At a Post-conflict Juncture:

An Assessment of Mental Health and Developmental Needs in Whiterock, West Belfast

August 2007 | Dr. David Connolly

Post-war Reconstruction &
Development Unit (PRDU)
THE UNIVERSITY of York

CCS
CORPUS CHRISTI SERVICES

Community Relations Council
Diversity Equity Interdependence

Published 2007

By
Corpus Christi Services

Designed and printed by
Impression Print and Design NI Ltd.
Unit d3 9 Ferguson Drive
Knockmore Hill Ind. Park
Ballinderry Road
Lisburn BT28 2EX

This Publication is available from
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Belfast BT12 7SH
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Contents

List of Illustrations

List of Abbreviations

CCS	Corpus Christi Services
CRC	Community Relations Council for Northern Ireland
CPN	Community Psychiatric Nurse
DHSSPS	Department of Health, Social Services and Public Safety
DSD	Department of Social Development
EHSSB TAP	Eastern Health and Social Services Board Trauma Advisory Panel
GP	General Practitioner/Practice
NIAMH	Northern Ireland Association for Mental Health
NIMDM	Northern Ireland Multiple Deprivation Measures
NISRA	Northern Ireland Statistics and Research Agency
PRDU	Post-war Reconstruction and Development Unit
SDLP	Social Democratic Labour Party
SF	Sinn Féin
TRC	Trauma Resource Centre (North and West Belfast)
UK	United Kingdom
USDT	Upper Springfield Development Trust
WHC	Whiterock Health Centre

Foreword

When we talk of conflict we immediately think of the thirty years of war that was an everyday occurrence in our communities. However, conflict can also be a non-violent and constructive process of human development that typically involves struggles for improved education, employment, health, and housing. It is when these core needs are not addressed and managed adequately that frustration and the risk of violence occur.

Therefore and based on the importance of learning lessons from the past, we must continue to work towards a more positive and concerted meeting of core needs within Whiterock. While this process must stem from existing knowledge about needs within the community, it is also essential to ensure that this knowledge is continuously tested and refined. Accordingly, on behalf of Corpus Christi Services (CCS), I am delighted to present the following report by the Post-war Reconstruction and Development Unit, which provides an assessment of mental health and other core developmental needs within Whiterock.

CCS has been providing services in the community of Whiterock and beyond for almost twenty years. While formerly an Action for Community Employment project, from 1999, CCS has been addressing the effects of *The Troubles* through a combination of programmes. Although we have concentrated on a range of issues: high unemployment, low self-esteem, better child-care, welfare advice and advocacy, this report has been motivated by the growing realisation that mental health is an underlying and daily need. Two additional factors have also led to this assessment: timing, since it comes in the wake of ten years of relative peace; and the opportunity for completion by an internationally experienced institution.

While this report presents a detailed assessment and builds upon practice-based knowledge and expertise within the community, the findings and recommendations in many ways ought to mark a new starting point. For this reason, CCS will endeavour to make the findings widely available in order to provoke further discussion in addition to community-wide planning and initiatives. Through these concerted efforts, we can continue to address the growing significance of mental health that, in Whiterock, is the direct result of over thirty years of conflict and a longer history of neglect and social exclusion.

Finally, on behalf of CCS, I would like to thank all those who made this assessment possible, both the interviewers and those interviewed. Particular thanks are due to the Community Relations Council for their generous financial support and to the author of the report, Dr David Connolly, for giving so much of his own time.

Joe Connolly
Chief Executive
Corpus Christi Services
June 2007

Preface

Whiterock, like any community, is steeped in rich cultural heritage, underpinned by shared values, and held together by common interests. However, Whiterock is also distinctive as it has experienced thirty years of large-scale and fundamental damage through *The Troubles*, which itself was preceded by twenty years of neglect. For these reasons, among others, it remains one of the most socially and economically deprived communities in Western Europe. Although the needs of residents are well-documented, there has been relatively little consideration of mental health, in terms of specific problems and needs, and their combined role in hindering the community's development. In particular, there has not so far been a systematic community-wide assessment of these problems and needs. The following report attempts to begin filling this critical gap.

At the same time, it is important to recognise that over the past ten years, since the start of the Northern Ireland peace process, a remarkable response to mental health has emerged at the community level in Whiterock. Consequently, there is now a considerable body of knowledge, experience and expertise, which this assessment hopes to build upon and advance. Such efforts are crucial since understanding and responding to mental health is evidently a complex and long-term task. Moreover, mental health is further complicated when its context is shaped by post-conflict dynamics. In particular, as this reports details, the term 'post-conflict' cannot be taken literally as the cycle of violence continues in parts of Whiterock, and for many residents the developmental needs and grievances that led to *The Troubles* remain unaddressed today. Despite the term being somewhat misleading, it is argued below that viewing the current problems, needs and challenges through a post-conflict lens is essential since it automatically asserts that long-term solutions must be strategic, integrated and community-wide.

Accordingly, I and the Post-war Reconstruction and Development Unit (PRDU) at the University of York have attempted to bring fresh perspective and expertise to this assessment. While this involvement instantly incorporates 15 years of lessons learnt from a diverse range of post-conflict countries, the central rationale of this study is to test and refine practice-based evidence in Whiterock, and for the first time to join the dispersed knowledge and insight of the complete range of service providers at this level.

Of course, no single assessment can provide a comprehensive and up-to-date account of a given community's needs. It has been equally appreciated throughout that gathering primary data in post-conflict environments is fraught with difficulties. Nevertheless, the adoption of a reflective and participatory methodology has enabled a more careful collection of evidence. Furthermore, this assessment would not have been possible without the expertise of all the staff at Corpus Christi Services and several other dedicated practitioners within Whiterock, who have once again demonstrated their commitment to consultation and self-appraisal. In addition, I am especially grateful to all the household heads, representatives of the community level response and other experts who shared their personal and professional experiences with honesty and courage.

As a result of all these efforts and commitment, I hope that this systematic study advances the understanding of mental health in Whiterock and guides the development of a more strategic and tailored policy and practice.

Dr David Connolly
Lead Investigator
PRDU, University of York, UK,
June 2007

Executive Summary

Since the early 1990s there has been a concerted international focus on the developmental needs of communities deeply affected by violent conflict and deprivation. Practitioners, policy-makers and scholars have all embarked on a gradual learning process of grasping the exact nature of impacts, designing the most appropriate approaches for recovery, and implementing the best strategies to bring long-term solutions. However, during the learning process, there has been a relatively slow realisation that mental health forms a crucial set of developmental needs. This lack of attention has formed a significant gap and it helps explain the thwarting of peace despite the large number of ceasefires, joint agreements, and injections of financial aid that have aimed to resolve decades of civil strife across the world. The insufficient attention is also strange because there have been significant advances in how mental health is understood and addressed outside conflict-affected countries. Therefore, towards correcting this separateness that has evolved, this report assesses needs within the local government ward of Whiterock, in the Belfast West Parliamentary Constituency, by investigating the mental health of the community in tandem with its other core post-conflict developmental needs.

Overall, this report finds that the community of Whiterock has reached a critical stage in terms of its residents' developmental needs. In taking a multidimensional and integrated approach, mental health and seven other sets of core developmental needs are assessed. Above all, there is no doubt that each set of needs continues to reflect severe and extensive social and economic deprivation, with particular deficits in the areas of employment, mobility, and skills training. Nevertheless, higher levels of satisfaction and slight improvements are noted in the areas of health, housing and schooling, which are perceived to have occurred slowly over the past ten years. The latter forms the first trend and main finding within the assessment.

The second and correlative trend is that a significant minority of residents believe that one or more of their seven core developmental needs have remained the same or deteriorated during the past ten years. In comparing the two trends, this assessment finds that a division within the community has emerged since the ceasefires and *The Agreement*. Furthermore, this division among households is particularly acute in the area of social relations, which centres on a perceived dismantling of the community through the dispute/feud in Ballymurphy and the rise in crime among other social disorders.

Deeply connected to the latter finding is the third stark trend that involves two-thirds of the households surveyed claiming a range of stress-related needs as a direct result of where they live. The various types of stresses cut across all six neighbourhood areas of the community and support the main practice-based assertion that mental health problems and needs are prevalent and far-reaching within Whiterock.

In terms of mental health problems, there is overwhelming evidence for an extensive range within the community. Diagnosis is complicated as the types of problems can be acute or chronic or both depending on the individual's circumstances. Indicators vary between psychological and physical manifestations, and the nature of the two root causes of the problems poses unique challenges to residents and service providers. That is, the long durations of *The Troubles* and the socioeconomic deprivation have each had direct and indirect effects but it is the interplay of these two root causes that makes the mental health problems complex. In addition, the continued cycle of violence through the dispute/feud in Ballymurphy, and other forms of social deprivation post-conflict have added new types of less accessible trauma for those both that have and have not suffered primary trauma during *The Troubles*. Consequently, a self-perpetuating cycle of mental ill-health has emerged. Furthermore, this report details how all of the above mental health problems reside at three levels: the individual, the family, and the community. Alongside problems, this report also investigates mental health needs, which are relevant to every resident of a given community and exist at each of the three levels listed.

This assessment does not evaluate the performance

and impacts of service provision in Whiterock but it does recognise that the working needs of the service providers are integral to the well-being of the community. Therefore, after examining their roles, this assessment finds that there is important diversity in the services offered, and that the providers have developed a uniquely close professional relationship with users and residents. The evidence suggests that this relationship is grounded in a reputable standard of services and the development of trust. The latter in turn is judged responsible for the slight progress so far in reducing the stigmatisation of mental health problems within the community.

Despite these notable achievements, this report identifies a number of concerns and weaknesses in relation to service provision for mental health. First, it is argued that the targeting of vulnerable groups and subgroups is a risky strategy. Although perhaps driven by well-founded reasons, the analysis below demonstrates how this strategy is highly subjective and could risk over-simplifying the causes and impacts of mental ill-health. More specifically, it is asserted that targeting and categorisation at this early stage in recovery risks adding to the stigmatisation of mental health within the community. Second, while the wider ripple effects of *The Troubles* are commonly acknowledged, there appear to be weaknesses in the design and delivery of practical strategies to address such collective forms of loss and damage. Third, it is found that the weaknesses in the response are determined by the misguided pace and non-recurrent nature of donor funding coupled with the limited level and type of support from the state and political leaders.

In addressing the above deficiencies and towards the pursuit of sustainable solutions, this report concludes with a set of recommendations that overall emphasise the need for a more integrated and coordinated response among service providers at the community level in tandem with closer professional relationships with the relevant statutory agencies and elected representatives. The recommendations also call for a tailored mental health promotion or public health approach that is based on the recognition that all residents have positive mental health needs in Whiterock. Although this ought to work alongside improvements in the treatment of mental ill-health, a public health approach would be particularly valuable considering the profound scale and depth of the mental health problems and needs, and in tackling the barrier of stigmatisation. It may also be the only way to address the trauma and damage at the familial and community levels, thereby ensuring the inclusion, though not the targeting, of vulnerable groups and subgroups.

Best practice needs assessments for post-conflict recovery and development take a broad and holistic view of needs in full appreciation of the impacts and challenges created by violent conflict. The following assessment adopts this model of best practice, which is also supported by an in-depth qualitative methodology. The study is small-scale but this reflects the demand for a concentrated focus on mental health alongside the seven other sets of developmental needs. The rationale for this assessment is to test and refine practice-based evidence, and to bring together for the first time the dispersed knowledge and expertise of the complete range of relevant service providers at the community level. Furthermore, in recognising the difficulties in gathering sensitive data in post-conflict environments and on mental health, this assessment has used a flexible and reflective approach involving three interrelated participatory techniques. Through this composition of methods, the data has been triangulated in several ways, which has ultimately produced a verifiable body of evidence.

With specific focus on mental health, this report argues that problems and needs have increased within the community, with the extensive scope and depth of impacts overwhelming the response. It is asserted that this increase has occurred for two main reasons. First, there has been a recent 'ripening' among residents wanting to confide and seek assistance because enough time has passed since *The Troubles*. Part of the recent ripening includes these and other residents who are now asking for help in order to cope with the effects of the current dispute/feud in Ballymurphy and other forms of social deprivation

and change that have emerged post-conflict.
Second, mental health problems and needs have increased because the service providers have now gained a more advanced and nuanced understanding of mental health. In other words, the service providers perceive an increase since they have developed a more detailed grasp of the causes, the groups and subgroups that are most vulnerable, and the impacts, among other trends. As explained below, this sophisticated understanding has taken five to ten years to develop as it required the fostering of a trusted and reputable standard of service provision. Such a standard would not have been possible for community organisations until recently because of the considerable challenges to gaining access to affected individuals while not forgetting the constraints from donor funding, organisational capacity, the volatile local dynamics, and the general political uncertainty in Northern Ireland during its first decade of post-conflict.

Therefore, based on these two reasons for the recent increase in mental ill-health and needs, it is only through building upon the service providers' experience, knowledge and expertise that an adequate response can be realised. In this sense, there is currently as much a juncture in service delivery as there is in mental health and other developmental needs within Whiterock.

1. Introduction : Post-conflict Whiterock in Context

This section introduces the six core themes of the assessment in terms of their conceptual, policy and operational underpinnings. The core themes are: protracted violent conflict; intergenerational deprivation; a range of seven core developmental needs; mental health; community level service provision for mental health; and the post-conflict context. Information is drawn from a review of the relevant literatures, and the analysis centres on the community of Whiterock, Northern Ireland, and international trends.

1.1 Protracted violent conflict

Several terms are used to describe *The Troubles* in Northern Ireland. It has been framed as a 'war' or 'low-intensity conflict', with the type of violence considered 'inter-communal', 'ethnic', and 'political' or 'secessionist' to be more specific. All are important in contributing crucial layers to our understanding. This report conceptualises *The Troubles* as a 'protracted violent conflict' because it pinpoints its nature as a root cause of mental health problems and other developmental needs. In other words, these problems and needs have not only been created and driven by the impacts of violent conflict but it is only through appreciating the prolonged duration of these impacts that we can then begin to understand the extensive scope and far-reaching depth of this primary trauma.

More specifically, the damage and destruction of violent conflict creates acute basic human needs but when it remains protracted, these needs become chronic and underlying (Luckham, 2004).[1] Over time, violent conflict is given space to extend its reach until it instils a profound trans-generational legacy among the psyches of individuals, families and communities. Relationships within and between these levels are often damaged or destroyed through the significant loss of trust, dignity, confidence and faith in others. These impacts then permit a cycle of violent conflict, with societies unable to resolve non-violent conflict peacefully (Miall, 2001, 15): "wars do not simply destroy part of what exists: they also prevent society from making new investments." (Maiese, 2003). Consequently, developmental needs become more difficult to address and resolve both by the conflict-affected and by third parties.

Officially, *The Troubles* spanned a period of thirty years, erupting in 1969 and signed off in 1998 with *The Agreement*.[2] The direct effects were extensive though distributed unequally, with concentrated pockets across the north (The Cost of The Troubles Study, 1999). Estimates vary but at least 3000 persons (0.2 per cent of the population approx.) were killed and tens of thousands injured as a direct consequence. Since then, inter-communal violent acts have ebbed slowly, supplanted by the introduction of tentative notions of liberal democratic peace, stability and normality. However, as this assessment finds, *The Agreement* has not marked the end of violent conflict. On the one hand, needs have continued and the magnitude of the thirty-year legacy has only really started to surface during the past ten years. Furthermore, during this post-conflict period, while it is unsurprising that traditional battle lines have persisted, it is the emergence of new and potentially deep intra-communal divisions that in many ways pose greater risks to a sustainable peace (Community Relations Unit, 2003; Bloomfield, 2004; Hill, 2007). In particular, the Bamford Review of Mental Health and Learning Disabilities (Northern Ireland) concludes that "the ceasefires have not been associated with any improvement in mental wellbeing" (2005:22-23).[3]

1 This ranges from human and material losses to the damage or destruction of societal infrastructure (welfare services, transport and communication systems, institutional fragility and political volatility). Emigration and displacement reduce the size of the labour force. Economic stress lessens productivity capacity, debt levels increase in tandem with security spending and resources are diverted (Maiese, 2003).

2 This is also commonly referred to *The Good Friday Agreement*, and perhaps less often, *The Belfast Agreement*. While beyond the scope of this report, it is important to note that *The Troubles* was merely one part of a much longer cycle of Anglo-Irish belligerence.

