it. They practice decision making, conflict resolution and problem solving together.

The recent work on Healthy Minds referenced at the beginning of this report sought to identify and provide some opportunities to build the capability of individuals, particularly staff and volunteers in different community settings to address the building of resilience at an individual, family and community level. The findings and recommendations from this report validates and reiterates the need for that work to continue at different levels and among diverse communities of interest. It recognises the need to develop emotional intelligence as core skills to build resilience and acknowledges the challenges for staff and volunteers working in and for communities in need to be supported in the building of their own resilience to undertake the work.

5.2.3 Individual Resilience Protective Factors

At an individual level building resilience is concerned with an on-going process and skills development that occurs over time and which is often accomplished through a series of clear actions with the formal and informal support of others. The National Institute of Mental Health reports that resilience involves behaviours, thoughts, and actions that can be learned and developed in anyone[26].

The work undertaken for this scoping study found a significant body of research and practice resources linked to building resilience in children and young people. Of particular note is the work undertaken in schools in Wakefield in Yorkshire where, in the framework they present, circumstances are outlined that moderate the effects of risk and increase the protective factors

26//ucsfhr.ucsf.edu/index.php/assist/article/a-personal-strategy-for-engaging-and-building-your-resilience/

for children and young people in increasing resilience. Their Multidimensional Model of Resilience is presented as a series of skills and factors that enhance well-being under stress. These are presented in summary below and in more detail in Appendix Seven.

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- **Resilience skills** such as assertiveness, problem solving, ability to maintain a balance between independence and dependence on others
- **Relationships Factors** related to familial relationships, positive role models, peer group acceptance and meaningful relationships with others
- **Community Factors** including avoidance of exposure to violence in one's family, community, and with peers, perceived social equity and a safe and secure community.
- **Cultural Factors** that recognise the significance of being "culturally grounded" by knowing where you come from and being part of a cultural tradition that is expressed through daily activities while also having tolerance for different ideologies and beliefs
- **Physical Ecology Factors** that increase access to a healthy environment, to recreational spaces, security in one's community and increasing sustainable resources.

Within this wider understanding resilience becomes much more than simply an individual's ability to overcome the challenges and adversity of their lives and to live longer. Dr Michael Ungar, Principal Investigator with the Resilience Research Centre suggests that *"In the context of exposure to significant adversity, resilience is both the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to negotiate for these resources to be provided in culturally meaningful ways"*[27].

Having outlined the framework for understanding and responding to developing resilience there is a need to integrate this into the context of the findings of this scoping study to date and to consider the implications for the response to the needs of UDA former ex-combatants in South Belfast.

5.3 Building the Resilience of Ex-Combatants

As indicated throughout this section resilience occurs as protective factors increase against the overwhelming influence of the risk factor, many of which have been identified previously in this report. These are summarised in terms of factors and outcomes in the table that follows

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27 **Source: Resilience Research Centre, School of Social Work, Dalhousie University** www.resilienceproject.org/

Risk Factors	Outcomes
- General socioeconomic, cultural and environmental conditions - Emotional and mental health concerns - Lack of role models - No specific services for men in Sandy Row area - Aging male ex-combatant population - The conflict and in particular post-traumatic stress disorder [PTSD] - Concerns that identity and culture are "threatened" or misunderstood - Emerging "prisoner or offender" population in PUL communities - Lack of specific services for ex-combatant community in South Belfast - Lack of knowledge of care pathways outside the area - Loss of camaraderie	- Poverty and loss of economic autonomy - Reduced opportunities and active discrimination in gaining employment with resulting impact upon health and well being - Range of physical, emotional and mental health concerns increasing in frequency and intensity - Lack of access to health education programmes to mitigate ill-health - Maladaptive coping mechanisms Substance abuse including prescribed medication - Masculinity, male culture and mental health concerns - Potential increase in "prisoner or offender" with no support for earlier intervention - Lack of access to support services - Isolation, alienation and disconnection
Protective Factors	**Outcomes**
- Resilient individuals within the ex-combatant community willing and able to support peers - Leadership among ex-combatant groups in South Belfast willing and able to work with others to address needs of former UDA members - Presence of social partners willing and committed to address health and other concerns for individuals and communities in need - Understanding of the potential preventative and earlier intervention aspects for health, well-being and community safety among and between regional government and public health agency representatives and	- Integrated approach to the promotion of positive health and well being - Collaborative initiatives to address positively moderate mental health and emotional health concerns - Clear understanding of quality assurance and protocols in place to assist community and statutory partnership working to address health and well-being in South West Belfast - Individuals with increased levels of satisfaction with their physical and emotional health - Individuals with reduced levels of suicidal ideation and substance abuse

community partners - Work undertaken to date by SRCF and its social partners that provides integrated approach to building resilience at different levels	- Individuals connected to ongoing support and care pathways relevant to identified need

Table 19: Resilience of Ex-Combatants

Having identified potential risk and protective factors and the outcomes for individuals and the UDA ex-combatant community of interest in South Belfast there is a need to consider response. This acquires utilising the protective factors and mapping the potential range of interventions required to enable individuals to access the resources needed to sustain the well-being of ex-combatants through individual, group and community interventions and initiatives.

The work undertaken within the SRCF Healthy Minds Project and Health Plan recognised the need for a range of proactive responses that might be utilised appropriately within community settings by volunteers and staff alike including the referral and response framework which can be found in Appendix Eight. These are also applicable to the ex-combatant community. Equally, the peer advocacy training developed for this scoping study including safeguarding adults, identifying need and the role and practice of advocates is of use to volunteers and staff in community settings in South West Belfast and potentially on a wider basis.

However, this scoping study has also identified a significant number of respondents vulnerable to and experiencing the impact of post-traumatic stress disorder, suicidal ideation and substance abuse. The SRCF Healthy Minds Project and Health Plan referred to the identification of need and intervention set across four tiers. Within this framework there is a clear delineation between the four tiers of response and the responsibility of specific agencies and services to provide the appropriate response.

Previous work undertaken by SRCF utilised a model of assessment and intervention that sought to map requirements for a strategic approach based on need and linked to the tiers of intervention. This report suggests that there is perhaps a need for the second tier to be modified to include, not only earlier intervention, but ongoing support. Ongoing support is required when an individual is in need of access to individuals and a range of services that can help build their resilience over time while enabling them to monitor positive change in their capacity for self-help and/or identify mutual concerns if their levels of vulnerability and risk were to increase. This is indicated in the table that follows outlining levels of intervention and the range of services to be offered at each level specifically for the ex-combatant community. It

also recognises that the interventions at tiers 1, 3 and 4 are also appropriate for any individual or community of interest in need of support to address their health and well-being needs.