3 Herein referred to as the Bamford Review.

As a community, the local government ward of Whiterock within the Belfast West Parliamentary Constituency (see Figure 1 below), provides a microcosm of the protracted violent conflict in both its initial and nascent manifestations. Although now synonymous with staunch republicanism, Whiterock was 'mixed' to a degree until the start of *The Troubles*. That is, with some exceptions, Catholics and Protestants generally lived adjacent in distinct housing estates. The Ballymurphy estate housed the former and since its construction in the late 1940s had enjoyed "relatively relaxed" relationships with the neighbouring "loyalist New Barnsley" and the local British army contingent. However, it had always been a "fragile peace" and tensions between the two communities had increased as civil strife spread across the north of Ireland from 1969. Symbolically, it was the annual commemoration of ancient rivalries in Easter 1970 that sparked a new cycle of violence in Whiterock (de Baróid, 2000: 3).

Despite its relatively late arrival, Whiterock remained an infamous zone of damage and destruction throughout *The Troubles*, and for profound reasons as this report explores. A total of 145 persons were killed within the one square mile of Greater Ballymurphy as a direct result (de Baróid, 2000: 386), with nearly 200 related murders occurring within Whiterock overall during the thirty years (population 5,424 persons, 2001 census (NISRA, 2005b)). The Ballymurphy estate may form the community's heartland but de Baróid goes further labelling it the "epicentre" of *The Troubles* (de Baróid, 2000: xxii). Of course, protracted violent conflict depends on myriad 'epicentres' and *The Troubles* was not an exception as other communities would verify. Nevertheless, de Baróid's dedicated study provides good insight, describing Ballymurphy as "a square mile of solid anti-state conspiracy" (de Baróid, 2000: 386). While this is useful when it comes to grasping the relationship between the wider community of Whiterock and *The Troubles*, it fails to account completely for the more recent manifestation of violent conflict.

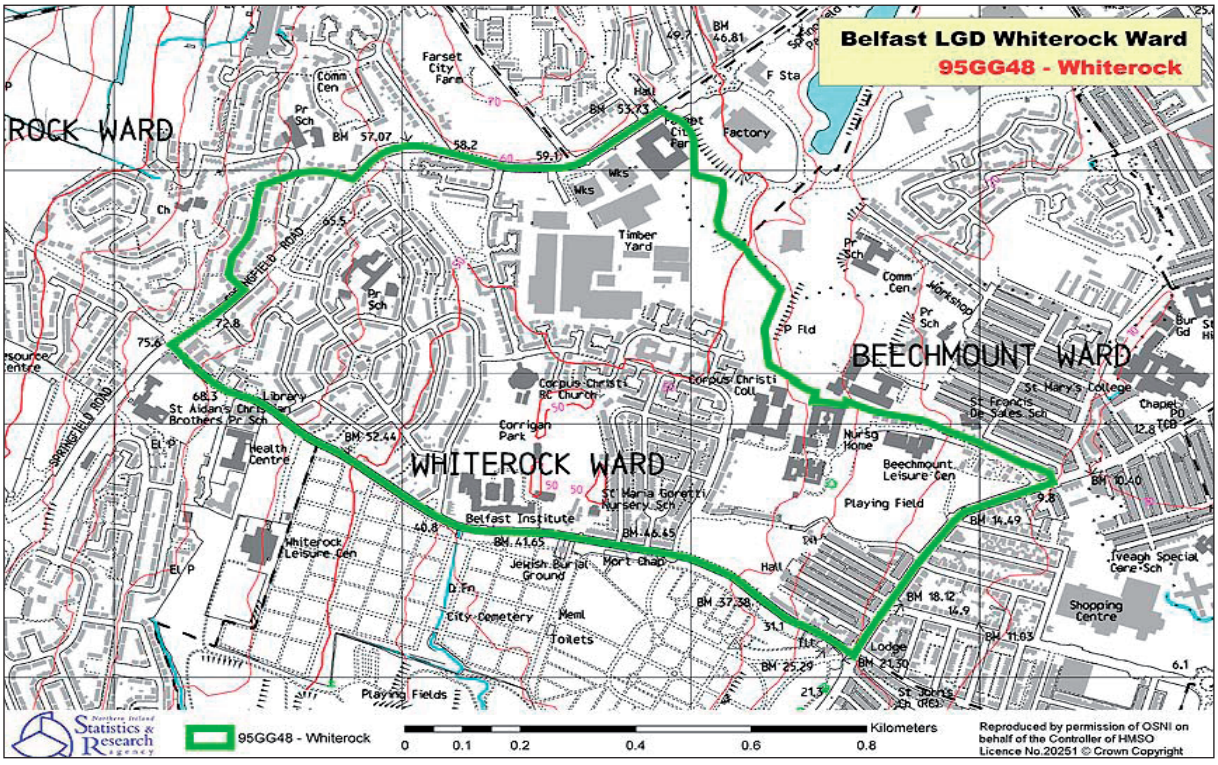

Figure 1. Whiterock ward, West Belfast
(Northern Ireland Statistics and Research Agency (NISRA), 2005b)

When and how the current collective violence started is hotly debated though largely academic for those affected. Locally referred to as a 'dispute' or 'feud' between rival families in Ballymurphy; such descriptions risk understating the impact so far. Spiralling in 2006, by March 2007 there had been 140 acts of criminal damage, 75 arrests, 55 searches, resulting in more than 700 relevant police-reported incidents. The acts of violence have included: murder, attempted murder, aggravated burglary, riotous behaviour, possession of an offensive weapon, possession of firearms, and threats to kill (McCrory, 2007: 17). Therefore, the description of "daily attacks" does not seem like an exaggeration. Similarly, the observation that the community is 'tearing itself apart' is more than metaphorical, with the deliberate targeting and damage of nearly thirty homes over a 12 month period (McCrory, 2007: 16).

1.2 Intergenerational deprivation

Deprivation consists of inadequate living conditions that hinder or prevent human development and even survival; it has economic and social constituent factors. In addition, deprivation can be both a cause and outcome of violent conflict, with horizontal poverty and inequality creating grievances and volatility within a society (Collier and Hoeffler, 2004; World Bank, 2004). Deprivation is also recognised as a root cause of mental ill-health (Bamford Review, 2005: 22-23).

Although introduced after 'protracted violent conflict', the assessment does not attempt to rank the two causes but it does examine the nature of their interrelationship and their impacts on needs. Factors of economic and social deprivation overlap but this assessment divides them into eight sets of developmental needs that are relevant to Whiterock, as outlined below. Accordingly, this assessment also seeks to add a more qualitative understanding to the Northern Ireland Multiple Deprivation Measures (NIMDM), which has become an official research tool for assessing needs in Northern Ireland since 2001 (NISRA, 2005a).

Deprivation in Northern Ireland is held to be among the worst in Western Europe. Between 1997 and 2002, the average gross weekly household income was 78 per cent of the UK average. The unemployment rate (6.2 per cent) has been consistently higher than that of the UK. Moreover, people with mental health difficulties have the lowest employment rate of all disabled people (18 per cent). More than a third of Incapacity Benefit claimants (37,000 people in 2002) have a mental or behavioural disorder, and just under one in five receiving Disability Living Allowance stated mental health reasons as the main disabling condition (Bamford Review, 2005: 22-23).

Within Whiterock, deprivation predates the protracted violent conflict as a root cause of poor mental health and other developmental needs. In essence, the community began as a rushed response to the massive demand for housing post-1945. As detailed below, flaws in the design, construction and management of the estates, in particular Ballymurphy, created a hotbed for deprivation. Overall, it is impossible to know if Whiterock's second generation would have broken the cycle of deprivation after Easter 1970 but it is certain that poverty and exclusion formed root causes of *The Troubles* which in turn maintained startling levels of deprivation for the third and now possibly the fourth generation of residents. It is therefore unsurprising that violent conflict continues.

In order to unpack intergenerational deprivation in Whiterock, it is necessary to examine each of the eight sets of developmental needs, beginning with the wider range.

1.3 Seven key developmental needs

In addition to mental health, the seven sets of developmental needs are: employment; health; housing; mobility; schooling; skills training; and social relations. The assessment concentrates on key aspects of each need since they are all complex and thus cannot be addressed in their entirety within this report. Although separated for analytical

convenience, it is important to stress this assessment appreciates that all eight sets of developmental needs are interlinked and interdependent. Accordingly, this report assesses each need in itself and in relation to mental health since the latter forms the focus of the assessment. In introducing these needs based on existing evidence, we can also see more clearly how economic and social deprivation, coupled with the protracted violent conflict, formed a formidable cause.

According to the NIMDM, Whiterock ranks the 3rd most deprived ward (within the top 1 per cent) overall out of 582 wards in Northern Ireland. 'Whiterock 2' comes first among all the 890 Super Output Areas in Northern Ireland (NISRA, 2005b).

Employment
Unemployment is chronic in Whiterock and there is a culture of endemic poverty. Within the NIMDM, it ranks 4th for income and 1st for employment. The most recent figures show that 10.4 per cent are unemployed, of which 41.6 per cent are long-term unemployed. A total of 58.6 per cent are economically inactive. 45.6 per cent aged 18-59 claim income support, 22.3 per cent aged 16-59/64 claim incapacity benefit, and 25.3 per cent aged 16+ claim housing benefit. 'Whiterock 2', has an unemployment rate of 38.5 per cent (NISRA, 2005b).

Health
There is a history of acute health problems, which stem in part from the infamously poor construction of housing.[4] The community currently ranks 4th for health deprivation and disability, with 32.3 per cent suffering limiting long-term illness, health problems or disability (20.4 per cent in Northern Ireland). A total of 60.5 per cent stated that their general health is good compared to 70.5 per cent across the province (NISRA, 2005b). This indicates a slight improvement as the community-based Corpus Christi Services (CCS) found a satisfaction rate of 56 per cent in its 1998 needs survey (CCS, 1998: V). More recently, the Upper Springfield Development Trust (USDT) uncovered a possible division between young people and families who are "generally satisfied with the quality and range of health facilities" and perceived to "receive better treatment" compared to the elderly and disabled" (USDT, 2007: 5).

Housing
Housing in Whiterock has also been notoriously overcrowded, with a population density of 69.65 persons per hectare compared to a rate of 24.15 for the Belfast Local Government District. Overall, in 2005, it came 24th in terms of living environment (NISRA, 2005b). At the start of the post-conflict phase, the CCS survey identified a significant level of housing-related complaints that all centred on the need for urgent repairs (CCS, 1998).

Mobility
In this assessment, mobility is gauged based on how often on average and why residents leave their community. This is an insightful indicator since residents were known to go outside the community infrequently if not at all, as identified in the CCS survey. This created particular problems as there were limited services within the area during *The Troubles* (CCS, 1998). By 2005, Whiterock was ranked 29th for proximity to services (NISRA, 2005b).

Schooling
With 31.7 per cent of the population aged under 16, schooling is a particularly crucial developmental need. During 2004-05, 32.1 per cent of school leavers had gained 5 or more GCSEs at grade C and above, 7.9 went on to higher education, and 18.6 per cent to further education. Overall, the community came 4th within the combined domain of education, skills and training (NISRA, 2005b).

4 De Baróid notes that 'no-fines' concrete (lack of cavity) rather than red brick was used (de Baróid, 2000: 9).

Skills training
In 1998, the CCS assessment recorded a rate of 65 per cent without qualifications, with 50 per cent stating that members of their household had received no skills training (CCS, 1998: IV). By 2005, only 3.6 per cent had a degree level or higher (NISRA, 2005b)

Social relations
Assessing social relations is especially instructive for two reasons: it is not measured by the NIMDM but there is other evidence that social relations have undergone fundamental change in Whiterock since the end of *The Troubles*; and it provides insight into the level of social capital within the community, which has emerged as a pertinent concept to understanding mental health (see subsection 1.4).

That is, violent conflict can also appear to create positive impacts, and the generations of Whiterock residents have taken pride in their "small tightly-knit community" (de Baróid, 2000: xxii), which has its roots in the proactive anti-poverty initiatives of the Ballymurphy Tenants' Association before 1970 (de Baróid, 2000: 12).[5] The basic needs that were campaigned for (in particular, adequate leisure facilities and housing) were not resolved but simply suppressed during *The Troubles* because 'hard' security was prioritised. Unsurprisingly, since 1998, grievances based on these needs have been able to surface, as manifested through crime, the popular perception that crime and anti-social behaviour have spiralled, and a weakening of the community's traditional sense of cohesion.[6] Therefore, it seems that the high-level of social capital within the community during *The Troubles*, quite suddenly became either undone or irrelevant.

1.4 Mental health

This assessment employs the term 'mental health' in keeping with current professional and academic discourse. There are varying definitions of this term but the following broad position is taken:

> Mental health is the capacity to live life to the full in ways that enable us to realize our natural potentialities, and that unite us with, rather than divide us from all other human beings who make up our world. (Guntrip, 1964); and
>
> Public mental health; the art, science and politics of creating a mentally healthy society (Friedli 2004, in Bamford Review, 2006: 13).

This definition has three significant overlapping implications that cut across theory, policy and practice. First, it proposes a holistic understanding of mental health, recognising that mental health needs interface with all other developmental needs and thus must be addressed within this wider structural context (Secker, 1998). Accordingly, it expands significantly upon the traditional reductive perspective on mental health (psychological, individualised, and problem-solving) to consider *also* the complex psycho-social interrelationship between the individual and his/her society (Hamber, 2004). With the latter realisation, the concept of social capital has become pertinent (McKenzie, Whitley and Weich, 2002).[7] In policy and practice, this holistic understanding has become operational through the public health approach.

5 Of course, violent conflict and deprivation alone did not foster the strong sense of community, as the assessment explores later.
6 Two-thirds within the CCS survey raised problems with vandalism, under-age drinking, and a lack of amenities, in particular, a lack of play areas (CCS, 1998: 5). Accurate statistics of crime are difficult to collect. However, it is useful to note that the NIMDM record less burglary and theft compared to Belfast and Northern Ireland but a higher percentage of "offences against the person" and criminal damage for the 2004/05 financial year. Overall, the community ranked 161st for crime and disorder, falling outside the top 10 per cent for this domain (NISRA, 2005b).
7 Definitions of social capital vary (Macinko and Starfield, 2001). In its basic sense, it refers to the factors that make a community feel close or tight-knit, thereby assuming a collective rather than an individualised perspective. Building positive social capital requires, "a set of informal values and norms shared among members of a group that permits cooperation among them" (Fukuyama, 1999). Therefore, it relies on voluntary participation and cooperation from individuals in tandem with cohesive networks and institutions (Lochner, Kawachi, and Kennedy, 1999; Colletta and Cullen, 2000).

Stemming from the first implication, it is also argued that mental health has a positive as well as a negative dimension. More specifically, it recognises that while some people have mental illnesses, every individual has mental health needs. Similar explanations refer to the positive notion of 'well-being' (Wilkinson, 1991), which "incorporates not only how people feel […] but also how people function" (Parkinson, 2006: 43).[8]

Last, best practice theory concludes that effective responses ought to go beyond traditional forms of ill-health prevention or treatment and bring in mental health promotion at the structural level, for example, at schools and work places. Some psychologists have advocated the inclusion of positive mental health and mental health promotion in policy and practice from the 1950s but Secker concludes that both notions are still at an "early developmental stage" within Europe and North America. Apart from typical teething problems among health experts, the reluctance stems from the well-founded fear that the structural-level efforts of mental health promotion will simply reinforce the root cause/s of poor mental health within a given society (Secker, 1998: 57-58, 61). For instance, during post-conflict, if positive mental health is promoted through a school system, that remains divided along religious or ethnic lines, then such an approach risks cementing the communal division that contributed to the mental ill-health in the first place. This risk should not deter positive and public mental health promotion but sophisticated coordination, strategy and capacity are required to simultaneously work at and reform structural level divisions.

The above evolution in discourse, at and between the conceptual, policy and practice levels, simply reflects the gradual realisation that mental health issues are complex. Apart from the challenges of enabling positive mental health, the World Health Organisation (WHO) estimates that, "[o]ne in four in the world have a mental health problem" (WHO, 2001 in Northern Ireland Association for Mental Health (NIAMH), 2007), and that such problems are common to all countries and cause immense suffering (WHO, 2007). For Kelleher, mental health problems have become "the new global epidemic" (Kelleher, 2003: 474).