Level of Intervention	Potential Response
Promotion, Prevention and Education **- h**elp health problems from developing	- Health promotion, awareness raising and brief interventions. - Utilise existing initiatives and resources. - Provide resilience education including emotional intelligence as a core programme for any individual within the community, including paid staff and volunteers.
Ongoing Support - identi**fication and monitoring of need**	- Develop Menszone dedicated space in South Belfast for access to range of support interventions outlined below. - Enable resourced and skilled peer health workers and volunteers within the ex-combatant community to develop with support from other social partners, particularly SRCF a number of positive interventions including; drop-in spaces, befriending, listening ear support peer education programmes, mentoring; advocacy structured peer support programmes; outdoor/environmental-based programmes; telephone and online support services. diversionary activities or support for life-style changes
Earlier Intervention **-** reducing the chances that a person will require medical or psychological treatment as a result of their circumstances	- Ensure peers whether paid or voluntary have adult safeguarding training and have a clear understanding of care and support pathways to access counselling and other therapeutic interventions.
Specialised intervention	- Ensure that identified individuals concerned with safeguarding adults at risk are aware of the services aimed at people needing more specialised support including psychotherapy and how best to access those.
Those who experience severe mental health issues	- Ensure that identified individuals concerned with safeguarding adults at risk are aware of the service provision in an acute setting for those experiencing more severe mental health difficulties and their role and responsibility in assisting adults at risk to access those services.

This report suggests that a similar range of services in place for earlier intervention can also be utilised by those in need of ongoing support as they build their resilience, capacity and confidence to take control in fulfilling their potential and achieving increased levels of physical, mental and emotional health and well-being. This addition to the second tier services provides an appropriate space for the development, particularly among the ex-combatant community for peer support.

There is a need also to acknowledge the work undertaken by the SRCF in their previous project on Healthy Minds and the resulting health plan. These suggested that;

- It is essential that any response to emotional health and well-being whether by individuals, groups or organisational meet requirements quality and consistency to ensure safety and support remains of paramount importance for provider and service user alike.
- An essential aspect of quality assured services and practice is the shared understanding of the pathways and referral mechanisms that provide the framework for day to day practice.
- Research undertaken for this report identified the concept and practice of social prescribing as potential mechanism to support the establishment and implementation of a well-being network in South West Belfast.
- *Social prescribing* (sometimes called community referral) is a mechanism for linking "patients" with non-medical sources of support within the community.
- While written from the perspective of statutory health providers, particularly those dealing with mental health, it manages to provide information, particularly referral mechanisms and language that could be adapted and used by a South West Belfast Emotional Well-being Network.

The value and contribution of the work to date needs to be considered and integrated into the generic response to emotional health and well-being for those vulnerable and at risk in the South West Belfast area and specifically to meet the needs of former UDA ex-combatants in South Belfast.

Such an integrated framework might well be offered as an innovative pathfinder approach to public health and other agencies locally, regionally and potentially on a global basis.

5.4 Using Peer Support to Build Resilience

Throughout the previous sections of this report significant attention has been given to the loss of camaraderie and its impact among those participating in the scoping study. Reframed in other settings, it is the loss of connectedness and isolation experienced by individuals in different communities of interest as referenced previously i.e. men in general, those who are homeless, older, gay, from minority ethnic communities and so on.

Reference was made earlier in this section for the need to recognise that building resilience is not simply centred on the individuals. It involves ensuring that a clear pathway to support and care is in place, visible and known to individuals along with the support to enter and use that pathway. Peer-based initiatives can enable marginalised individuals and group to access main-stream health care as well as community support provision.

This report found that peer-based approaches have been used increasingly as a health promotion strategy to reach and sensitise young people to health and social related issues. They are based on the principle that young people tend to discuss personal issues with their peers rather than with others whom they may regard as less empathetic or non–judgemental. Within a health and well-being context peer support enables formal and informal opportunities to be created to promote health and risk reducing actions that result in healthier lives.

A significant amount of work has been undertaken in terms of young people's peer support projects[28] which identifies the positive characteristics' of such an approach that are equally applicable to the ex-combatant community of interest. It suggests that peer-based programs increase protective factors and promote personal resilience through: access to positive role models; a safe space; knowledge of help services; opportunities to learn and develop skills; peer support/shared experiences; access to help services; and building a sense of attachment/belonging.

Peer education/leadership initiatives represent an approach by which ex-combatants might provide a source of support for their peers. The desk research for this study identified a range of resources available to inform the design and development of a peer based education programme in building resilience.

The www.riskandresilience.org.uk framework for building resilience is broken down into 8 main areas as follows:

1. Loving myself (self-awareness)
2. Expressing myself (self-management)
3. Working it out (responsible decision-making)
4. Being heard (effective communication)
5. Living together (social awareness)

28 http://mypeer.org.au/planning/what-are-peer-based-programs/theory/resilience-theory/

6. Keeping safe (risk awareness)
7. Getting informed (information management)
8. Knowing where I am going (self- efficacy)

This framework can also be considered in terms of the development of emotional intelligence as a core element of building resilience. Emotional intelligence is linked to an individual's ability to understand internal emotion as well as developing connected and collaborative relationships with others. It is of note that SRCF has previously referenced emotional intelligence in their Healthy Minds Project and as a core element of any sustained training programme for community volunteers and staff supporting the vulnerable and marginalised.

- It is essential that any response to emotional health and well-being whether by individuals, groups or organisational meet requirements quality and consistency to ensure safety and support remains of paramount importance for provider and service user alike.
- An essential aspect of quality assured services and practice is the shared understanding of the pathways and referral mechanisms that provide the framework for day to day practice.
- Research undertaken for this report identified the concept and practice of social prescribing as potential mechanism to support the establishment and implementation of a well-being network in South West Belfast.
- Social prescribing (sometimes called community referral) is a mechanism for linking "patients" with non-medical sources of support within the community.
- While written from the perspective of statutory health providers, particularly those dealing with mental health, it manages to provide information, particularly referral mechanisms and language that could be adapted and used by a South West Belfast Emotional Well-being Network.

In summary, this section of the report has sought to consider the factors that result in positive or adverse outcomes for individuals who have experienced similar circumstances in their lives. It suggests that the higher the levels of resilience, the better that individuals, families and communities can adapt and manage challenging situations with lesser degrees of harm and hindrance in their health, well-being and day to day living.

The section has outlined opportunities that exist to build resilience at a community and family level and acknowledges the innovative work undertaken to date by SRCF to begin to develop initiatives to address these in collaboration with their social partners.

The primary focus of the section remains however, the building of individual resilience overall and the specific implications for the health and well-being concerns for the ex-UDA combatant population in South Belfast.

This scoping study suggests that programmes and activities to build resilience could be developed within a framework that addresses prevention, earlier intervention and referral to specialised services. This would be based on a shared understanding among health professionals and community support staff of the risk and protective factors that are impacting upon individuals and the appropriate care and support pathway required in response.

The study has identified in particular the need for focused on-going support interventions that assist in the reduction of risk factors and increase protective factors among ex-combatants in south Belfast. Resources exist that could be adapted as a resilience programme for the use of this particular community of interest, alongside other support services and activities provided by paid staff and volunteers. Use could also be made of the work undertaken to date by SCRF in promoting the skills and understanding emotional intelligence and opportunities for social prescribing.