Despite the evolution in thinking and the universal relevance, the understanding of the relationship between violent conflict and poor mental health, and the significance of the latter in building peace have developed slowly. It is only really since the later 1990s that the relationship and significance started to gather systematic attention, coming in the wake of the many internal armed conflicts and subsequent high number of post-conflict scenarios across the world. Current thinking realises that man-made trauma incurs specific barriers to coping and healing, with the survivor continuing to suffer as if "frozen in time" (Brahm, 2004). Unable to cope, individuals are unable "to carry on with life and to function in society" (Gutlove and Thompson, 2003).[9]

Despite this grasp of the impacts at the individual-level, the impacts at the collective or societal level "remain largely unconsidered" (Pouligny, 2005: 5; van der Merwe and Vienings, 2001). This is particularly significant where violent conflict is the root cause or source of primary trauma (Hamber, 2004; Le Touze *et al*). Its importance is recognised though. The United States Institute of Peace (2001) draws attention to the "dramatic influence" of "shared trauma" on communities, which can cause society to "lose the sense of trust" and be transmitted across generations. Hamber (2004) has advanced the discourse with the two concepts of 'politicisation of everyday life', and the 'legacy of authoritarianism'. Similarly, Baum (1999) warns that a high-level of social capital is not necessarily positive since it may

8 In using this definition, this assessment includes though looks beyond Post-traumatic Stress Disorder and Secondary Traumatic Stress Disorder.
9 Gutlove, and Thompson (2003) list "cognitive, emotional, physical, and behavioral effects on individuals." Herman identifies three common manifestations of post-traumatic stress: hyper-arousal, flashbacks, and indifference (Herman, 1997: 35). Survivors in Guatemala displayed feelings of overwhelming sadness, shame, embarrassment, shyness and guilt, in addition to silence/shutting down, anger/frustration, helplessness, isolation and prolonged mourning (Le Touze, Siolve and Ziwi, 2005: 196-197).

merely reflect how a criminal gang or paramilitary group has maintained its authority within a community. While these observations are important, overall, the understanding of post-conflict mental health in its holistic sense is emergent and rhetoric-heavy, as evidenced by the uncertainty that continues to haunt reconciliation and truth recovery processes. Accordingly, it is unsurprising that mental health is a socially stigmatised and unspeakable need, which forms a recurring barrier to progress in affected contexts (Barry, Doherty, Hope, Sixsmith and Kelleher, 2000).

Research and practice-based evidence to date concur that there are significant mental health problems and needs in Northern Ireland. In 2000, it was estimated that 158,000 persons had a medically identified mental illness in the course of a year (Accept Northern Ireland, 2000, in NIAMH, 2007). A 2001 survey found the rate of mental health problems to be 20 per cent higher than in England or Scotland, with 24 per cent of women and 17 per cent of men affected (Bamford Review, 2005: 22-23). The common problems include depression, anxiety disorder, schizophrenia, and bipolar affective disorder (NIAMH, 2007). Furthermore, it is recognised that attendant needs are complex and "may extend beyond the disorder itself", including, "difficulties with thinking and decision making, problems with esteem or self confidence, difficulties with social tasks and functions." (Bamford Review, 2005: 21). It is also widely held that the prolonged nature of the strife has created trans-generational trauma (suffering through a parent's suffering) (Eastern Health and Social Services Board Trauma Advisory Panel (EHSSB TAP), 2004: 6). Self-harm and the substantial increase in suicide over the past 20 years among younger people are considered direct and indirect effects (Bamford Review, 2005: 22-23), and the family is identified as a critical level where problems and needs are retained (Potter, 2004: 77; Hill, 2007).

Compared to the other violent conflict and deprivation-induced developmental needs, mental health in Northern Ireland has received relatively little attention from statutory and voluntary agencies, donors, policymakers and academics. As a consequence of this and other factors detailed below, the elite-level approach to understanding and addressing the deficit has developed incrementally, in keeping with the international trends outlined above. Public awareness grew initially in the wake of the first ceasefires in the mid-1990s (The Cost of The Troubles Study, 1999) with a focus on ex-combatant rehabilitation. Although restricted to individualised trauma, consideration then broadened to victims in terms of both rehabilitation and compensation. This became the first significant entry point, with the extensive Bloomfield recommendations published and accepted in full by the British government in 1998. Although the Bloomfield report and that of the Social Services Inspectorate of the same year both recognised the wider impacts of *The Troubles*, a victim-centred paradigm was adopted to drive top-down policy and practice from the start of the peace process.[10] However, this has always been problematic because the notion of individual victimhood has proved both vague and contentious. Politicised opposition aside, there has been an objective fear that the victimhood paradigm will lead to a dangerous hierarchy of problems and needs although there has been broad consensus that certain groups of individuals (in particular, children, young people, adults, and elderly) are vulnerable and thus require specific interventions (Bamford Review, 2006: iii).[11]

10 Following Sir Kenneth Bloomfield's 'We Will Remember Them' (1998), the Victims Liaison Unit was created alongside the Northern Ireland Memorial Fund (1999), which were proceeded more recently by the Victims Unit at Northern Ireland's Office of the First Minister and Deputy First Minister. The concept of individual victimhood also prevailed within *The Agreement*'s 'win-win' or 'positive-sum' recognition of rights and needs, and the former is still reflected in the remit of the police's Historical Inquiries Team. Furthermore, the Interim Commissioner for Victims was appointed in October 2005 to review the support for victims and survivors. While the 2007 findings represented an official broadening of the approach, the recommendation for a new fund for individual victims and survivors (McDougall, 2007: viii) demonstrates the continuation of the victim-centred paradigm.

11 For an insightful review of the debate on victims, see Potter (2004).

Further still, it has been realised gradually that such a restricted focus and ultimately reactive service delivery alone cannot provide an adequate response to mental health problems and needs (Social Democratic Labour Party (SDLP), 2003; Sinn Féin (SF), 2007; McDougall, 2007: ii).

While the focus on victims has dominated top-down policy and practice, it is important to note the simultaneous, though lower profile, development of a public health approach in official mental health policy. The public health approach is distinct as it seeks to reform existing social, economic and cultural structures.[12] In doing so, the public health approach reflects a holistic psycho-social understanding, recognising that mental health has positive as well as negative dimensions, and thus emphasises the need for mental health promotion and the importance of building social capital (Bamford Review, 2006: 19-20).[13] Consequently, it can be considered more proactive and needs-based (Bamford Review, 2006; McDougall, 2007: ii). The rise of this approach and understanding also traces the gradual realisation that so much of the trauma and victimhood is inherently collective (Bloomfield, 2004: 83; Hill, 2007).

Although rooted in a ten-year policy tradition, the public health/mental health promotion approach has proved difficult to achieve on the ground (Bamford, 2006: 13) since structural change ultimately requires political stability and autonomy. Furthermore, the operational response to communal mental ill-health at the familial and community levels has until recently lacked a discernable strategy. It is only with the Neighbourhood Renewal Strategy, gradually rolled out from 2003 for the top 10 per cent of deprived wards (Department for Social Development (DSD), 2003), that the extent of joined-up action required has started to be recognised.[14]

Again, Whiterock illuminates the province-wide trends outlined above. By the mid-1990s, there was a growing realisation that mental health problems and needs demanded attention. A local policy framework for West Belfast emphasised the individualised need for grief support and post-traumatic stress counselling for anxiety and depression because of the perceived prevalence of bereavement, separation, and addiction (Clár Nua, 1995). The needs survey completed by CCS shortly after *The Agreement* emphasised that, "[t]he effects of the 'troubles' have been particularly felt with almost every family experiencing some trauma since 1969" (CCS, 1998: ii). Reflecting on a less tangible and more collective form of loss, de Baróid astutely surmises that people in the community "were suddenly without the cause that had made some sense of the suffering that had been inflicted upon them." (de Baróid, 2000: 384). Of course, seven years on, it is the greater realisation of this latter impact among several others, including the mental health costs of the renewed violence, which have proved more discernable during this needs assessment.

Accordingly, Whiterock equally testifies to the systemic gaps in addressing mental health problems. At the same time, it is also insightful because it has witnessed the recent introduction of mental health promotion initiatives by the USDT, and a Neighbourhood Renewal Strategy is currently emerging. These points bring us to the importance of the community level response.

12 Health Promotion Agency for Northern Ireland, 1999; Department of Health, Social Services and Public Safety (DHSSPS), 2003: 18; NIAMH, 2007.

13 In October 1998, the DHSSPS operated a Task Force on Mental Health Promotion to raise mental health awareness (Health Promotion Agency for Northern Ireland, 1999). The independent Bamford Review of mental health policy and legislation in Northern Ireland (2002 - 2006) has played a key role in advocating a greater prominence of this overall approach.

14 Alternatively, the cross-border suicide prevention strategy, 'Protect Life – A Shared Vision' (launched 30 October 2006) focuses on individuals but also aims to de-stigmatise mental health and promote suicide prevention and awareness (DHSSPS, 2007).

1.5 The community level response

In assessing needs, this report also considers the role of the community level response to mental health problems and needs. Focusing on voluntary organisations and general practitioners/practices (GPs), the types of services that both directly and indirectly impact on mental health and how the services are provided demand attention. After all, the community level of the response forms the clearing house for problems and needs and thus provides the immediate and direct line of defence and prevention.

More curiously it is also of interest because during post-conflict in general the response at this level is effectively carrying out the responsibilities of a weakened state, that is, where the government is either unable or unwilling to provide directly for its citizens.

Nevertheless, the increased reliance on community level responses has brought two main challenges. First, the operational concept of coordination has become more critical, in terms of adequate and efficient arrangements among statutory and voluntary service providers at this local level, and between this level and statutory agencies at the sub-national and national levels. This is unsurprising since coordination is notoriously weak for mental health and developmental needs. Often combined with 'collaboration' and 'cooperation', coordination is deemed by some to be "a handy political device" that attempts to cover up the inevitable conflicting values and expectations of stakeholders (Lankshear, 2003: 457; Weiss, 1980; Øvretveit, 1995; Inter-agency Standing Committee, 2007).

The second challenge centres on the difficulties in securing strong participation among service users and potential beneficiaries in both shaping and helping to deliver the response to their problems and needs (Barry *et al*, 2000). Ideas on participatory outcomes and methods are invariably vague though *en vogue* because they promise empowerment, which in turn is held to be the key to sustainable solutions.[15]

In Northern Ireland, the community level response has become prominent for four reasons. First, the top-down policy and practice eventually realised that a grander and more communal-oriented policy was required as the scale and complexity of the problems and needs became more apparent, as outlined in subsection 4.1. Second, a community level response is possible because, compared to other post-conflict contexts, Northern Ireland has been able to foster (to a degree) capable and independent indigenous responses to developmental needs (Bamford Review, 2004: 2).[16] Third, unlike statutory agencies, voluntary organisations are known overall to enjoy the trust of the communities (McDougall, 2007: ii). As Potter (2004: 77) adds: "suspicion is strongest where the need to assist is greatest, i.e. where the conflict has had its most intense manifestation". Therefore, it is appreciated that only the response at the community level can enable access to those with problems and needs (*The Agreement*, 1998: 22; EHSSB TAP, 2004: 5). Last, the 'contracting out' of the public sector and welfare services also stems from more global changes in the relationships between international economy, the state, and economic policy (Øvretveit, Mathias and Thompson, 1997; Giddens, 1998; Heginbotham, 1999).

15 Secker warns against solely expert-led approaches and thus emphasizes the importance of including participatory methods as well "since these will have the support of the people concerned". He raises some evidence of small-scale action in addressing structural inequities "at a local level on everyday problems defined by local people themselves" in non-conflict societies, with particular focus on poverty reduction (Secker, 1998: 61).

16 That is, despite the violent conflict lasting for thirty years and the significant levels of deprivation, basic services such as education and health for the most part managed to continue uninterrupted – an achievement that was of course supported by the strong coping mechanisms of the conflict-affected.

In keeping with international trends, adequate coordination and user participation form two of the main challenges. TAPs were created in 1999 to coordinate and strengthen collaboration among and between statutory agencies, government departments and community organisations, with one TAP positioned within each of the HSS Boards (Bamford, 2006: iii). The EHSSB TAP also restructured a Trauma Implementation Group from a "purely statutory group into a cross-sectoral 'executive' with the support of the Community Relations Council." (EHSSB TAP, 2006a: 5).[17] Although there is consensus that TAPs perform a critical role in this respect, there is equally the conclusion that service provision is "complicated" and "uncoordinated" (McDougall, 2007: ii, 16; Victims Unit, 2002).[18] Similarly, user participation has received considerable attention but the goal of empowerment and community-driven development remains elusive.[19]

With Whiterock falling within the EHSSB, this assessment is particularly timely as the latter has relatively recently formed a TAP. Coordination among service providers has been a core need. By 1999 there were at least 60 community organisations trying to meet the many developmental needs but with "no structured network" for mental health (de Baróid, 2000: 386 and 382). Although the EHSSB TAP praised the wider and complementary services of the voluntary sector (EHSSB TAP, 2004: 5), by 2006 it tentatively concluded that the emergence of varying one-stop-shop models within the community level response was hampering coordination (EHSSB TAP, 2006a: 13). Similarly, the following investigation of the level of user participation and empowerment is important in considering the recent introduction of the Neighbourhood Renewal Strategy.

1.6 Post-conflict

'Post-conflict' forms the last core theme within this needs assessment. Opponents of this term, within and outside of Northern Ireland, may argue that it is unhelpful for at least two main reasons. First, some may contend that it is reductive with such labelling actually hindering a given community or country from shedding its 'conflict' legacy and image, and thus from moving on. Second, some may contest that it is misleading since the signing of the peace agreement has not stopped violence on the ground. Both arguments are important but the first tends to be unrealistic by underestimating the persisting influence of structural conditions. The second pinpoints, though then tends to sidestep, the problem of continued violence. Instead and in transcending these two criticisms, this assessment adopts 'post-conflict' as a core theme because it helps to explain why and how current mental health and other developmental needs continue to be rooted in violent conflict and generational deprivation. Accordingly, it then strengthens our understanding of how these causes and needs ought to be addressed within the community. In these ways, 'post-conflict' has analytical and normative value, respectively.

The term 'post-conflict' groups together numerous countries in Africa, Asia, Europe and Latin America that experienced protracted ethno-political conflict followed by peace agreements during the 1990s (Paris, 2004: 3). In this modern interpretation, Northern Ireland became one of many new post-conflict societies, joining Mozambique, Sri Lanka, Bosnia-Herzegovina, and Guatemala among others. There are many explanations of this phenomenon, and many concentrate on the internal dynamics of each context. An equally important factor has been the role of the leading international states and their concerted realisation that peace agreements and

17 In addition, TAPs are charged with conducting needs assessments, mapping surveys, service gap analyses, lobbying and professional development training (EHSSB TAP, 2004: 4-6; 2005: 5; 2006a: 3; and 2006b: 1-5).
18 The Interim Commissioner for Victims has supported the continuation of TAPs, as has Bamford (2006), but noted a conflict of interest since the main recipients of funding are linked to TAP members (McDougall, 2007: 58).
19 Health Promotion Agency for Northern Ireland, 1999: 4; and DHSSPS, 2003; DSD, 2003; Bamford Review, 2005: 11-12; NIAMH, 2005: 12; McDougall, 2007.

stability were more expedient, and thus the need for intervention (Luckham, 2004). In many ways, *The Agreement*, like peace accords elsewhere, came only after years of peace making initiatives. However and in considering the fifty years of potential lesson learning after the Second World War, it is therefore extraordinary that post-conflict peace has proven so difficult if not impossible to attain (Barbanti, 2004).

As the main indicator, despite the number of peace agreements signed, the ensuing series of post-war peace have been remarkably violent (Collier, 2003; World Bank, 2004: 8; MacGinty, 2006). This not only points to the simultaneous challenges of building peace and leading development during deep insecurity; the regularity suggests that the role and impacts of peace building and development are contributing to this counter-intuitive phenomenon. In other words, weaknesses in peace agreements and the intractability of violent conflict account for the crucial shortfalls but equally responsible are the processes of peace and development. In particular, it is becoming increasingly clear that the timing of donor funding and how it is spent have monumental implications for the post-conflict society. Figure 2 below conceptualises and contrasts two opposing trajectories that prevail after conflict: donor funding alongside local capacities.

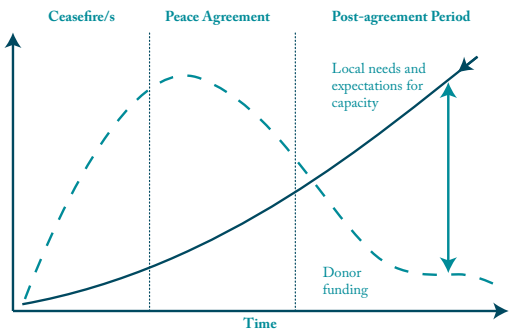

Figure 2. Donor funds versus local capacities[20]

Based on the three broad phases, Figure 2 asserts that it is typical for donor funding to rise swiftly with the launch of the ceasefire/s until it peaks just after the peace agreement. While such a push is important at the elite level, the development of local capacities takes much longer and thus runs at a very different pace. As the post-conflict period progresses, Figure 2 asserts that funding tends to decline rapidly as the needs and expectations for capacity development at the community level increase. In other words, as Collier and Hoeffler (2004) found, high-levels of funding cannot be absorbed at the start while later there is insufficient funding to be absorbed. The resultant outcome is significant dissonance and tension between the funds available and what is needed to protect the post-war peace and development. To re-emphasise, Figure 2 is not intended to provide a comprehensive account of all post-conflict shortcomings but it does demonstrate how donor funding can become a recurring structural challenge.

Accordingly, as an analytical lens, 'post-conflict' is valuable in trying to grasp the developments in Northern Ireland over the past 10-15 years. As noted in subsection 1.1, ceasefires have been announced and in many ways maintained but violent conflict has not disappeared. For some and as this report details, the post-conflict environment is in many ways worse. EHSSB TAP with direct relevance to mental health echoes the Bamford Review's conclusion above, noting that, "needs are changing over time" and in particular "arise as a consequence of ongoing organized crime, much of which is paramilitary-related" (EHSSB TAP, 2005: 5).

Furthermore and as examined below, the massive injection of donor funding through the 1990s may have delivered *The Agreement* but salient developmental needs remain, which risk an escalation in violent conflict and continued deprivation.[21]

20 This figure is adapted from a chart created by Professor Sultan Barakat, Director of the PRDU at the University of York, UK. For a more detailed account, see Barakat (2002: 801 - 815).

21 For example, Peace I (1995 - 1999) contributed 692 Million Euros; Peace II (2001 - 2006) rose to 796 Million Euros, which contrasts sharply with the estimated 200 Million Euros under Peace III (2007 - 2013).

Proactive development and conflict prevention are essential activities but are undoubtedly more difficult if not impossible when service providers lack stability in terms of a long-term vision and funding. This is especially relevant to mental health. WHO (2003: 3; 2007) specifically notes such problems and needs take time to resolve, which clashes with the short-term commitment of donors.[22] The inadequate amount, unsuitable pace and non-recurrent nature of funding have all been raised as significant post-conflict challenges to addressing and meeting mental health needs (Bamford Review, 2005: 3; 2006; EHSSB TAP, 2006a: 3; McDougall, 2007: iv).

Finally, the 'post-conflict' lens brings fresh value because it contains insightful comparative knowledge and substantive lessons, which if harnessed correctly could lead to a more deliberative approach to meeting needs. For Whiterock, as outlined in Section 6, this offers the opportunity to shift away from the previous weaknesses in planning and decision-making.

Overall, this introductory section has explored the nature of the two root causes of mental health problems and needs, in terms of their specific and combined impacts. Clearly, there are many complex interrelationships, with protracted violent conflict and intergenerational deprivation also forming cyclical outcomes of unresolved mental health and other developmental needs. Although there has been a multifaceted response, the scale and depth of the challenges continue to overwhelm, which has led recently to the heightened consideration of service delivery at the community level. While identifying all these trends in other post-conflict contexts provides solace, such commonalities confirm that policy and practice are also drivers. Before detailing how the Whiterock needs assessment has added value to this knowledge, it is important to summarise how the primary evidence has been generated.

22 Similarly, Das (2002) outlines the comparatively inadequate attention given to mental health in post-conflict Afghanistan and East Timor. It could be argued that the late arrival of mental health occurs for natural and logical reasons, that is, the need to address first political and security concerns (for example, power-sharing arrangements, justice, decommissioning, and policing) – a process perhaps of 'working through' at the societal level. Alternatively, the de-prioritisation of mental health could be interpreted as a deliberate bias within elite-driven peace processes. For more on the latter as a wider international trend, see Silove (2004).

2. Assessment Methodology

The evidence for this report's findings is grounded in primary/field data, which was collected from the full range of relevant stakeholders within Whiterock. This section thus reviews the unique nature of this foundation by outlining the scope of the data, how it was collected, the reasons for the selection, and how the data has been analysed. Before this though, the use of secondary data in the assessment is considered.

Furthermore, it needs to be appreciated that assessing needs is a difficult task. McKillip advises that this field "gives rise to much controversy" since there are "complex philosophical and methodological debates surrounding the conceptualization, definition and measurement of need" (McKillip, 1987, in Clarke, 2005: 16). Therefore, at the same time, this section also reminds throughout that it is worthwhile to keep in mind how these key 'debates' have been negotiated and the inevitable limits of the methodology.

2.1 Review of the literatures

This assessment started with a review of the academic and policy-based literatures (statutory reports, policy documents and other reliable Internet-based data) relevant to the six core themes of the assessment, as introduced in Section 1.

The review then focused on the literatures that addressed these core themes in relation to Northern Ireland, and where possible, the community of Whiterock. Further secondary data, in the form of reputable media-based reports, was also gathered to provide insight into the specific context of the community and its needs.

2.2 Scope of the assessment

The scope of the assessment was deliberately limited in three ways and for well-founded reasons. First, it intentionally focused on primarily assessing mental health. By December 2006, practice-based evidence from CCS indicated that such needs and problems had increased and become more serious, thus objective empirical research was needed to test and clarify these findings and working assumptions. At the same time, it was argued that the community level response to mental health had grown and diversified during the post-conflict phase, thus it was essential to draw together the knowledge, expertise, and experience of the different service providers. In other words, there was a need for a *community-wide* assessment and understanding of mental health. In addition to the practice-based evidence, these trends also matched trajectories in mental health provision in other post-conflict contexts, as examined in Section 1.

Although mental health forms the focus, it was agreed that the assessment would also consider a wider range of core developmental needs. The opening section reviewed best practice theory, which informs that developmental needs are interlinked and interdependent, and thus demand a holistic understanding. Accordingly, the set of core developmental needs act as the structural conditions and indicators for assessing mental health both directly and indirectly. Since it was not possible to investigate all developmental needs, it was necessary to tailor seven sets of needs that were most relevant to mental health and the community, and to concentrate on key aspects of each of these core needs.

Second, the assessment was consciously limited to the local government ward of Whiterock. Accordingly, the field data is taken solely from households within this community and interviews with organisations, GPs, institutions, political parties and individuals that work there.[23]

23 These may be referred to as 'the stakeholders', and 'the service providers' when not including households.

Consequently, it needs to be understood that the assessment is a concentrated study though inclusive of the range of service providers that make up the response to mental health and it is held to be representative in different ways of residents within the community.[24] Furthermore and as detailed below, the sampling strategy allows tentative generalisations whereby the main findings can be applied to other comparable communities outside of Whiterock.

Last, the scope was determined by time and budget. The period, 5th January 2007 to 30th March 2007, was the only available window while the assessment did not enjoy unlimited resources. Nevertheless, the small-scale nature of the study does not detract from the validity and importance of the findings. The limits in time and budget were counterbalanced by utilising the extensive relevant experience of the PRDU coupled with the local expertise of CCS, which helped facilitate the assessment.

Moreover, before starting, it was concluded that a small-scale though multi-levelled (within the community) study was more appropriate based on the existing type and level of knowledge of mental health within the community. In other words, there was a paucity of systematic investigation. As noted above, there was a greater and urgent need to generate a more in-depth and objective understanding, which would be strengthened by consideration of the other main developmental needs.[25] It was hoped that this new type and level of understanding, that included though looked beyond the individual-level, would address critical gaps in the service providers' practice-based insight. In this way, the assessment carefully builds upon and tests the latter but it is mainly exploratory in nature.

Based on the need for these characteristics (in-depth, objective and exploratory), it was decided that qualitative methods were optimal to achieve the aims of the assessment. In this sense, it seeks to understand and interrogate the level and nature of mental health problems and needs in the community according to the symptoms/manifestations, the identification of vulnerable groups and subgroups, the causes, and the impacts. Qualitative assessments also tend to be associated with a holistic perspective – seeing things in their context and for stressing how things are related and interdependent. Clarke refers to this type of needs assessment as a, "front-end analysis designed to determine the extent to which developmental needs exist or to diagnose the nature and extent of a particular problem prior to the search for solutions" (Clarke, 2005: 15). Towards this 'search for solutions', this assessment includes a critical review of where the current response perceives its crucial strengths and weaknesses, and provides a framework of new directions, which sets out how the response might change in the future. Last, it is hoped that a qualitative methodology contributes to a more balanced mental health promotion strategy. As Secker advocates:

> …if health promotion is to develop a mental health promotion agenda consistent with its principles, it is essential to recognize the value of qualitative research alongside that of experimental methods and to reflect that recognition in the research strategies we develop. (Secker, 1998: 64)

2.3 Approach to gaining access

All interviews and surveys were arranged through the proper and official channels, and with informed consent. The initial step was to compile a comprehensive list of all the pertinent service providers and any other institutions, organisations, groups, and individuals within the community. This

24 The assessment could not reach every relevant service provider working at the community level despite efforts to do so. In particular, at least eight interviews were not returned. Nevertheless, the range of voices is inclusive of at least each type of service provider. Further, at least one main group and subgroup of stakeholders were not interviewed directly: children, and ex-prisoners.

25 In particular, there was an absence of other relevant community-wide studies on mental health or developmental needs in general.

was determined first based on full consideration of all the possible types of service providers and relevant actors, and then completed using the knowledge and insight of CCS in cooperation with other local experts. The stakeholders on this comprehensive list were invited to participate in focus groups or individual interviews, and these respondents were then asked to suggest additional service providers in order to maximise inclusiveness.

It was anticipated that access to households would be more problematic because the survey questions addressed sensitive issues, and access in general to households in post-conflict societies invariably faces obstacles.[26] Gaining the acceptance and trust of household heads was crucial in order to gather in-depth and accurate data. For these reasons, the surveys were conducted by CCS staff, in particular, those with a long-standing rapport with the community and who would thus also be known/recognised by householders. This was carefully judged to be the optimal approach but it naturally risked bringing a level of bias to the surveys. The measures used to identify and manage these biases are detailed below. Access to the small sample of users raised similar challenges and thus both sets of focus group interviews had to be conducted by the relevant CCS staff.[27]

Despite the notable achievements in gaining and maintaining access, it is prudent to assume that the assessment inevitably had positive and negative impacts. Barakat *et al* (2002) and Goodhand (2000) emphasize the impossibility of an interviewer remaining neutral, especially in the post-conflict environment. Commonly referred to as 'reactivity', the interviewer's presence potentially influences the behaviour and responses of respondents (Jacobsen and Landau, 2003: 102). This includes the possibility that the assessment may have unwittingly supported vested interests; for example, Pratt and Lozios remind that research can empower, which can make others hostile (Pratt and Lozios, 1992: 17 - 19). Where possible, this was alleviated and controlled by making the aims of the assessment clear and by relying on the guidance of the key respondents and gatekeepers. While reactivity is unavoidable, it is also important to give respondents credit in their ability to listen, understand, and form realistic expectations. Furthermore, there may be potential benefits for interviewees, "[k]nowing they are contributing to a worthwhile endeavour can be gratifying; it may increase confidence." (Arksey and Knight, 1999: 127).

In cementing the credibility and respect afforded to the assessment, the preliminary findings were presented to the community on 21st March 2007. All those who had participated during the data collection were invited to attend and make final contributions.[28]

2.4 Primary data gathering techniques

This evaluation used three participatory techniques to gather the primary data: focus groups; interviews with individual respondents (face-to-face and via email); and the household survey. In total, there were 7 focus groups (including 2 with CCS service users), 12 semi-structured interviews with individual respondents, and 69 household heads surveyed.[29] Accordingly, the assessment was multi-levelled within the framework of the community.

Multiple and interrelated qualitative methods were employed in appreciation of the unique "restrictions imposed by armed conflict" and its aftermath. While

26 See Barakat, Chard, Jacoby and Lume (2002).

27 Interviewers received detailed training and guidance on how to approach respondents, householders and users in a sensitive manner. For example, the timing of the visits sought to respect the needs and priorities of the households. Each survey and interview began with a uniform introduction that explained the reasons and aims of the assessment, and how information would be used, while stressing and demonstrating confidentiality. Each interview and survey was concluded with a request for further comments and questions, and an invitation to the preliminary findings.

28 See Connolly (2003) for further practical guidance on conducting ethical research with vulnerable groups.

29 The lead investigator conducted 5 of the focus groups, with CCS staff conducting the 2 user groups. Of the 12 semi-structured interviews, 1 was completed by the lead investigator, 1 by email, 8 by CSS staff and the last 2 interviews were with CCS counselling and welfare staff. A complete list of interviewees is included in Appendix A, with respect for confidentiality and anonymity.

keeping to the aims of the assessment, Barakat calls for a, "flexible, innovative and reflective approach" since "highly structured methods" are prevented by the "multitude of unpredictable parameters which tightly control appropriate and possible action" (Barakat *et al*, 2002: 991 and 1001). In other words, gathering data in post-conflict environments is invariably difficult since 'meanings' are often contested and perhaps even politicised for a variety of reasons. Using multiple and interrelated methods has allowed the assessment to triangulate and check the data for verifiable patterns and inconsistencies, and thus produce more reliable evidence. Arksey and Knight concur that "different angles and bringing together a range of views" can create "new and alternative explanations", which "better capture the social complexity" of needs (Arksey and Knight, 1999: 22).

The focus group, interview and survey questions were mainly semi-structured in order to gather in-depth and qualitative data. They all stemmed from the purpose of the assessment and thus centred on an investigation of the six core themes. Once drafted, the wording of the questions was amended slightly based on constructive feedback from a workshop with staff from CCS and other community experts. In addition, the survey was piloted in Whiterock before the sample proper of households started.

All interview and household questions followed a strategic structure of clusters linked to the core themes, which was important for several reasons. The order reflected the degree of potential sensitivity, from an initial request for straightforward information to socio-economic data as the last cluster. The strategic structuring strategy was used to develop trust before more personal questions were asked, and allowed the interviewer to proceed through the questions in a logical manner which made sense to the respondents (Arksey and Knight, 1999: 39). The questions that, in subject matter, were relevant to two question clusters, were placed at the end of a section to provide a logical lead question to the next one. Reflecting the overall strategy, the more basic and less sensitive questions within each cluster were placed before questions of a sensitive or opinion/value-based composition.

Nevertheless, it was also important to consider the possibility of bias in the interviews and surveys, since respondents may have been motivated by the perceived intentions of the interviewer, mistrusted the aims and credibility of the process or "used it for their own purpose", thereby resulting in "false or incomplete" information (Barakat *et al*, 2002: 993-994). Alternatively, the time taken by semi-structured interviews can also reveal inconsistencies and instil more trust (Barakat *et al*, 2002: 993). Pratt and Lozios draw attention to the danger of specialists attaching too much causal weight or interest because of their own 'specialism'. This bias was balanced by also asking household heads to prioritise and explain the major problems facing the community, which itself generated insightful observations (Pratt and Lozios, 1992: 2 and 6).

2.5 Selection of samples and representativeness

There were three main sets of samples for analysis: the service providers; the households; and the CCS users.

The selection procedure for the sample of service providers has already been described above in relation to gaining access to the community. The assessment attempted to reach all relevant service providers (voluntary and statutory) and achieved a cross-section at a minimum. Service providers were identified systematically, with 'snow-balling' as a final check. Care was also taken to interview service providers with short and long-term engagements. The continuity of interviewees and the subsequent analysis of commonalities and shifts in perception ensured the respondents' credibility. In sum, the sample of service providers is representative of the community level response to mental health within Whiterock.