The rationale presented, the process undertaken and the success of peer support interventions with young people and in other communities of interest suggests that a similar approach is undertaken in regard to ex-combatants.

6.0 Shoulder to Shoulder – Moving Forward

In the introduction to this report reference was made to the overall emotional health development plan purpose and outcomes in Sandy Row and the wider South Belfast area. These include;

- Strengthen individuals.
- Strengthen the community, in this specific case, the PUL ex-combatant community of interest in South Belfast.
- Reduce structural barriers to mental health.
- Reduce discrimination and inequality in society and promote access to support for people who are vulnerable.

These outcomes are used as the framework to set out the summary of conclusions and recommendations for the study.

6.1 Strengthen Individuals

Not surprisingly the study found that there is not one size fits all solution to the emotional and mental health needs of former UDA ex-combatants in South Belfast. The diversity of need is reflected in diversity of experience, individual environment including levels of vulnerability and resilience and access and willingness to use support available.

In generic terms the scoping study population experience many of the same health and well-being challenges as citizens and particularly men living in areas of multiple deprivation and particularly in the South Belfast area. These include:

- As an aging population of men living in poverty.
- The physical health challenges linked to deprivation including heart disease, in particular Cardiovascular Disease and Chronic Obstructive Pulmonary Disease (COPD) and related health behaviour issues, such as obesity; mental health; and cancer.
- The context and impact on health and wellbeing of diverse forms of violence such as elder abuse including domestic violence, forms of hate crime and anti-social behaviour and property and personal assault crime.
- Family breakdown and roles and responsibilities as fathers and grandfathers.

-

- Lifestyle challenges including poor diet, drug and alcohol issues including self – medication and the misuse of prescribed drugs.
- Reluctance to admit the need for support with emotional and psychological problems as men to ask for help from existing support mechanisms.
- Cultural beliefs about the behaviour of “hard men” i.e. more likely to drink alcohol to excess, more likely to misuse drugs, more likely to work, very long hours, more likely to be involved in accidents, less likely to take part in health improvement programmes, less likely to eat a healthy diet and more likely to be overweight.

The scoping study found that there is a gap in the services to address the needs of men’s health and well-being in the area. One of the other providers in the area is to provide some therapeutic interventions for men in their new premises in the Village area and there are diverse opportunities to engage in sporting activities.

However, the need for a Men’s Zone to service the South Belfast area need would be recommended with the same urgency that many years ago the same arguments were made in terms of women only provision.

In a Men’s Zone, such as that outlined in the best practice examples in Appendix Nine there would be an opportunity to provide initiatives and response at all levels of intervention from prevention to identification and referral to those most at risk and in need of the safeguarding services of statutory providers. A project such as this could meet the needs of diverse communities of interest within the male population including those who are homeless or from minority ethnic groups living in the area. It would also address issues such as isolation and access to information on other issues that impact upon health and mobility for men in the medium to longer term.

It might also provide the opportunity to develop a statutory–community health partnership approach in terms of outreach and health focused campaigns as well as the possibility of piloting the social prescribing model outlined in the Sandy Row Emotional Health plan.

Crucially it would enable a structured and integrated approach to the building of resilience outlined in section five of this report , among individuals, families and communities, in South west Belfast in general and specifically for the former UDA ex-combatant population.

Examples of asset transfer and multi-agency safeguarding centres already exist within the domestic and sexual violence arena in Northern Ireland as do the best practice projects in men’s health outlined in the Mind report and in the Men’s Health Ireland network. Organisations such as the Men’s Action Network in L’Derry are operating locally as well as contributing to men’s health development in Northern Ireland. They have expressed their

willingness to share their expertise and experience in any developments in South Belfast if required. In addition, there is an emerging network of projects such as Men's Sheds and parenting programmes in Belfast and on a regional basis that would also contribute to future developments.

Careful consideration would also have to be given to increasing accessibility to a safe, shared and healthy space for men throughout the South Belfast area.

6.2 Strengthen The Community, in this Specific Case, the Former UDA Ex-Combatant Community of Interest in South Belfast

The study has found areas of significant concern identified through the research with the respondents form the former UDA ex-combatant members. These include similar issues shared with other ex-combatant groups relating to socio-economic status, psychosocial, behavioural and lifestyle factors. Specific and significant concerns were identified in the study.

31% of respondents were unemployed and 68% agreed that they had been "refused employment due to their background". This had subsequent adverse impacts upon economic autonomy and social mobility as well as influencing overall health status.

There are a small number of the respondents who appear to have successfully re-integrated back into communities and are coping, as many individuals do, with the "ups and downs" of day to day living.

34 % of respondents described their bodily pain as severe to very severe levels and 33% as moderate. Overall the status of their physical health currently impacts adversely on their regular daily activities.

Respondents' perspectives on their current or future life status was pessimistic. The lack of sense of purpose for the future has also to be viewed in contrast to the previous experience of a clear identity and role as ex-combatants during the conflict.

Many reported high levels of isolation both physical and emotional. This proved to be a distinctive feature that impacted upon the lives of many of the respondents. 41% of the respondents are living alone. 46% lived with their partner. For others it was the isolation from family, friends and the wider community because of the context of the conflict and their role as ex-combatants that was particularly challenging. A third of respondents agreed with the statement that *"I have no-one close to me who is likely to look after me in old age".*

Levels of calm and peacefulness among respondents were particularly low with 28% experiencing these positive states of being none of the time and 35 % only a little of the time with similar low levels in terms of energy and feeling “full of pep”.

A significant percentage of the respondents from the former UDA ex-combatant community in South Belfast are struggling to cope with day to day situations such as decision making and concentrating on whatever they were doing. Similarly high percentages report being unable to face up to their problems, feeling unhappy and depressed, lacking self–confidence and thinking of themselves as a worthless person.

The impact of the legacy of the conflict is significant Just over half [57%] considered that they had experienced moderate to severe psychological harm which is high in comparison with the harm form physical injury [33%]. Similar high levels of harm are also expressed in terms of the ability to express worry and unhappiness [54%] with 66% recognising the impact on their ability to confide about personal problems.

Estrangement from family members [50%], awareness of the suffering caused to family members by the situation [65%] and ability to express affection [48%] may be likely to further exacerbate isolation and limit use of available support from family networks.

The degree and duration of Post-Traumatic Stress Disorder [PTSD] expressed by respondents is a concern for all those concerned with the emotional and mental health legacy of the conflict. 61% agreed with the statements that they had directly witnessed terrible scenes during the conflict that they did not want to think about, but where they are still bothered by memories or upsetting dreams about them and also that they try to avoid situations that trigger a reminder of them. 57% experience feelings of anxiety and panic when they are reminded of them. This resulted for some in the avoidance of media cover of any similar conflict events anywhere in the world.

The report found significant reporting among many respondents of new and emerging fears and anxieties created by the Historical Enquiries Team, Supergrass Trials, recent public disorder events and a perceived political crisis in the PUL community.