Where the community forms the primary unit of analysis, the household represents the secondary or strategic unit. This was advantageous because where more than one member of the household was present for the interview (the desired though not always possible arrangement) then it allowed individuals to address issues of shared responsibility, mutual capacities and vulnerabilities. It also provided a suitable linkage of analysis between the individuals and the community. In general, where more than one household member is present, respondents typically appear less suspicious or inclined to misinform. However, it also poses two main risks. First, it assumes that the household is the functional unit of mutual support, which may not always be the case. Second, practical constraints may mean that only one household head can answer on behalf of the household and this can result in male or female bias. The assessment counterbalanced these risks by establishing a basic profile of the household before the survey and by conducting a mixture of both male-head and female-head only surveys in addition to interviews with both heads present.

A sample of 69 households, 3.77 per cent of households in Whiterock[30], was selected and surveyed and thus reflected the small-scale parameters of the assessment. At the same time, it needs to be remembered that this sample size was optimal since the assessment deliberately used multiple techniques because of the common challenges to gathering accurate data in post-conflict contexts. In other words, the household surveys form a crucial though ultimately only one of three interrelated layers of data.

The selection of households was non-random because of the size of the sample (in relation to the total population of Whiterock), and in reflecting the nature of the assessment: to gain a close, in-depth and nuanced understanding of needs.[31] Rather than a purely random choice, the households were selected based on a quota. First, it was important to ensure that all six areas or estates of Whiterock were reached: Ballymurphy, Whiterock (an estate in itself), Springhill, New Barnsley/Springfield, Sliabh Dubh, and the Falls. Second, each area was then assigned a target number of households that reflected the area's total number of households. Within each area, interviewers were then directed to include: an equal number of 'typical' and 'vulnerable' households; and to ensure a geographical spread of these households (from the centre to the periphery). After this, the selection of each household was made by the interviewer based on his/her expert knowledge of the households in that area.[32] In sum, the sample of households was representative of the community in terms of all the constituent areas and the main types of households.

Traditionally in social science research it has been argued that only random samples can be truly representative of a given population. However, such assertions came from an inadequate understanding of empirical studies in contexts affected by violent conflict. Accordingly, mainstream thinking on sampling and representativeness has changed as social scientists have gained a more informed understanding through their engagement in the proliferation of conflict and post-conflict contexts from the early 1990s (Barakat *et al*, 2002). One of the main realisations has been that random samples are not always optimal because of the emergent understanding of conflict and post-conflict (compared to other social phenomena). Accordingly, generalisations (from sample to population) can be made but should remain tentative (Arksey and

30 It was also appropriate based on the constraints of time, budget and manpower.

31 The target number of households for each area was based on the electoral register cross-referenced with the interviewer's expert knowledge of that area. Definitions of 'vulnerable' and 'typical' households came from insight gleaned from CCS's practice-based evidence and general knowledge of the community. From this, a distinguishable profile for each of the two types of households was designed to guide interviewers in their selection. Please note that the use of 'vulnerable household' as a category within the sample does not contradict the main finding below that cautions against the use of such categories within practice.

Knight, 1999: 64; and Devine, 1995: 145). However, again it is important to remember that it is the use of multiple methods that strengthens the validity of this report's findings. Therefore, representativeness is maximised where the findings from the household surveys align with the findings from the focus groups and individuals interviews.

Alternatively, the small sample of CCS users was selected randomly based on the expert knowledge of the relevant CCS staff that conducted each of the two focus groups. This sample consisted of three clients of welfare advice service, and two clients of the counselling service. The welfare advice users also received support from CCS through the counselling service and work-training.[33]

Last, it is important to note that this assessment also strived to be gender-balanced, in terms of the household heads surveyed, the representatives from the service providers, and the interviewers themselves.

2.6 Primary data analysis

The primary data was analysed progressively and systematically during three main stages. First, under the core themes, the data gathered by the focus group and individual interviews were organised and collated in tandem with the household surveys. This formed the preliminary analysis, which closed with the presentation of some of the initial findings in Whiterock on 21st March 2007. The second stage involved a tightening of the preliminary analysis in light of the feedback, and through testing further the emergent understandings with alternative explanations. The last stage focused on drawing together the final conclusions and recommendations, as presented within this final report.

Throughout the three stages of analysis, the field data was cross-checked within and, where possible, against the policy-based literature. The validity of the findings is thus grounded in consistent evidence and the isolation of inconsistencies.

Based on this critical and transparent review of the assessment methodology, it is now possible to move to the main findings.

33 The three CCS welfare advice users were all women and single-headed householders. Two were dependent on benefits and one was in long-term employment. Two were aged between 40-50 years and the third was between 35-40 years old. All three had lived in the community for between 15-40 years. Two had used CCS for "many years" while the third had been a client for "the last few months" (Focus Group 7, 25 January 2007). One of the CCS counselling clients was female, aged 40-45 years, and had lived in the Ballymurphy estate all her life. Her husband had taken his life, and she was the mother of three children. She was also using the welfare advice for three years. The second client was male, 46-50 years old, and from outside the community. His child had been murdered and he was separated from his wife (Focus Group 6, 25 January 2007).

3. Understanding Mental Health and Developmental Needs

This section primarily assesses mental health problems and needs within Whiterock by examining the different types and manifestations, and the existence of vulnerable groups and subgroups. The analysis then unravels the two root causes, the cycle of violent conflict, and intergenerational deprivation, before identifying the three main levels (individual, family and community) where the impacts of mental health occur.

In strengthening this focus, the section begins with a brief and selective assessment of the other seven core developmental needs, which in turn form the structural conditions of mental health in the community. After reviewing the data from the household surveys, focus groups, and individual interviews, the analysis reveals that three distinctive though interlinked trends in developmental needs have emerged, which provides a more inclusive and informed understanding.

3.1 Three trends in developmental needs

Trend 1:

> Life has improved – feel sense of less danger – nobody getting shot. No soldiers up and down the street every five minutes – different atmosphere - we live in a quiet street with good neighbours.[34]

> I think there are more opportunities for training and employment and more social barriers have been pulled down.[35]

Trend 2:

> Housing has got worse - mine needs a lot of work […] Other things have not changed much either.[36]

Trend 3:

> I am not as troubled but I am still aware that not everybody has signed on the dotted line. There are still people out there that don't want peace but hopefully it will get better.[37]

> During the height of *The Troubles* you were always looking over your shoulder although the community was closer then.[38]

The first two trends point to a distinct division within the community. On the one hand, the majority of respondents consider that their developmental needs are at least adequate, with an improvement over the past ten years - since the ceasefires and *The Agreement*. Conversely, a significant minority are unsatisfied. That is, they perceive that the seven sets of needs have either not improved or deteriorated during the post-conflict period. The division is illustrated clearly by the following analysis.

First, household heads were asked if they thought there are sufficient/insufficient opportunities for their households in finding new employment in the future. Figure 3 below shows that just over half of those surveyed answered 'sufficient', which is an indicator of limited economic growth. One of the main reasons for this response is that household members are 'very happy' with their current jobs, in terms of performance and in general.[39] The small sample of CCS users also raise that there are more opportunities now because of the increased investment since the end of *The Troubles* and that people are more prepared to travel for work.[40]

34 Ballymurphy household head
35 New Barnsley/Springfield household head
36 Ballymurphy household head
37 Falls household head
38 Sliabh Dubh household head
39 The high number of 'no answer' among the household surveys is explained by the number of retired household heads surveyed in addition to those who for different reasons felt unable to answer this question on behalf for their other household members.
40 Focus Group 6, 25 January 2007 Focus Group 7, 25 January 2007.

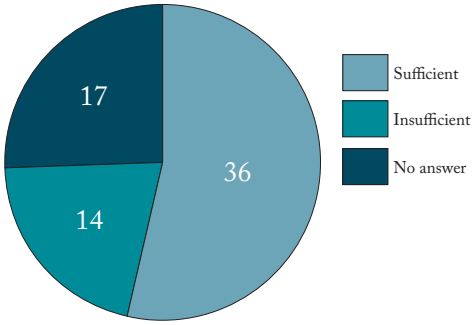

Figure 3. Employment opportunities

Second, household heads were asked to assess the access to and standard of health services available to their household. Figure 4 below presents an important though less obvious division. Interestingly, all but one of the CCS users considers the health services inadequate, in particular, the provision for mental health.[41]

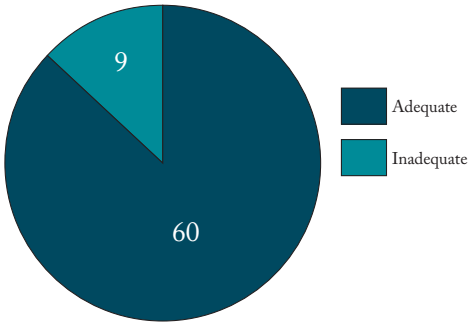

Figure 4. Access to and standard of health services

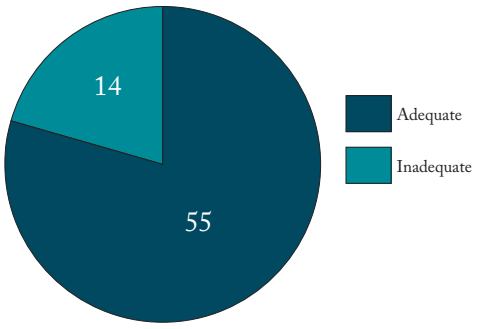

Figure 5. Qualtiy of housing

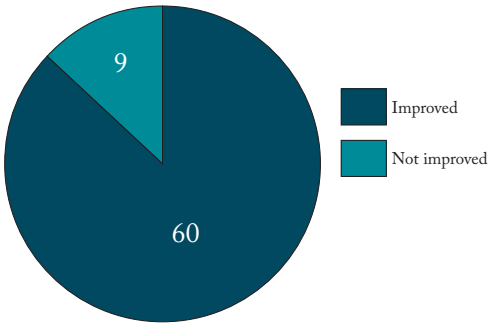

Figure 6. Improveent in housing over past ten years

Third, household heads were asked two questions about their housing: to assess if the quality is adequate or inadequate (see Figure 5); and if the quality has improved over the ten years (see Figure 6). Splits are visible in both.

There are two recurring explanations for the improvement: a more dedicated service provision by the Housing Executive; and more commonly, household heads had bought their house during the past 10 years and had sufficient funds to maintain an adequate standard or raise this standard through repairs and extensions. A resident from Sliabh Dubh describes: "I think housing has improved for me anyway - I used to live in a hostel but now I have my own home." The CCS users echo these points. However, the two counselling clients assert that the repair of the older housing is not a prioritised service within the community. This had become a major source of stress for one of the clients who could not get their front door fixed for a long time and feared vandalism in the area.[42]

The fourth developmental need assessed is mobility, which is a key indicator of mental health problems and needs. Reflecting its economic and social dimensions, household heads were asked how often they and the members of their household go outside the community for employment, school, and leisure. Figure 7 below illustrates a predominantly positive

41 Focus Group 6, 25 January 2007 Focus Group 7, 25 January 2007.
42 Focus Group 6, 25 January 2007; Focus Group 7, 25 January 2007.

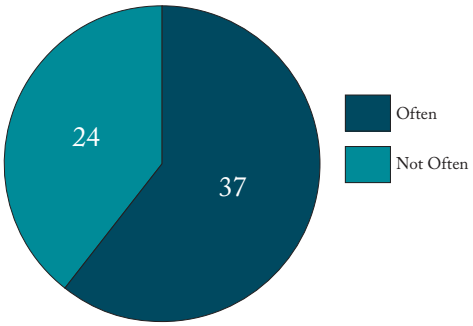

Figure 7. Mobility: going outside the community

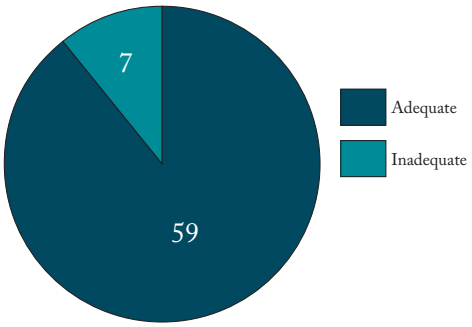

Figure 8. Standard of schooling

response but nearly one-third of households state that they did not go outside the community often, which was a common phenomenon during *The Troubles*.[43] In strengthening the insight from this indicator, all of the CCS users describe how they still do not (like) to leave the community as a continued mindset from *The Troubles*.[44]

Fifth, household heads were asked to assess the standard of primary and secondary schooling in the community as adequate or inadequate.

Figure 8 shows that the division is not as deep in terms of numbers. However, many of the '59' refer to it as 'very good' which contrasts sharply with the 10 per cent (approx.) of the households surveyed that feel primary and secondary schooling is inadequate. CCS users assessed schooling as adequate overall.[45]

Sixth, household heads were asked if members of their household had received skills training. Figure 9 below shows that this has occurred for little over half the households.

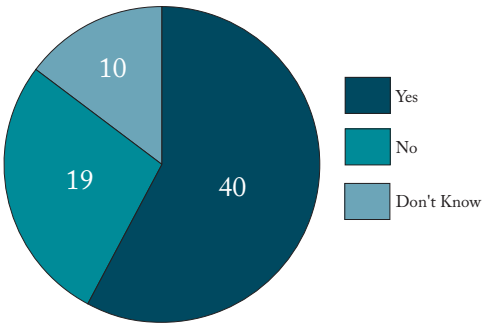

Figure 9. Skills training

Social relations forms the seventh developmental need assessed. Accordingly, household heads were asked to assess if social relations have improved or deteriorated within their household and among their wider family and friends over the past ten years.

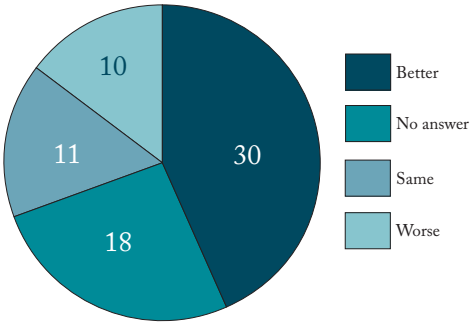

Figure 10. Social relations in households and communtiy

In furthering the evidence for the two trends, Figure 10 illustrates that over one-half of the households judge that social relations have improved or stayed the same (traditionally considered to be strong, as one of the few positive effects of *The Troubles*) during the past 10 years. Although a significant number did/could not answer this question, it is more insightful that 15 per cent (approx.) of those surveyed feel social relations have deteriorated.

43 Employment and leisure are the common reasons for going outside the community. 'Not often' is defined as less than once per week. Two caveats need to be noted here. Ten householders are not included in the above because it poor health and old age prevents them from being more mobile. This factor is also relevant to some of the 24 that claim not to leave often.

44 Focus Group 6, 25 January 2007; Focus Group 7, 25 January 2007.

45 Focus Group 6, 25 January 2007; Focus Group 7, 25 January 2007. Three household heads feel that they do not have sufficient knowledge to answer this question.

Supporting evidence for the above division across the seven developmental needs was also gleaned from the focus group and individual interviews, that is, among those that have come to specialise in the provision of social, health and economic welfare services.[46] Based on the two trends, it would be tempting to conclude that a class division (along social and economic lines, and in access to social services) has emerged during the processes of post-conflict development. However, such a 'comfortable' conclusion cannot be reached by this assessment because there is insufficient evidence and too many exceptions. For example, a long-time carer within a hostel (for vulnerable women) observes: "access to social services (the Housing Executive, schools and nurseries) for young mothers has improved over the past five years."[47]

Instead, the assessment uncovers another possible explanation, which in turn forms the third trend in developmental needs within Whiterock. To see it, we need to turn back to the issue of social relations within the community. While Figure 10 is important, it illustrates household heads' assessment of social relations in relation to their household *and* the community. As noted, '18' or nearly one-quarter of households did not provide a definite answer to the question. Towards a more complete understanding and as the third trend, Figure 11 below isolates the views on social relations at the community level.

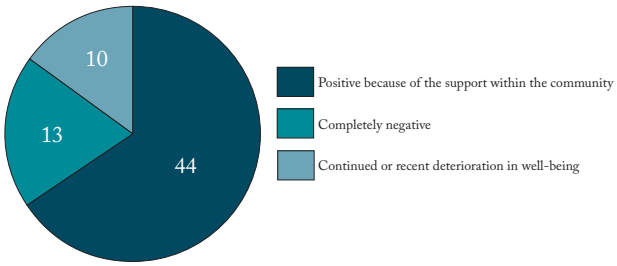

Figure 11. Social relations in the community

In sum, Figure 11 reveals a greater dissatisfaction with social relations at the community level although the fact that over one-half prioritise the community as a mechanism of support is not ignored by this assessment.[48] Before this though, it is essential to explore further the reasons for the dissatisfaction and perceived deterioration. For the ten household heads that perceive the latter, six blame the dispute/feud in Ballymurphy and the other four refer to a more general breaking-up of the community.

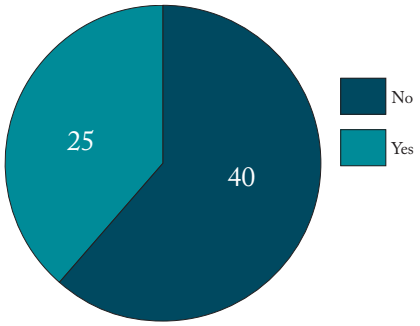

Figure 12. Other human needs

Further layers to this picture or trend are added with the answers to two questions that occurred later in the household survey, perhaps when household heads felt more at ease. Figure 12 shows a slight increase in those that felt they had other needs not raised by the survey.

The two common though unprompted answers are the perceived rise in anti-social behaviour and the intimidation from the dispute/feud.[49] Three CCS users identify the same needs while one does not identify any other needs.[50] Moreover, the second of the two questions directly prompted the household heads to specify their needs as a result of where they lived. Figure 13 below illustrates these needs.

Therefore, the third trend in developmental needs centres on two significant perceptions: potential strains within social relations at the community level; and the positioning of stress as a need at the level of

46 For example: Springwell House Interview, 5 March 2007; CCS Counselling Service Interview, 26 January 2007; CCS Welfare Advice Service Interview, 19 January 2007; Focus Group 5, 19 January 2007; Youth and Community Worker Interview, 2 March 2007. The existence and approximate level of these needs are also supported by the two main political parties: SF Interview, 8 February 2007; and SDLP Interview, 19 January 2007.
47 Focus Group 5, 19 January 2007.
48 Two household heads did not answer this question.
49 Four households did not answer this question.
50 Focus Group 6, 25 January 2007; Focus Group 7, 25 January 2007.

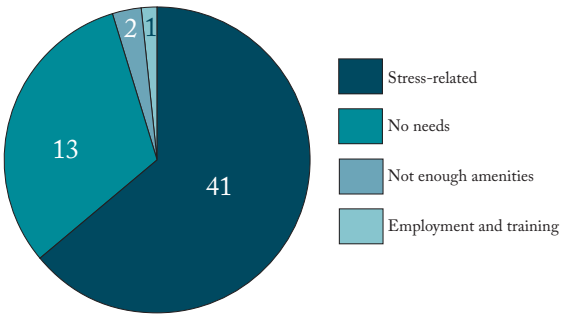

Figure 13. Needs from living in the community

the individual and/or household.[51] In particular, the latter encompasses a range of problems and proves prevalent across the six areas of Whiterock. Based on the nature of this trend and to understand it further, it is insightful to focus on mental health.

3.2 Mental health in focus

The following assessment of mental health considers the types and manifestations/symptoms of mental ill-health, vulnerable groups and sub-groups, main causes, and wider impacts. However, it must be appreciated from the start that overlaps occur, for example, low self-esteem can be a symptom of poor mental health and/or a wider impact while also acting as a cause of other and perhaps more acute mental health symptoms, such as depression. Nevertheless, these headings are ultimately useful in analysing and clarifying the nature of mental health within Whiterock.

3.2.1 Types and manifestations of poor mental health

First, building on the household survey findings stated above, there is overwhelming evidence from the service providers of poor mental health types within the community. On the one hand, it is evident based on the number of such patients and clients being counselled and treated by community organisations and the GPs. For example, CCS has been counselling for eight years and 83 individuals accessed the counselling service in 2006. Springwell House is at "full capacity" at the time of interview with "27 residents".[52] The North and West Belfast Trauma Resource Centre (TRC) notes that, "[n]early 100 per cent of our clients who attend this service present poor mental health needs", which amounts to 210 new clients per year.[53] The GP manager lists over 300 with varying symptoms (see below); and a GP similarly concludes that "the majority of our patients display […] both physical and psychological problems" that fall under the broad umbrella of mental health needs. The same GP asserts that a previous study had found "a high incidence of psychological problems in North and West Belfast".[54] Therefore, it is unsurprising that basic awareness of poor mental health types and their manifestations extend across every organisation and individual interviewed, including SF and SDLP.[55]

Second, respondents confirm that people within the community demonstrate both chronic and acute types of mental health problems. Depression is a common example of the former, with the GP manager recording "265 patients with severe chronic depression", in addition to "36 with dementia" and "56 severe mentally ill patients".[56] As detailed later,

51 Five household heads did not answer this question.

52 Springwell House Interview, 5 March 2007. The Ballymurphy Women's Centre and Springhill House have also started to provide 80 additional hours of alternative therapies (Upper Springfield/Whiterock Intervention Programme, 2007). Further evidence stems from the fact that some of the community counselling services were initiated based on previous needs assessments (CCS Counselling Service Interview, 26 January 2007). Certainly in this case, counselling is not donor-driven. Admittedly, not all these patients and clients necessarily reside in Whiterock but these figures hint at the total number of those affected in the community that have yet to be identified. More specifically, a GP manager cautions that their figures for depression are not accurate as "a lot fall through the net" (GP Manager Interview, 23 January 2007).

53 TRC Interview, 6 March 2007.

54 The GP is a member of the Total Purchasing Pilot which commissioned this review of health needs by the University of Ulster (GP 2 Interview, 23 February 2007). See Whittington and Thompson (2000). Sharon Campbell (Coordinator of EHSSB TAP) confirms the significant difference between the impact of trauma in Northern Ireland compared to the rest of the UK (Sharon Campbell Interview, 16 March 2007).

55 SDLP Interview, 19 January 2007; SF Interview, 7 March 2007. It is also emphasised in Focus Group Interview 1, 19 January 2007; and Youth and Community Worker Interview, 2 March 2007.

56 GP Manager Interview, 23 January 2007.

mental health is assessed as especially chronic because of the intergenerational cycles of trauma caused by *The Troubles*. However, while anxiety (fear or stress) is found by some to be acute[57], one of the GPs notes that it could also be "chronic", with it actually forming "our biggest mental health problem".[58] Sharon Campbell clarifies the discrepancy noting that symptoms can seem acute on the surface but may actually be chronic – remaining undetected for long periods of time "given the fear within and between the communities".[59]

Third, respondents typically refer to the other manifestations of both chronic and acute types, as ranging from psychological indicators ("poor" or "low" "self esteem", "paranoia", "personality disorder" "suicidal ideation") to more physical and detectable signs ("addiction", "self-harm", "poor physical health", and "suicide"). More colloquially, the signs are those who appear to be "on a short fuse" or "bad with their nerves".[60] Local teachers describe kids demonstrating "heightened levels of aggression", and a "lack of participation" as if children "were not sleeping properly". It was added that trying to teach and support these children then results in "[c]ontinuous low-levels of stress for teachers".[61]

3.2.2 Vulnerable groups and subgroups

It can be argued that those susceptible to mental health problems and needs broadly include all victims and survivors of *The Troubles*, which could entail the entire population of Whiterock. The reasons for this broad lens - the profound intergenerational impacts of the conflict and the extensive range of causes - are detailed below but for now it is useful to consider the evidence for specific groups and subgroups that are identified as particularly vulnerable, and to reflect on the validity of such categorisation.[62]

Over half the respondents interviewed hone in on "young people" because they are affected deeply by marginalisation and social exclusion (with emphasis on access to basic resources), in addition to experiencing directly and indirectly the effects of the thirty-year conflict. That is, some may be old enough to remember the tensions of the pre-ceasefire environment and/or seeing their older siblings and parents suffer from, for example, chronic depression.[63] It is believed that, worse still, "[m]any do not understand the conflict".[64] It is important to stress that there are many different connections made between this group and poor mental health, ranging from those who are "out on probation and have major psychological needs" to a much larger body of young people who "have a sense of not being able to do anything".[65] Significantly, respondents referred quite often to the emerging increase in suicide among young people.[66]

Three relevant subgroups of young people are identified. First, "young men" (16-18 years) come to the fore because of a perceived tendency for self-destructive behaviour, namely, drug abuse and a "drink culture", while one organisation believed that 16-17 year olds "seem to fall through a hole in the statutory provision".[67] Youth leaders identify a crucial

57 CCS Counselling Service Interview, 26 January 2007.
58 GP 1 Interview, 23 January 2007.
59 Sharon Campbell Interview, 16 March 2007.
60 Focus Group 3, 19 January 2007; Focus Group 4, 19 January 2007; CCS Welfare Advice Service Interview, 19 January 2007; GP 2 Interview, 23 February 2007; Springwell House Interview, 5 March 2007; TRC Interview, 6 March 2007; SF Interview, 7 March 2007; SDLP Interview, 19 January 2007.
61 The respondents only observe the latter effects on boys since so far girls have typically not displayed the effects until later in their adolescence (Focus Group 4, 19 January 2007).
62 While this report does not possess sufficient evidence to promote a prioritisation of vulnerable groups, it is important to reflect the insight and understanding of respondents at the local level.
63 SF Interview, 7 March 2007; Focus Group 1, 19 January 2007; Interview CCS Counselling Service Interview, 26 January 2007; Focus Group 3, 19 January 2007; SDLP Interview, 19 January 2007.
64 Focus Group 1, 19 January 2007.
65 Focus Group 3, 19 January 2007; and SDLP Interview, 19 January 2007, respectively.
66 Focus Group 1, 19 January 2007; Focus Group 2, 19 January 2007.
67 GP Manager Interview, 23 January 2007; and Whiterock Health Centre (WHC) Interview, 29 January 2007, respectively. Focus Group 4, 19 January 2007 agreed.

gap, finding that "11 year olds are full of life but with 16 year olds we feel like we are working with the dead".[68] This subgroup could in fact be part of a longer history of mental health conditions among families.[69] The second subgroup is "young mothers" because there is "not enough support" for their needs within the community.[70] The third subgroup "young children" and "young adolescents" could be interpreted as (though not restricted to) a direct consequence of the mental health needs of their parents – the first two subgroups (from 10 years ago).[71] This latter observation is made by the GP manager, who adds the "lack of support and help" in the home due to the "low educational attainment and depression" of the parents, and the strained capacity of the children's hospital.[72] Furthermore, the same respondent notes that as this third subgroup grow older, it is the "young mothers who are left to deal with an increasingly difficult body of youth […] as the older and more competent generation dies".[73]

Women in general form the second main group. Evidence comes from expert organisations that provide counselling and welfare guidance and the consistent observations of the SDLP and SF. Particular symptoms include "low self-esteem", "emotional problems" and "general poor well-being".[74] One focus group also agrees that "the wives of ex-prisoners" form a significant subgroup of women, who have less access to mental health services compared to their husbands.[75]

The last two vulnerable groups involve the elderly, and the "travelling community". They are different in that the former has care and welfare services available, for example, CCS provides a specific elderly care service. Nevertheless, the elderly are perceived to be particularly susceptible to mental health illnesses, in particular those who are housebound, isolated and lonely.[76] Only one organisation raises the travelling community as a vulnerable group but this lack of consistent evidence may simply reflect the actual exclusion of this group in general and in relation to mental health needs. The organisation adds that their awareness is recent, with women in particular coming to use their services for the first time. Symptoms include "even lower self-esteem" (compared to women in the settled community) and frustration due to illiteracy.[77]

As raised at the beginning of this analysis, approaching mental health needs by grouping types of vulnerable people poses risks. Above all, it can lead to an over-simplification of these needs simply because a list of categories, like the one used above, will never be exhaustive. For instance, this assessment is fully aware of the inevitable constraints in identifying vulnerable groups and subgroups. Perhaps some were not raised during the focus groups and individual interviews because they have not been identified properly based on the challenges to uncovering mental health needs. Alternatively, some subgroups may not have been talked about openly because of the associated stigma within the community.[78] A similar constraint may have occurred when it came to exploring in detail ex-prisoners as a subgroup. There are undoubtedly

68 Focus Group 2, 19 January 2007.
69 Focus Group 4, 19 January 2007.
70 Focus Group 5, 19 January 2007.
71 Focus Group 3, 19 January 2007; CCS Counselling Service Interview, 26 January 2007. Focus Group 3 refers directly to children as young as 4-6 years old (Primary 1 and 2) in one of the local schools.
72 Youth leaders concur that the "majority of young people have low motivation" (Focus Group 2, 19 January 2007).
73 GP Manager Interview, 23 January 2007; CCS Counselling Service adds that depression and anxiety states form the under-addressed mental health issues for parents, and the resultant weaknesses in parenting has left the youth in the community "rudderless" (CCS Counselling Service Interview, 26 January 2007).
74 Focus Group 3, 19 January 2007; SDLP Interview, 19 January 2007; SF Interview, 7 March 2007.
75 Focus Group 3, 19 January 2007.
76 Focus Group 3, 19 January 2007.
77 WHC Interview, 29 January 2007.
78 For example, while young people are undoubtedly a vulnerable group based on an objective analysis of the data, it must be noted that this emphatic evidence came mainly from representatives of the community organisations, GPs, institutions and political parties. Of course, many of these people are the parents of, or at least feel responsible for, the young people within the community. Therefore, it would have been insightful to ask young people who they thought formed the vulnerable groups within their community. The point is that it is essential to consider 'who' and 'why' does the identifying when it comes to establishing an accurate picture of vulnerable groups. Denial will inevitably exist at the levels of the individual and his/her peers.

former prisoners within the community but these subgroups (men and women) were not discussed in detail by respondents and the assessment was unable to reach them directly. This could have been the result simply of unfortunate/constrained timing on the part of the assessment or it may have reflected that this subgroup was difficult to access in a number of different ways and for well-founded reasons.[79]

Moreover, categorisation inevitably fails to recognise the complexity of a person's background and the potential layers of problems and needs. For instance, it is reasonable to assume that there are young women who are also the wives of ex-prisoners, and of course some of these may not have mental health needs for a variety of reasons. Therefore, selective lists and the inaccurate one-size-fits-all labelling of groups and subgroups could unintentionally lead to the undesirable design and delivery of services that do not reflect actual needs, and a hierarchical approach to addressing and meeting mental health problems and needs. In addition, it is difficult to see how the boundaries set by such categories will lead to a more open and informed discussion on mental health within the community and thus to the de-stigmatisation of such problems and needs.

Therefore, without contradicting the preceding evidence, this assessment still accepts that the categories like the ones above are valuable but perhaps limited to a rudimentary approach to understanding mental health needs and in introducing the depth and scope of the demand for service provision. In order to appreciate completely this conclusion, it is essential to examine the past and ongoing causes of mental health needs within Whiterock.

3.2.3 The cycle of violent conflict as a cause

> Our house was always getting raided, my brother before he died was in jail, the army and police used to come all the time.[80]

The assessment finds that the cycle of violent conflict forms one of two complex and interconnected causes of mental health problems and needs. As outlined in the Introduction, the first part of this cycle consisted of *The Troubles*, which created extensive immediate and long-term impacts for the residents of Whiterock. Figure 14 below isolates the main specific impacts on the 69 households surveyed.

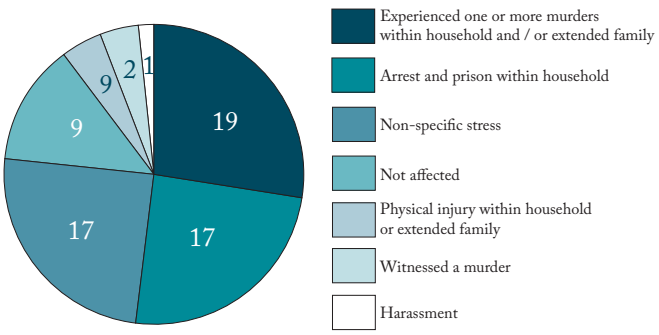

Figure 14. Impacts of *The Troubles* on households

It is important to note that the above impacts represent the first and most significant impact that each householder refers to. Therefore, many of the household heads (apart from the 9 not affected) list more than one impact from *The Troubles*, thereby demonstrating the layers of impacts as a result of the violent conflict.