Feelings of abandonment, betrayal and negative thinking was expressed by some respondents in regard to the political situation for ex-combatants from the PUL community, particularly in the lack of positive benefit to them and PUL deprived communities from the peace process.

Some had a sense of abandonment in terms of the former UDA as an organisation and particularly when contrasted with the strength and impact of the camaraderie experienced during the conflict. This scoping study suggests that it is more than goodwill and friendship. The elements of trust and loyalty built in conflict situations brings an added connection that is

often not recognised nor fully understood by those who have not experienced the same conditions.

The losses described by many of the respondents in this research include loss of identity and of purpose, a transition from a position of strength experienced during the conflict to *“not quite certain who I/we are now”*.

Work on transition management suggests that this shift of “hearts and minds” requires the same attention as the changes brought about by decommissioning and the structures of combatant groups.

The study found clear evidence from the respondents that depression and suicidal thinking is a reality for many. Almost 62% had experienced feeling seriously depressed at some time and 38% experienced times when they have not wanted to go on living. This situation is exacerbated by the sense of lack of fulfilment within different aspects of their lives. Only a quarter of respondents thought that in their old age they will look back on their lives with a sense of achievement, a quarter neither agreed or disagreed with the statement and almost half of the respondents stating they felt no sense of achievement with their lives.

This study concluded that given the profile of the respondents in this study, the expression of despair and abandonment there are clear indications of heightened risk of suicidal thoughts and tendencies factors for a number of ex-combatants participating in this study. This is further exacerbated by the experience of physical and emotional isolation and the added factors of social and economic injustices referenced previously in the study.

A significant number of respondents 85% believed that their “comrades” had more physical and emotional problems than others of their age. Conversely almost the same number 84% agreed that fellow loyalists are good at hiding the problems they face while only 10% agreed with the statement that the peace process has made it easier for ex-combatants to cope financially, emotionally and socially.

There was overwhelming recognition [91%] positive response rate that there are forms of support lacking but that ought to be put in place for “older” loyalists who were ex-combatants.

The scoping study has found that there are a significant number of adverse factors that reduce the levels of resilience for individuals within the ex-combatant population to cope with day to day living and to further exacerbate their health and well being challenges. However, the scoping study has also identified a framework for action to address resilience building as a process that addresses individual need as well as increasing access and use of existing care and support pathways. Crucially it builds upon preliminary work and shared understanding while mapping future opportunities for all social partners to develop robust preventative and earlier intervention initiatives to assist health and well being.

In addition, the peer researchers and the respondents were invited to make their own suggestions as to how positive initiatives might be put in place to address the health and well-being issues identified in this scoping study.

These included:

- Calling and befriending service similar to the Good Morning model but for ex-combatants and staffed by trained volunteers who would also be ex-combatants.

- Purpose built building to work from that could provide a drop-in as well as offering a more formal assessment of need, vulnerability and risk where required. This would ensure identification of concern for service users presenting at tier 3 and 4 and needing referral to statutory providers as well as providing a listening ear service for those at tier 2. Those interviewed were also clear of the need to build the capacity and resource the activities of peer health workers, similar to the models used on other minority communities of interest.

- Ex-combatants most disconnected from others visited at home and encouraged to become more involved with activities in the community.

- Signposting to the services of others such as the Trauma Centre, Counselling Benefits, and Housing advice , Storytelling programmes and advocacy advice.

The report also indicated the potential for individuals and groups to access programmes in shared history, identity and culture both within their own networks and to consider the availability of programmes available through the Fellowship of Messines. The recent public policy announcements in terms of future shared space may also provide opportunities to seek resources to respond to the issues identified in this report.

Resourcing will always be a challenge, particularly at a time of budgetary cuts. However, the economic benefit needs also to be considered in terms of prevention and less spend on prescription drugs and primary health care.

It is suggested therefore that funding be sought for the peer health workers and associated programme costs but that the premises required are integrated into the Men’s Zone recommended above. Similar models have been developed in safeguarding and justice centres where diverse communities of interest have the opportunity to experience both shared space and have their own particular safe space requirements met.

For the former UDA leadership in South Belfast and in Belfast as a whole there is a need to consider the governance and accountability structures that would enable such funding to be accessed. The enterprise and community development trust model developed in Lisburn and South Down area provides one example of how this might be achieved. The assistance of the Sandy Row Community Forum Manager could be harnessed in terms of the CLEAR standards outlined in their Emotional Health Plan to progress funding and ultimately commissioning from the public sector as well as access to the resources of charitable foundations.

6.3 Reduce Structural Barriers to Mental Health, Discrimination and Inequality in Society and Promote Access to Support for People who are Vulnerable

There is clear evidence throughout this report of the diverse levels and type of prejudice and discrimination experienced by individuals who were involved in the scoping study research.

This disadvantage and the subsequent impact on equality of opportunity can operate at an individual or group level and be perpetrated by individuals, groups and institutions that struggle to meet the requirements to deal with the re-integration of former UDA ex-combatants following their commitment to decommissioning, the deconstruction of violence and the building of peace.

Discussion also took place on the overall environmental context of the perceived levels of 'legitimacy'[29] of loyalist ex-combatant groups with statutory and other public agency representatives. Opportunities are emerging in terms of regional initiatives' to address the re-integration of ex-combatants from diverse jurisdictions. This report undoubtedly contains data, analysis and conclusions that would be of benefit to regional Government on an inter-departmental basis. Advisory Group members for this study are also individuals who provide assistance to OFMDFM and individual government departments in regard to health and well-being and the challenges and opportunities experienced by ex-combatants. It is recommended therefore that some of these members, including the Sandy Row Community Forum Development Manager create opportunities to share the information from the report including its conclusions and recommendations.

Particular thanks to the Advisory Group members who supported the stages of the project development and Glenda Davies, the Sandy Row Community Forum Development Manager, who coordinated and managed the project from concept formation to delivery.

Part of the discussion on overcoming structural and other barriers needs to acknowledge the validity and positive consequences of the use of the peer researchers in developing access to

29 Mitchell, C. (2008). *The Limits of Legitimacy: Former Loyalist Combatants and Peace-Building* in Northern Ireland Irish Political Studies Vol. 23, No. 1, 1–19, February 2008

the participants and in enabling them to share their views and concerns in the way that they did.

The foresight and vision of Seamus Mullan and other members of the Public Health Agency staff in supporting and funding this scoping report is acknowledged, particularly in agreeing to the use of peer researchers for the project.

The use of ex-combatants to access and engage with others, particularly those most disconnected from support needs to be understood as a “pragmatic necessity”. On the other hand, ex-combatants and particularly former UDA leaders and members need to address their own issues in regard to structure, governance, accountability and quality standards if they are to work within a collaborative commissioning partnership with statutory agencies on behalf of local and regional Government bodies.

The evidence from this study outlines the disconnection and reluctance to use available support mechanisms because of concern and experience as to the response of others to their identity as ex-combatants. The data contained in this report provides an indicator of the potential adverse impact in terms of the loss of human life because of physical, emotional and mental health issues of this is not addressed.