The individual interviews and focus groups add how, at the personal level, direct causes include physical injury, various forms of intimidation, and imprisonment in addition to witnessing and having family members and friends murdered, injured and

79 At the same time, the fact that ex-prisoners are not raised as a vulnerable subgroup may also suggest that their mental health needs are being addressed, as mentioned during one focus group interview above.
80 Whiterock household head.

imprisoned. Practice-based evidence proves that such brutal trauma has resulted in numerous emotional and psychological conditions (in particular, anxiety (fear, stress, and nervousness), grief, loneliness/isolation, and paranoia), which can be acute or chronic in nature. Even for those that are not scarred by the more obvious effects of the protracted conflict, it would have been near impossible to escape the attritive effects of intimidation and other pressures (for example, disenfranchisement) from living in a community that frequently, though unpredictably, experienced rioting and the destruction of infrastructure, not forgetting the regular stop-and-searches, arrests, and house raids. In sum, the residents of Whiterock grew up in a community at war with the state, which became a hotbed for mental health problems and needs.

All of this is supported by statements from household heads in all six of the areas. For example:

> Army raiding home – disturbing children, frightening children, wrecking the home - no consideration very unpleasant. I witnessed shootings and violence – a soldier being shot dead. My husband was never at home – he was active in the struggle. Jailed also. My nerves are bad – lived on my nerves – they shot us out of our first flat.[81]

> I lost my brother. He was a victim of the Shankill Butchers. I had to identify his body, I have never been able to talk about that day, or never will. When I close my eyes I still see that awful sight that met me when I identified my brother – that is all I am saying.[82]

> I was shot – left paralysed down my left side; it was a sniper in Corry's timber yard. My neighbour was also shot. He died leaving a family of seven kids and a wife. I have never been able to work. I don't go out any more.[83]

> I do not feel as anxious now but the impact of the conflict has left an impression on me.[84]

The Troubles has also indirectly caused mental health problems and needs. This causal relationship is much more difficult to define and is beyond the scope of this assessment. Nevertheless, it is sufficient to note that the unstable environment outlined above contributed to sustained unemployment, alcohol abuse/addiction, domestic violence and other forms of tension within families which led to dysfunctional relationships and the break-up of marriages. In particular, many of the organisations refer to the prevalent addictions to prescriptive drugs, which were given by GPs to mainly women most likely as a short-term 'switch-off' measure to prevent depression. As the cycle of conflict perpetuated, the dependency on anti-depressants and other medication grew as people tried "to just get on with things".[85] The households surveyed echo this indirect relationship and the resultant dependency on prescribed medication. For instance:

> I don't go outside the area, never have, over the years, have spent some time in and out of hospital, had drink problems, but I'm starting to get help and now have my grandchildren.[86]

81 Ballymurphy household head.
82 Whiterock household head.
83 Springhill household head.
84 New Barnsley/Springfield household head.
85 CCS Welfare Advice Service Interview, 19 January 2007; SDLP Interview, 19 January 2007; Focus Group 1, 19 January 2007; Focus Group 3, 19 January 2007; TRC Interview, 6 March 2007; GP 1 Interview, 23 January 2007; Springwell House Interview, 5 March 2007; CCS Counselling Service Interview, 26 January 2007. Many of the 41 household heads that claim stress-related needs (see Figure 13) mention that they are using prescribed medication.
86 Whiterock household head.

> I take medication; have tried to come off it but I end up feeling worse. My medication helps me cope. I would never get out of bed in the mornings if I didn't have my medication.[87]

> Yes, I had a nervous breakdown and was hospitalised for six weeks. It caused my family and me a lot of stress. I still take medication for my nerves.[88]

> I am bad with my nerves but living here gives me more confidence although I don't go out much without my medication.[89]

With the ceasefires in the mid-1990s and the new drive for peace and development under *The Agreement*, many though not all of the direct causes above have gradually phased out. Regardless, the mental health problems and needs overall remain unaddressed and thus continue. For example, some people are still addicted to anti-depressants while for others the trauma remains the fulcrum in their lives. Although the post-conflict phase has brought numerous and wide social and economic benefits, peace seems to have been a shock in several ways and consequently people have found it "difficult to cope". A worker in the community recalls how one resident remarked that, "'I could cope with the war; it is the peace that I cannot manage'". There is practice-based evidence that the inability "to handle peace" is multi-levelled and forms "trans-generational trauma", that is, 'the children of *The Troubles* have become the parents in the community in the wake of the ceasefires and *The Agreement*.'[90] Accordingly, the initial emergence of relative stability and security were not considered normal and new challenges came with the demand for daily adjustments and long-term change. As two respondents neatly summarise:

> After the conflict was over, a lot of people got depressed even people who had not suffered greatly during the conflict. It seemed it was only then that we realised what we had gone through. It was easier to cope with someone dying in *The Troubles* than after them. We seemed to be more hyped-up during the conflict nothing affected us.[91]

> We just got on with it before. I didn't realise the post-conflict would be so difficult to adjust to until now.[92]

The Troubles itself represented a formidable cycle of violent conflict but just as people within the community had the opportunity to adapt to and enjoy relative peace, a further cycle has emerged in the form of the dispute/feud within Whiterock, with particular impact on the residents of the Ballymurphy area. The reasons for this new conflict are not the concern of this assessment but there is no doubt that it has become a direct and indirect cause of mental health problems and needs, as alluded to in subsection 3.1. First and crucially, the form and manifestation of the violence are very different from that experienced during *The Troubles*. While there have been one murder and numerous attacks, the violence has consisted mainly of low-level though persistent intimidation between opposing sides and the systematic destruction of the 'middle ground', from the local primary schools to homes within the area.[93] In other words, the reductive mindset that has driven internecine communal conflicts across the world – 'choose a side or one will be chosen for you' – has returned to Whiterock but this time the two or more sides lie *within* the community. Even the two names for the violence are opposites and thus generate ambiguity and uncertainty.[94]

87 Whiterock household head.
88 New Barnsley/Springfield household head.
89 Falls household head.
90 CCS Counselling Service Interview, 26 January 2007.
91 Focus Group 6, 25 January 2007.
92 Focus Group 7, 25 January 2007
93 One set of respondents recall how the mothers of one family had spat into the prams carrying the babies of another family outside a school in the area (Focus Group 4, 19 January 2007).
94 For the author, a 'dispute' suggests a logical or discernible disagreement over conflicting rights and/or interests. A 'feud' denotes a more deranged, bitter and nonnegotiable form of hostility.

The recent nature and heightened sensitivity surrounding the feud prevents a detailed analysis. Nevertheless, at this initial stage there is evidence to suggest that the violence has already built upon the mental health problems and needs caused by *The Troubles* while also adding some new. One of the local GPs describes:

> The cause of chronic anxiety also has it roots in the post-conflict feuding. Families feel unsafe. We have even had problems in the surgery where contending families have been using our services in the surgery or from sitting in the waiting area.[95]

Such direct links were found in the household surveys, for example:

> I do not bother with anyone now but years ago as I was growing up it was a good place to live… I am bad with my nerves as I and my son are the only ones in the house and I worry more at weekends with the scum that are ruining our community.[96]

More indirectly, the pernicious nature of the violence is judged to be a contributor to mental health needs because it has created a palpable increase in tension and fear. There is consensus that the latter are uncontrollable and make the community feel helpless since it is still struggling to make sense of the violence, never mind develop viable solutions.[97] The following statements by three household heads exemplify this anxiety.

> I would like things to return to normal in Ballymurphy[98]

> I would like to see an end to all the trouble going on in Ballymurphy. Old people are being tortured in their own homes. Something needs to be done.[99]

> Hopefully the fighting stops in Ballymurphy. We need peace on our streets.[100]

Moreover, many respondents feel that the emotional and psychological well-being of some within the community is now *worse* compared to during *The Troubles*.[101] This is for two reasons. First, some residents claim not to have experienced trauma during *The Troubles* but have developed mental health problems and needs as a consequence of the dispute/feud.[102] Second, the perception that mental health problems and needs have deteriorated comes from those that have suffered from both the thirty-year conflict and the dispute/feud.[103] Local teachers remark: "[w]e could deal with the pressures of the 1970s but we cannot deal with this"[104]

3.2.4 Intergenerational deprivation as a cause

This assessment finds that social and economic deprivation is the second of the two main causes of mental health needs and problems. First, it is important to appreciate that both factors of deprivation are intergenerational. Moreover, deprivation has a longer tradition and legacy compared to *The Troubles*

95 GP 1 Interview, 23 January 2007.
96 Ballymurphy household head.
97 One focus group agrees that some of the staff are at times too afraid to enter certain streets to carry out their work because of the feud/dispute, thereby creating a double impact on mental health (Focus Group 3, 19 January 2007). As both factions send their children to the same primary school, intimidation within and between classes has been observed. For some, schooling has been disrupted in this way and through the staggering of classes in order to prevent physical confrontations (Focus Group 4, 19 January 2007). The Healthy Living Centre programme, within the USDT, aims to enable additional counselling sessions and to enhance the provision of the Stress Clinic in response to the heightened needs overall (Upper Springfield/Whiterock Intervention Programme, 2007).
98 Whiterock household head.
99 Springhill household head.
100 Springhill household head.
101 Focus Group 3, 19 January 2007; Focus Group 5, 19 January 2007; GP Manager Interview, 23 January 2007.
102 CCS Welfare Advice Service Interview, 19 January 2007. The fact that some people in the community claim not to have suffered considerably during *The Troubles* should not detract from the profound impacts of this protracted violent conflict. As detailed in the Introduction, conflict affects people in different ways. Furthermore, the instances of positive effects at the societal level from *The Troubles* are explained below.
103 The latter observation caused one of the GPs to conclude broadly that "the main mental health problems are related to both *The Troubles* and the feud" (GP 1 Interview, 23 January 2007).
104 Focus Group 4, 19 January 2007.

and could thus be considered a more entrenched determinant of mental health. In terms of economic factors, respondents refer to the stubborn impacts of "second and third generation unemployment", the resultant dependency on state benefits, and "poor housing and social conditions".[105] In addition, one of the political parties observes that "some women don't work because they are looking after their families and some of these may also be taking anti-depressants".[106] Despite the prevalence of noted benefits, two respondents feel that the state has been completely neglectful when it comes to addressing mental health issues. One GP specifically challenges that, "mental health is poorly served due to historical funding issues and is orientated to a hospital bed consultant service", while the TRC notes, "a general lack of government initiatives."[107]

Although *The Troubles* brought social cohesion and many other such benefits to the community, in terms of long-term social development then the overall impact is deprivation, which many respondents consider an equally significant driver of mental health.[108] In other words, traditionally there is a strong sense of community but residents invariably have felt trapped at the bottom of a class structure, remaining insulated and isolated from other communities. Poverty has endured because "low educational attainment led to low self-esteem and prevented people from seeking work."[109] A respondent, who has extensive teaching experience in the community, recalls a common phrase that people from other parts of Belfast used in the past: "if you come through the Murph [Ballymurphy] you are no good'".[110] Clearly, this perception still resonates today even among residents, with one stating: "only rich people get good jobs or have any future."[111]

Perhaps the most significant and timely inquiry when it comes to understanding the relationship between deprivation and mental health is whether economic and social needs have improved and if these improvements have ameliorated mental health problems and needs. Only three expert respondents observe no change in the causes. A GP notes:

> …the causes are enduring and have not changed during the 30 years of my career. The morbidity and mortality continue at unacceptable levels and are for the most part preventable due to lifestyles.[112]

Therefore, the majority of respondents believe that economic and social needs overall have improved slightly and thus changed in noticeable ways. Accordingly, some of these respondents consider that the mental health for some within the community has improved as a direct result. For example, Focus Group 4 refers to positive change, with the significant example of "better housing", and the re-generation of New Barnsley where the "streets have been cleaned up and now there is a sense of pride about the place".[113] Moreover, this gradual alleviation is supported overall by the household heads, as Figure 15 illustrates.

However, at the same time, Figure 15 shows that nearly one-half of households feel that their mental health problems and needs are the same or have deteriorated (since the ceasefires and *The Agreement*) with one-third claiming the latter. Crime and the feud are the two recurring reasons for those that do not perceive an improvement. In addition, the TRC cautions that some clients find it hard to cope with any change in their living environment and circumstances.[114] In other words, this demonstrates that an improvement in an individual's economic and social needs does

105 Focus Group 1, 19 January 2007; Focus Group 3, 19 January 2007; GP Manager Interview, 23 January 2007. Focus Group 4, 19 January 2007 concurs.
106 SDLP Interview, 19 January 2007.
107 GP Manager Interview, 23 January 2007; GP 2 Interview, 23 February 2007.
108 SF Interview, 7 March 2007; TRC Interview, 6 March 2007. A GP believes it is better to consider "deprivation in the broadest sense, including lifestyle issues" (GP 2 Interview, 23 February 2007).
109 WHC Interview, 29 January 2007.
110 Focus Group 5, 19 January 2007.
111 Focus Group 6, 25 January 2007.
112 GP 2 Interview, 23 February 2007. The other two were TRC (Interview, 6 March 2007), and Springwell House (Interview, 5 March 2007).
113 Focus Group 4, 19 January 2007.
114 TRC Interview, 6 March 2007.

not necessarily improve an individual's mental health needs. In fact, these improvements can be trumped by other factors such as crime and intimidation. Springwell House reminds that it really depends on "individuals, resources and interventions".[115] More specifically, this assessment uncovers two types of social deprivation that help explain why the mental health needs of nearly one-half of the households remain the same or worse despite an improvement in developmental needs overall.

The first new damaging type of social deprivation is the erosion of the community's cohesion – its sense of purpose or social capital. Until the late 1990s, people in Whiterock were united in several ways. This

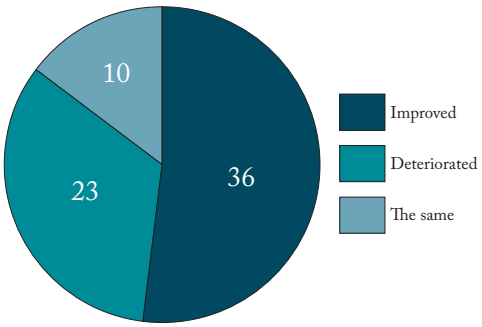

Figure 15. Status of mental health problems and needs

report unfortunately cannot detail the richness in this cohesion but it is sufficient to note that the main connectors included strong familial and religious values, vibrant social identities and enshrined cultural traditions. At the same time, people were also united and driven by *The Troubles* and a powerful sense of resistance, although to varying degrees within the community. A CCS counsellor reflects that the popular support for the cause "focused and united the community".[116] Accordingly, the ceasefires and *The Agreement* have defused the latter sense of communal survival and purpose along with a clear sense of a common enemy, which in turn has created a vacuum within Whiterock. Several respondents conclude explicitly that, "[w]e have lost our social cohesion – there is no 'togetherness' anymore", "[p]eople need a sense of belonging within the community", and "now we don't have any purpose or philosophy.[117]

The timing and benefits of social and economic development during the post-conflict stage have also opened the community to new uncharted processes. The pervasiveness of marketisation and the decline in welfarism had already started in Belfast like other parts of Ireland, the UK and elsewhere but it was the ceasefires and *The Agreement* that cemented these processes through an acceleration of international investment and economic growth. The opening up of 'no go' areas had proximate and ripple effects. Communities overwhelmingly voted for peace but perhaps were less informed and prepared in adjusting to the 'more globalised' changes that came in tandem. As in other urban centres, from Dublin to Rio Janeiro, the underlying values and core ideas of communities have been both suddenly and gradually reshaped and restructured.

There have been manifold impacts but it is the perceived growth in materialism and its impact on individual, familial and societal 'identities' that comes to the fore during this assessment. Some respondents argue that the family unit is fundamentally weakened with familial relations becoming "more transient" and with less stability in the home.[118] Another set of respondents believe the family unit has become "worthless and demoralised."[119] Of course, the family unit in general in Whiterock was under immense strains during *The Troubles* but it was the conflict, economic deprivation, the prominence of the Church in life, and traditional religious values that had kept it together overall. A resident reflects:

> I enjoy living here in Ballymurphy - good neighbours - lived here all my life. It was more of a community years ago than it is now. Mothers' Social Group - I enjoyed for many years. Local Bowling Club for 30 years.

115 Springwell House Interview, 5 March 2007.
116 CCS Counselling Service Interview, 26 January 2007.
117 CCS Welfare Advice Service Interview, 19 January 2007; Focus Group 5, 19 January 2007.
118 Focus Group 4, 19 January 2007; Focus Group 5, 19 January 2007. In agreement: Springwell House Interview, 5 March 2007; and CCS Welfare Advice Service Interview, 19 January 2007.
119 Focus Group 1, 19 January 2007.