The report author and members of the Advisory Group wish to thank all the peer researchers, and in particular Eddie Kelly from Belfast South Community Resources, in co-ordinating activities with the peer research team and Jackie McDonald who ensured a robust response from former UDA members across the South Belfast area.

Thanks are also due to all the respondents who shared aspects of their lives and offered other suggestions that might inform developments based on the project. These have been taken directly from the questionnaires and are included as an Appendix Ten simply to illustrate the frequency of the call for peer support as well as more understanding from other agencies and providers.

The recommendations that follow are small in number but require a significant level of cross sectoral co-operation for delivery.

During the research interviews one respondent commented *“We seem to have been left behind in the peace process. No jobs, no money and no political representation. We need people who know how to help us.”*

The recommendations that follow are made in the hope that the scoping study and the combined efforts of the partners involved in the Advisory Group, particularly the PHA and the Sandy Row Community Forum are supported by others as they seek to reduce the levels of health inequalities and impact that directly affect those who contributed and shared their

stories for this report and to work together to provide opportunities to build the resilience of individuals and communities as they seek healthier lives in the future.

7.0 Recommendations

1 Public Health Agency to take forward scoping study recommendations relevant to their role and responsibilities in collaboration with Sandy Row Community Forum using Personal and Public Involvement values, principles and practice.

2 Consider the feasibility of developing a Menszone in South Belfast in a public-community partnership approach with shared and dedicated space to meet men's health and well-being needs at different levels of intervention.

3 Seek resources to take forward the Building Resilience Framework as an innovative initiative that will provide positive health outcomes for communities and individuals in South West Belfast and potentially for a wider audience.

4 Seek resources to provide safeguarding adults at risk resilience education including emotional intelligence as a core programme for any individual within the community, including paid staff and volunteers.

5 Seek funding to build a robust response to the needs of PUL ex-combatants initially through a pilot in South Belfast to include;

- Two resourced and skilled peer health workers.
- Robust protocols on place for the identification, assessment and response to the needs of male ex-combatants.
- Provide a series of programme interventions including the possibility of a model similar to the Good Morning telephone befriending service for those most vulnerable and disconnected from others.
- Consider the opportunities to use the services and projects of others such as the Trauma Centre for PTSD and the Fellowship of Messines in terms of cultural identity to maximise integrated opportunities for PUL ex-combatants to access a range of support interventions.
- Develop relationships with a range of other providers to assist in effective delivery.

6 The former UDA leadership in South Belfast and in Belfast as a whole to consider the governance, quality assurance standards and accountability structures that would enable commissioning and funding for the programme and interventions above to be accessed.

7 Representatives from the Advisory Board to share the data, analysis and conclusions that would be of benefit to regional Government on an inter-departmental basis and locally to health care providers and public agencies.

Shoulder to Shoulder Report Appendices

Appendix One

ILM Endorsed Award – Introduction to Advocacy

Aims

- Increase knowledge and understanding of advocacy
- Understand roles and qualities of the effective advocate
- Provide opportunities to identify key elements that support effective advocacy
- Explore pathways to support and safety for advocate and advocacy partners

Objectives

- Identify types of advocacy and their purpose
- Analyse the qualities and roles of an effective advocate
- Develop a good working knowledge of the identification of needs of the advocate partner
- Use a range of communication skills to identify and respond to vulnerable and at risk advocate partners
- Utilise knowledge and advocacy skills to present case study of advocate partner[s]
- Identify own role, responsibility and actions in balancing rights and responsibilities with

Appendix Two

Shoulder to Shoulder – Advisory Group Membership

Briege Arthurs - South Belfast Partnership Board

Eddie Kelly - Belfast South Community Resources

Glenda Davies - Sandy Row Community Forum

Jackie McDonald - South Belfast UPRG

Jim Morgan - Belfast Health Development Unit

Appendix Three

Sandy Row Community Forum – Emotional Health Plan

Our Vision

Individuals, families and communities in South West Belfast with improved emotional health and well-being through shared support and services.

Our Aims

- Promote positive emotional health and well-being for individuals, families and groups.
- Prevent emotional and mental health illness when possible.
- Provide or ensure provision of high-quality person centred interventions as needed at different levels and at an earlier stage.
- Demonstrate commitment to dignity, rights and quality assurance in all aspects of planning and response to emotional health and well-being needs.

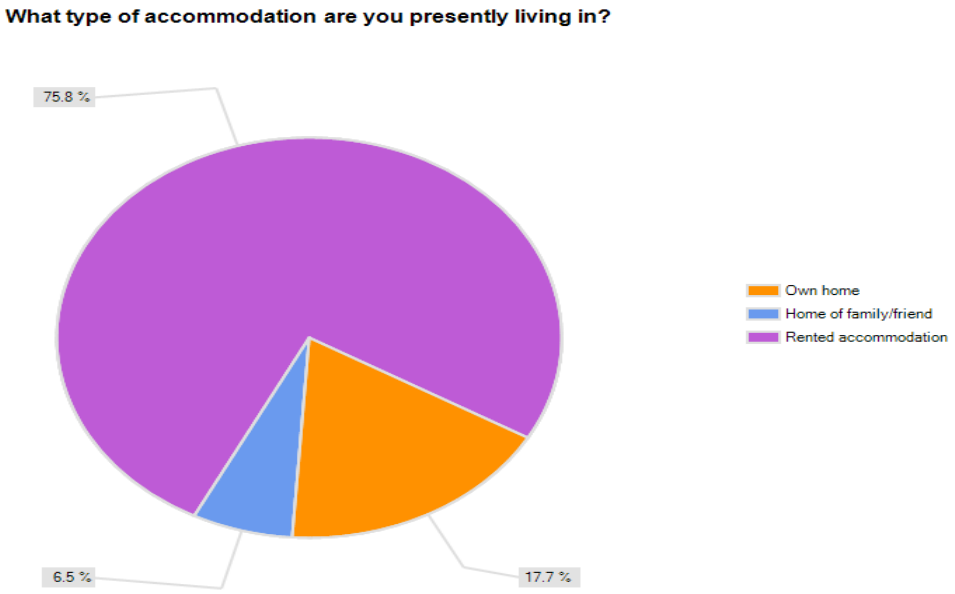
Our Goals

- Individuals, families and groups in our community have access to activities that promote their emotional health and well-being.
- The physical and social environment promotes emotional and environmental health and well-being.

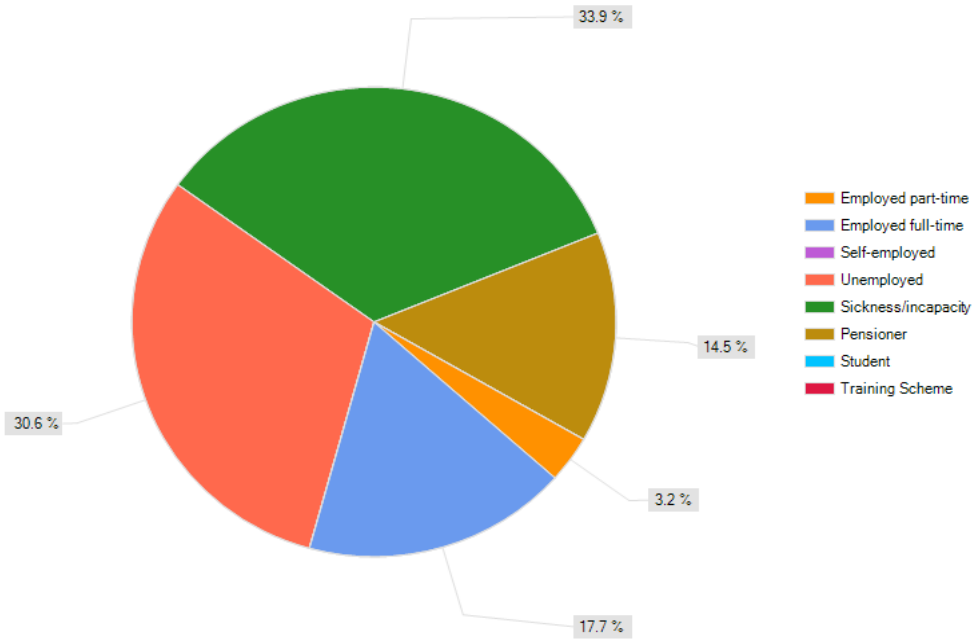
- Social networks and a range of services are established and working together effectively, efficiently and with equity for individuals, families and groups in the community.
- Quality assured practice, policies and principles are in place to respond to emotional health and well-being needs, particularly for those, in need of extra support, at risk and in crisis.
- Resourcing is in place that adequately matches the emotional health and well-being needs of individuals, families and groups in the disadvantaged and deprived community of Sandy Row.
- Service planning and delivery meets best practice principles and health policy guidelines in ways that are meaningful and satisfying for all.

Appendix Four

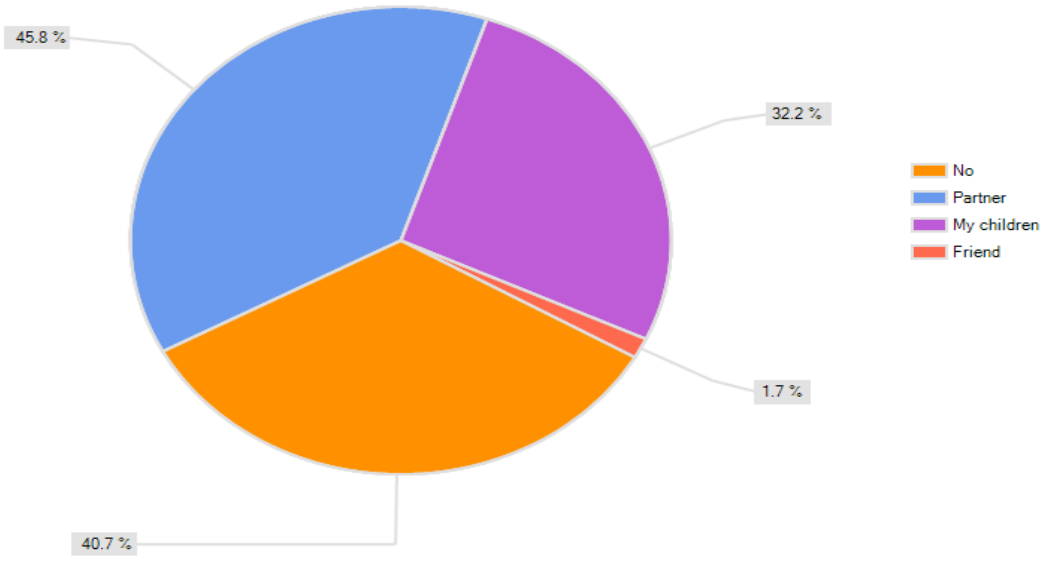
Additional Survey Results



What is your present economic status?



Does anyone live with you?



	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

How often do you have EIGHT or more drinks on one occasion?	16%	14%	11%	41%	18%
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	41%	16%	14%	21%	8%
How often during the last year have you failed to do what was normally expected of you because of drinking?	43%	14%	13%	22%	8%

	No	Yes, on one occasion	Yes, on more than one occasion
In the last year has a relative or friend, or a doctor or other health worker, been concerned about your drinking or suggested you cut down?	43%	18%	39%

	Yes	No
Have you ever felt you should cut down on your drinking?	52%	48%
Have people annoyed you by criticising your drinking?	59%	41%
Have you ever felt bad or guilty about your drinking?	48%	52%
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?	60%	40%

	Yes	No
Have you been prescribed any medication by your GP for anxiety or sleeping difficulties during the last year?	54%	46%
Have you been prescribed any medication for depression (anti-depressants) by your GP during the last year?	48%	52%

Appendix Five

My Life Counts Framework

Purpose

Assist parents and children aged 4-7 years and their supporters to access pathways to shared learning and development with positive outcomes for all.

Aims

- Provide opportunities to assist learning and development for parents and their children individually, in groups and as a community of interest in the South West Belfast area.
- Strengthen the connections among and between family groups and social partner networks for mutual benefit.
- Assist parents and children to deal with the transition from pre-school into and through Keystage 1.
- Develop community based preventative and earlier intervention services and programmes so that children and families can have a wider and more easily accessible range of family support services.

Objectives

- Design and facilitate a project and utilise services from a range of social partners that assist parents and children to deal with the transition from pre-school into and through Keystage 1 phase of development.
- Provide a series of parallel programmes for parents and children as groups and together that address best outcomes to strengthen individual and family resilience and achievements.
- Facilitate and organise opportunities for parents to access information and services from a range of social partners.
- Facilitate collaborative engagement among and between social partner providers and parents that shares learning, concerns and informs service planning and delivery.
- Implement quality assurance mechanisms to ensure that the project contributes to all aspects of sustainability and renewal within diverse communities of interest in the South West Belfast Neighbourhood Renewal Area.


Health
Lifeskills
Relationships between Parents and Children
Emotional Wellbeing
My Life Counts
Preventative Education
Learning and Achievement
Relationships with Others
Identity

Appendix Six

Nine Characteristics of Resilient Families

In Strengthening Family Resilience, (The Guilford Press, 2006), resilience specialist Dr. Froma Walsh identifies nine characteristics that resilient families share. These characteristics reveal the family belief systems, organizational patterns and communication/problem-solving skills that foster resilience in adults and children.

- **Finding meaning in adversity.** Resilient families view crises as shared challenges that together they can understand, manage and make meaningful in some way. They see their emotions as human and understandable under the circumstances and believe in their ability to learn from their experiences and move forward.

- **Positive outlook.** Resilient families have an optimistic rather than pessimistic view of life. Members see each other's strengths and offer encouragement to overcome difficulties or accept what can't be changed.

- **Transcendence and spirituality.** Resilient families have beliefs and values that offer meaning, purpose and connection beyond their personal lives and troubles. They find strength and comfort in their cultural and religious traditions and experience spiritual inspiration in a variety of ways, including nature, the arts, service to others and faith in a higher power.

- **Flexibility.** Resilient families adapt to change. They're able to adjust their family roles and rules to fit new life challenges while maintaining the rituals and traditions that provide stability in their relationships. Their flexibility depends on strong, yet nurturing leadership, guidance, protection of children and mutual respect in the marital relationship.

- **Connectedness.** Resilient families pull together during times of crisis. They're able to function as a team and support each other while respecting individual needs, differences and boundaries.

- **Social and economic resources.** When they can't solve problems on their own, resilient families reach out for help by turning to extended family, friends, neighbours, community services and/or counselling.

- **Open emotional sharing.** Resilient families accept and encourage a wide range of emotional expression (joy, sadness, fear, silliness, etc.) in adults and children. Family members take responsibility for their own feelings and accept others who have different feelings. They value positive interactions and appreciate humour, even as they cope with difficult circumstances.

- **Clarity.** Resilient families practice clear, consistent and honest communication. Family members say what they mean and mean what they say; thus, they avoid sending vague, confusing or mixed messages to each other.

- **Collaborative problem solving.** Resilient families manage their difficulties by working together to understand a problem and identify ways to solve it. They make decisions

together in ways that allow family members to disagree openly and then resolve those disagreements through negotiation, compromise and give-and-take. These families seek to repair the hurts and misunderstandings that go along with conflicts and act proactively to solve current problems and prevent future ones. They also learn from their mistakes

Appendix Seven

Multi-dimensional Model of Resilience

Developing resilience is a personal journey. Individuals do not all react the same way to traumatic and stressful life events. An approach to building resilience that works for one person might not work for another. People use varying strategies with some variations that may reflect cultural differences. An individual's culture might have an impact on how he or she communicates feelings and copes with adversity—for example, whether and how a person connects with significant others, including extended family members and community resources. With growing cultural diversity, the public has a greater access to a number of different approaches to building resilience. Some or many of the ways to build resilience discussed may be appropriate to consider in developing your personal strategy. Below are guidelines towards building your resilience:

- Take Care of Yourself—Pay attention to your own needs and feelings. Engage in activities that you enjoy and find relaxing. You should exercise regularly. Taking care of yourself helps to keep your mind and body primed to deal with situations that require resilience.
- Establish and Maintain Connections—Good relationships with close family members, friends, and others are important. Accepting help and support from those who care about you and will listen to you strengthens resilience. Some people find that being active in civic groups, faith-based organizations, or other local groups provides social support and can help with reclaiming hope. Assisting others in their time of need also can benefit the helper.
- Monitor Your Exposure to Media Coverage of Violence—Staying informed of current events is important; however, avoid overindulging yourself and be able to note when you have heard (radio), seen (television), and read (newspaper) the same horrific story over and over again. Take needed breaks from the media.
- Avoid Viewing Problems as Impossible—you can't change the fact that highly stressful events occur, but you can change how you interpret and respond to these events. Try looking beyond the present to how future circumstances may be a little better. Note any subtle ways in which you might already feel somewhat better as you deal with difficult situations.
- Accept Changes as Part of Life—certain goals may no longer be attainable as a result of adverse situations. Accepting circumstances that cannot be changed can help you focus on circumstances that you can alter.
- Progress Towards Your Goal—Develop some realistic goals for yourself. Do something regularly—even if it seems like a small accomplishment, which enables you to move toward your goals. Instead of focusing on tasks that seem unachievable, ask yourself, "What's one thing I know I can accomplish today that helps me move in the direction I want to go?"

- Take Clear Actions—Act on adverse situations as much as you can. Take decisive actions, rather than detaching completely from problems and stressors and wishing they would just go away.
- Maintain a Hopeful Outlook—Optimism is learned and nurtured over a period of time. An optimistic outlook enables you to expect that good things will happen in your life. Try visualizing what you want, rather than worrying about what you fear.
- Keep Things in Perspective and Avoid “Catastrophizing”—Even when facing very painful events, try to consider the stressful situation in a broader context, and keep a long-term perspective. Avoid blowing the event out of proportion, such as catastrophizing everything. Noted mental health researcher and clinician Aaron Beck describes “catastrophizing” as fortune telling, meaning you predict the future negatively without considering other, more likely outcomes. For example—“I’ll be so upset, I won’t be able to function at all.”
- Nurture a Positive View of Yourself—Developing confidence in your ability to solve problems and trusting your instincts helps build resilience.
- Engage in Opportunities of Self-Discovery—People often learn something about themselves and may find that they have grown in some respect as a result of their struggle with loss. Many people who have experienced tragedies and hardships have reported better relationships; a greater sense of personal strength even while feeling vulnerable; increased sense of self-worth; a more developed spirituality; and heightened appreciation for life.

STAYING FLEXIBLE IS THE KEY

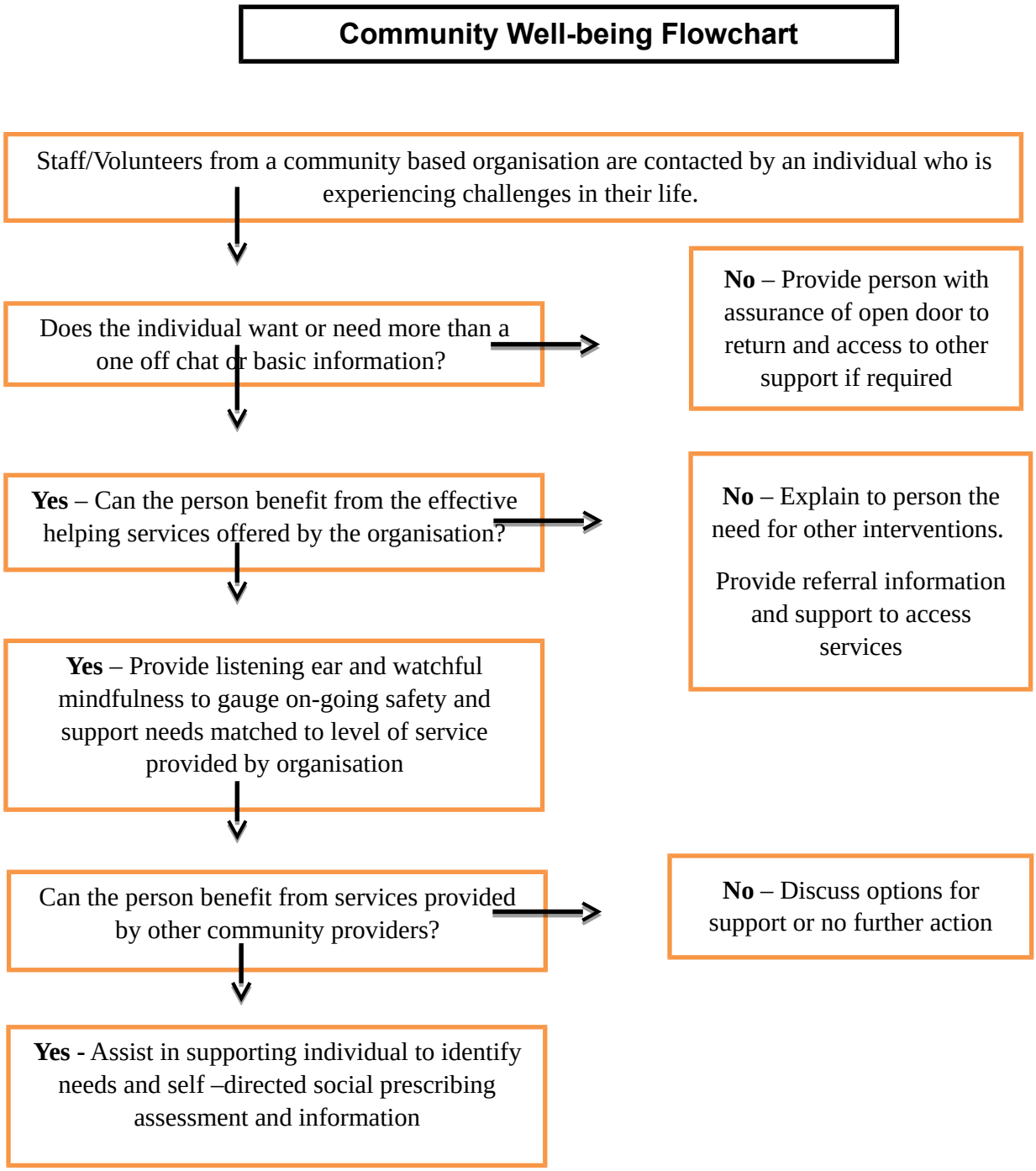
Resilience involves maintaining flexibility and balance in your life as you deal with stressful circumstances and traumatic events. This happens in several ways, including:

- Letting yourself experience strong emotions, and also realizing when you may need to avoid experiencing them at times in order to continue functioning.
- Stepping forward and taking action to deal with your problems and meet the demands of daily living, and also stepping back to rest and reenergize yourself.
- Spending time with loved ones to gain support and encouragement, and also nurturing yourself.
- Relying on others, and also relying on yourself. Remember, you are not an island.

Many common mental health and wellbeing self-help strategies are built around improving people's resilience:

- Cognitive behavioral therapy
- Mindfulness
- Positive lifestyle choices (diet, exercise)
- Self-talk
- Thought records
- Self-care and self-soothing

Appendix Eight



Appendix Nine

Best Practice

Menzone – Case Study by Jack Smith, Menzone drop-in support worker

"Menzone is the men-only drop-in session held every Wednesday evening (5pm to 9pm) at Mind-in-Bradford, which caters for men of all backgrounds facing mental health difficulties. Our aim has been to create a warm and caring atmosphere to enable men to chare experiences and coping strategies, thus allowing them to explore alternative ways of improving their mental well-being. We find that our service helps to reduce social isolation, increase self-confidence, encourage friendships and generally improve the quality of members' lives.

On the whole, the drop in is fairly unstructured, However, we do host a variety of activities, such as a presentation by Roger King of "Love the Miracle You Are" – a series of discussions focusing on improving self-esteem and developing a positive mental attitude. This proved a great success with much openness, honesty and mutual-support being expressed. It also attests to the value of Menzone's men-only environment, which allows men to let their guards down and escape the pressures exerted by the social norms of male invulnerability. Menzone also has weekly meditation sessions. These help to combat the stress and anxiety felt by many of the men. We are also looking at the possibility of expanding this into an anxiety support group.

However, it's not all touchy-feely emotional openness at Menzone as indicated by the increasing popularity of Menzone's weekly football sessions (attendance has grown to the extent that we can't accurately describe it as a 5-a-side anymore!). Last season, Menzone entered a team into the Yorkshire and Humberside Positive Mental Attitude Football League. We had mixed success (we have the oldest players in the league by far!) but the experience has helped the men to develop teamwork skills and a sense of camaraderie.

Other activities are chosen according to democratic principles. These have included: day trips to the seaside and countryside; various museums; and indoor sporting pursuits such as snooker and ten-pin bowling."

Taken from: Wilkins, D and Kemple, M. (2011). *Delivering Male: Effective Practice in Male Mental Health.* London. The Men's Health Forum.

Appendix Ten

Respondents Recommendations from Questionnaires

- We need people who can listen to and advise others with a genuine understanding of what they are going through. Other ex-combatants would have a better relationship and provide better support.
- Think GPs should be able to spot the signs and the history of ex-combatants to be able to refer them to proper health agencies. I think there could be more help from the people who can relate to the plights of these ex-combatants and advise them or these agencies as well.
- Help with most things i.e. drugs counselling.
- Need someone who has been through it and felt the pain that I have to talk to.
- Group therapy run by ex-prisoners of all combatants - Protestant and Catholics. In what format I don't know.
- Better employment opportunities. People in authority need to appreciate the problems ex-prisoners/ex-combatants have, many were victims themselves. Who was responsible for the environment that brought us to the conflict?
- Need place to for assistance
- Places to talk with other people who understand?
- Some sort of emotional support to help ex-combatants to cope with trauma incurred during the conflict. Possibly some sort of drop-in centre.
- I think the Government should provide more in the form of getting ex combatants in to work.
- Unable to take some jobs after my conviction has left me financially weak compared to others my age.
- The Government should provide at least one place to meet with ex combatants in every area for people to get together and share their feelings and to know they are not alone. There should be some sort of service to help people like me but I have never heard of any in loyalist areas.
- Think there should be more community involvement!
- Just someone to speak to for some people.
- We seem to have been left behind in the peace process, no jobs, no money, and no political representation. We need people who know us to help us.
- We need people trained who can talk with empathy to former combatants and politically motivated ex-prisoners - have a knowledge of what they went through.

- More support needed for us and must be run by fellow loyalists.
- I'm not aware of any support for Loyalist ex-combatants and strongly believe there should be. I also believe they should be run by people who understand what ex-combatants went through.
- The thing that causes me the most stress is the pain and suffering my family went through.
- We need one to one engagements/mentoring.
- Hel p to get out of the cycle.
- Get people out of the rut they're in.
- They say it's too late for people to start worrying about them now and some weren't really worried what we as an organisation we're trying to do to help those who needed it
- Some willing to take courses to help but as paid job i.e. ex-combatants but without some if the same problems as those with drugs and alcohol problems. I will talk to you but no-one else.
- New faces for future programmes.
- Listen, not just prescribe
- Input from health professionals who are giving referrals into community groups.
- Give understanding and help to those who need help.
- Health agencies to deliver.
- Need confidence in those who listen from the depths to level they can understand.
- Call to ex-combatants and monitor their health and well-being.
- Help those in need of help and convince those people that help is there for them. Lot to be done to start people to start trusting in those organisations who are there to help. Hard to do after years of going through the troubles and being let down by those they did trust.
- Peer education on drugs and drink.
- Peer trained counsellors who are ex-combatants.
- Back to work schemes and training.