> My husband was politically active minded *[sic]* and I was not. I was afraid to speak out. It was difficult during *The Troubles*. I kept to myself.[120]

The same two sets of respondents above add that materialism and the resultant irrelevancy of the church and Catholicism has created detrimental impacts at the societal and individual levels; ranging from though not limited to a, "poverty of the soul" to an "absence of male role models".[121] A GP concurs that while "people now have money in the community", they "do not have the skills to use it wisely or to access the help that they may need."[122] Therefore, it can be concluded that the main traditional coping mechanisms with the community, that had ensured its strength during *The Troubles*, have become undone in the post-conflict phase.

The second main type of social deprivation is the consensus among respondents and householders that people within the community have so far felt less safe during the post-conflict period as a direct result of crime. References were consistently made in the interviews and the surveys to the daily challenges posed by vandalism, drugs, anti-social behaviour and a fear of youth in general.[123] For example:

> My needs are met and I am looked after but I feel more threatened. Kids now days would not think twice of stabbing you.[124]

> My nerves are bad because there are too many children. I don't know, maybe it's because during *The Troubles* we made it our business to know the kids in case they got into trouble and we could help them.[125]

Moreover, in mirroring wider debates in other parts of Ireland and the UK, these references consistently perceive crime to be 'spiralling out of control' since the end of *The Troubles*. Statistics can be used to support or negate this perceived increase but such indicators are selective by nature and difficult to trust considering the challenges to establishing such information in general and in post-conflict. Alternatively, it is certain that the conflict in many ways prevented crime from occurring because of the level of social cohesion and the pervasive control mechanisms imposed by the state (police and military) and non-state/paramilitary forces. This led to one set of respondents lamenting that in many ways "[i]t is a pity that *The Troubles* stopped".[126] Such comments may appear a little strange on the surface so it is worth including the following explanation of another respondent who is also receiving counselling from one of the community organisations:

> We felt more safe [*sic*] during *The Troubles*… there was a war on, people were scared to do drug dealing but they are not now. Children are out of control; they have no fear. Parents now do not know what they are doing. Before the IRA [Irish Republican Army] controlled the youth and kids; now parents do not know how to. The kids themselves were involved in the conflict and had a sense of purpose; now they have nothing. The political situation is all over the place and that creates anxiety. We cannot trust the police.[127]

This observation is supported by youth leaders and other experts who warn that "the young people are in a dire situation […] and have reached bottom of

120 Ballymurphy household head.
121 Focus Group 4, 19 January 2007; Focus Group 5, 19 January 2007.
122 GP Manager Interview, 23 January 2007. Focus Group 4 (19 January 2007) note that the average disposable income is far greater now.
123 SF Interview, 7 March 2007; Focus Group 3, 19 January 2007; Focus Group 7, 25 January 2007; Focus Group 6, 25 January 2007; Youth and Community Worker Interview, 2 March 2007; CCS Welfare Advice Service Interview, 19 January 2007. Respondents in Focus Group 5 (19 January 2007) report a, "fear of children (aged 10, 11 and 12) hanging around the road on a Friday and Saturday night. The elderly are too afraid to go out – it can be threatening – some windows have been broken in the hostel. People are afraid to challenge them; there is a lack of authority".
124 Falls household head.
125 Falls household head.
126 Focus Group 4, 19 January 2007.
127 Focus Group 6, 25 January 2007.

the barrel", "growing up without society, no means to move forward" and "no support structures."[128]

Therefore, with the traditional mechanisms reduced and in many ways withdrawn, it is easy to understand how crime and perceptions of crime have found the space to develop and increase. More important than the outcome of this debate and with a focus on mental health, it ought to be realised that the popular perception of an increase in crime can be equally as destructive as the immediate impacts that it creates at both the individual and societal levels.

3.3 Impacts of mental health

So far the analysis has already provided insight into the impacts of mental health problems and needs within Whiterock through examining the different types and symptoms of mental ill-health, the existence of vulnerable groups and subgroups, and through exploring the two main causes. Nevertheless, it is necessary to concentrate on the wider impacts within the community, as described by the respondents and household heads, by drawing together the main findings and emphasising how exactly the impacts and the causes are mutually-reinforcing and the three main levels where needs reside. This analysis ought to be particularly valuable for the response since in-depth community-wide evidence is still being refined.[129]

Primarily, mental health problems impact at the personal level creating individual-based needs. For example, the CCS Counselling Service raises the pattern of passiveness: "[t]here is no mental energy to identify your own needs and to work out a solution […] it is easier to accept things than to confront them".[130] This mentality is also demonstrated through the weaknesses in social mobility, which means that people will not leave the community for work or leisure.[131] These issues demand counselling and medical treatment for psychological and emotional disorders (across all age groups) as a result of the cycle of violent conflict, and/or social and economic deprivation. Of course, these needs ultimately should be prevented from occurring, which depends greatly on improved security. Similarly, an equitable access to social services, and the opportunities to get involved in sports and leisure activities are both prerequisites to good mental health.[132] Furthermore, mental health problems hinder individuals from developing socially and economically. Consequently, "parenting skills" and work-based training represent the practical needs for adults and young adolescents.[133] Activities that provide children and teenagers with "self-worth" ought to come with early interventions.[134]

Following from this, it is also clear that mental health needs reside at the level of the family. The assessment finds that the family unit, like the wider community, has also reached a post-peace agreement juncture. Before and during *The Troubles*, the family unit was the cornerstone of the community and overall provided informal support to its members where mental health needs arose. As argued above, in the wake of the ceasefires and *The Agreement*, one of the main drivers of family cohesiveness has been removed while emerging social and economic processes have introduced a reordering of values and core ideas that weaken the relevance of the family in the context of a more modern society.[135]

128 Focus Group 1, 19 January 2007; and Focus Group 4, 19 January 2007. One example is the lack of leisure services. It is noted that Whiterock Leisure Centre had introduced "midnight soccer" for kids, which had provided an important alternative for young people. At the time of the assessment, it is believed that this initiative has stopped due to insufficient funding (Focus Group 2, 19 January 2007).

129 Staff from the TRC acknowledge that the "assessment of the wider impacts and knock-on effects is ongoing" (TRC Interview, 6 March 2007). Sharon Campbell concurs though hopes that processes associated with the Historical Enquiries Team will be informative (Sharon Campbell Interview, 16 March 2007). Focus Group 4 (19 January 2007) believes that "[o]ne of the causes is mental health needs not being properly defined and understood".

130 CCS Counselling Service Interview, 26 January 2007.

131 Focus Group 4, 19 January 2007.

132 For example, youth leaders observe the stark differences in the mental health (and wider needs) of children involved in regular sports activities compared to those that do not have these outlets (Focus Group 3, 19 January 2007).

133 Focus Group 1, 19 January 2007.

134 Focus Group 4, 19 January 2007.

135 Drawing upon practice-based evidence, a CCS counsellor describes how an individual's "inability to manage their own lives to their own and their family's best advantage" form significant threats to the wider cohesion of the family group, and with "this accumulation of stress" having "a ripple effect out into the community." (CCS Counselling Service Interview, 26 January 2007).

Third, this assessment also discerns that mental health problems and needs exist at the community or structural level, which permeate through primary and secondary schools, work places and civil society groups. The primary trauma from *The Troubles* and deprivation combined with secondary traumas under the post-conflict environment are both having large 'dismantling' effects on the community. As noted, there is consistent evidence that the community as a whole has reached a critical stage in its development. Accordingly, needs exist within professional and communal settings and also centre more broadly in terms of the community's purpose and identity; common goals are either unclear or simply absent. Therefore, a response to these sets of communal needs must address the systemic gaps. Equally, it ought to build upon the many positive notions of community identity that can be maintained and recovered while also respecting how the community has moved on and in anticipation of further changes.

The challenges posed to addressing mental health problems and needs on these three levels cannot be overstated. Such challenges simply reflect the bottom-line finding of this assessment that poor mental health is prevalent and needs are complex within Whiterock.[136] Moreover, the difficulty in gaining access to mental health at each of the three levels proves a formidable barrier for the response. Respondents consistently refer to this challenge which pinpoints an underlying need: the stigmatisation of poor mental health. This is traced back to the tradition of suppressing problems under *The Troubles* (resistance and inwardness), the hardship in general (insular backgrounds and weaknesses in schooling), and notions of 'internalising' passed down by the Catholic Church.[137] It would also be a mistake to neglect the impact of wider traditional or patriarchal values. Unsurprisingly, several counselling experts emphasise the specific reluctance of young men "to go near counselling and alternative therapy".[138] For young people, access is constrained since it is "very difficult to see and understand what is going on inside their head" with many displaying "a siege mentality from within". For younger children, important protection measures automatically take priority.[139] Last, it must also be remembered that mental health forms one component within a broad spectrum of developmental needs, complicated further by the fact that the full range of needs are interlinked, yet the causal linkages are uncertain.[140]

Despite these challenges, this assessment also uncovers a number of important opportunities in developing an adequate response to mental health needs. First, several local organisations involved in counselling observe a recent ripening in some people's willingness and ability to talk about their mental health needs and problems.[141] Second and in relation to the dispute/feud and in contrast to during *The Troubles*, now at least there is a diverse range of mental health services in place and an increasing recognition within the community that this support can be trusted and used. Third and in strengthening the former, the weakening of the family unit may also make professional and long-term intervention more acceptable. Fourth, people within the community have had ten years to adjust to the post-conflict reality. As one focus group concludes: "now people have to focus on their own needs - they don't have a choice".[142] Fifth, that this assessment occurred and the wider realisation that mental health is a crucial and complex set of needs suggests that a more concerted effort and deliberative understanding is growing among service providers, donors and local leaders. Last, it is always important to remember that

136 Sharon Campbell concurs that needs would exist at all three levels but that ultimately it depends on the experience of the individual and the opportunities that they have taken/sought/been given for post-traumatic growth (Sharon Campbell Interview, 16 March 2007).
137 Focus Group 1, 19 January 2007; SDLP Interview, 19 January 2007; Focus Group 3, 19 January 2007; Focus Group 5, 19 January 2007.
138 Focus Group 2, 19 January 2007.
139 Focus Group 5, 19 January 2007; and Focus Group 1, 19 January 2007, respectively. Of course, the assessment is aware that the reluctance to seek help may itself be another manifestation of trauma.
140 The links are detailed above but trauma is coupled with other vulnerabilities such as poor health, unemployment, underachievement and addiction (CCS Welfare Advice Service Interview, 19 January 2007). This is in-line with mainstream opinion. For example, Sharon Campbell defines needs generally as the complex impacts arising from conflict-related trauma. The respondent also recognises the interconnections between acute, chronic and ongoing needs as communities move forward (Sharon Campbell Interview, 16 March 2007).
141 Springwell House Interview, 5 March 2007.
142 Focus Group 4, 19 January 2007.

people are resilient and the residents of Whiterock are certainly not an exception.[143]

In conclusion, there are three trends in developmental needs within the community. The first two reveal a division among residents, involving a majority who consider that their needs have improved during post-conflict, against a large unsatisfied minority in this respect. The third trend signifies significant specific dissatisfaction with social relations within the community, which was linked to stress-related needs. In exploring further the latter trend, this assessment finds that mental health problems and needs prevail within Whiterock, with an array of types and manifestations of mental ill-health. Vulnerable groups and subgroups exist but it is asserted that the use of such categories has limited value when considering the complexity of mental health. While consideration of the violent conflict and the intergenerational deprivation verifies the individualised trauma, the analysis of these two root causes equally reveals a more profound communal form of loss, damage and insecurity. In sum, mental health problems and needs are layered and continue to mount because primary traumas remain and more recent traumas have emerged through the new cycle of violence and social deprivation.

Based on these challenges and keeping in mind the opportunities raised above, it is appropriate to turn now to the community level response to mental health.

143 Despite the fear of youth explained above, one educator reminds that, "all considering, it is a miracle that children are as good as they are." (Focus Group 4, 19 January 2007).

4. The Community Level Response to Mental Health

In Whiterock, there is already a developed and active response to addressing and meeting mental health problems and needs. GPs, community organisations, statutory agencies, schools, political parties – not forgetting family and friends - are all playing a role directly through the provision of medication, counselling, alternative therapies, and in tackling other interconnected needs with various services and other forms of support. Accordingly, in assessing the community's needs, it is incumbent to include the local-level response to mental health by identifying some of its achievements, and in pinpointing the main weaknesses in terms of both policy and practice.[144]

It is crucial to underline that this section does not formally evaluate the community level response to mental health. This complex task undoubtedly lies far beyond the scope of the assessment. Instead, the analysis of the response is grounded in the local service providers' self-critiques, the household surveys, and the experiences of a small sample of service users. The data from each of these three channels is compared and contrasted throughout in order to identify several distinctive patterns.

Although rudimentary, to include a 'self-assessment' of the local response is also essential since such service providers form an integral part of the community. Therefore, a review of their professional needs is necessary for conceptual and pragmatic reasons towards developing a comprehensive understanding of the community's needs. In other words, the needs of service providers and residents are interdependent.

4.1 Roles of service providers

The assessment uncovers two main strengths in the roles of service providers: the diversity in the service provision; and their uniquely close relationship with users and residents.

4.1.1 A diverse local response

Based on the data gathered, there are currently a range of programmes, projects and activities aimed at directly improving mental health. It is useful to focus on four of the main services: medical treatment; counselling; alternative therapies; and the broader area of welfare.[145]

As the first part, medical treatment primarily involves medication and psychiatric care.[146] As one of the GPs describes:

> We have always employed our own practice-based psychiatric nurse and CBT [cognitive behavioural therapy] therapist, which require the partners to invest their own funds. It is available to all our patients.[147]

Medical treatment is also available through the WHC, which consists of Community Psychiatric Nurses (CPNs) and social workers as "part of the statutory system", caring for both "severe and chronic mental health needs […] of those aged between 18 and 65 years."[148]

Counselling for psychological needs forms the second service and seems to be increasing, especially among, though not restricted to, community organisations.[149] Clients aged 18 or over will either stem from referrals (from GPs, statutory

144 Regrettably, it is beyond the scope of this assessment to consider the local response to all developmental needs.
145 This assessment attempts to include (directly and indirectly) all the relevant local actors within Whiterock. Of course, this has not been possible for practical reasons. Therefore, although the range of services and their providers outlined below can claim to be representative of the community, it is appreciated that not every actor has been included.
146 GP Manager Interview, 23 January 2007.
147 GP 2 Interview, 23 February 2007.
148 WHC Interview, 29 January 2007.
149 Organisations include CCS since 1999, TRC, and the USDT's Healthy Living Centre since 2003 (CCS Counselling Service Interview, 26 January 2007; TRC Interview, 6 March 2007).

organisations, and other organisations) or may come to the organisations directly.[150] There are two crucial defining aspects to counselling by community organisations in Whiterock: a number of clients do not reside within the community;[151] and the service is not "time limited" since it recognises that trauma does not have a quick solution.[152] As well as a general service, counselling can also be specialised for those considered at high risk of suicide.[153]

The third main type of service is alternative therapy, which similarly appears to have increased in recent times. This involves complementary alternative medicines, and occupational therapy for basic and functioning needs through support groups and one-to-one sessions.[154] A particular example is physiotherapy for somatic pain/pain relief.[155] One organisation provides "87 hours of therapy, with 30 clients on the waiting list." In this instance, clients were mainly self-referrals with some referred by CPNs.[156] As an interesting variant, there is also evidence of empowerment processes. WHC organises 'assertiveness groups' in the form of its Vulnerable Adults Policy and the Equal Lives Policy, risk management education, and through helping individuals lobby for appropriate medication.[157]

The fourth, though equally, important service consists broadly as the provision of welfare, which has direct and indirect impacts on mental health needs. Services take in the provision of stable and regular educational and social development, in addition to more *ad hoc* services. The former includes the local primary and secondary schools but also several civil society organisations. For example, resident associations and youth centres include the Ballymurphy Residents Association (which concentrates on local strategies towards getting people interested in the community), Whiterock/Westrock Residents, the Whiterock Community Centre, and Springhill House. The Corpus Christi Youth Club describes itself as a "facilitator of social development and life skills from childhood through to adulthood". The USDT, a well-established organisation that impacts on Whiterock ward, provides sports and educational activities. The USDT is particularly significant for this assessment because it has organised a number of 'healthy living' and 'mental health needs' awareness days in recent years.[158]

One of the main *ad hoc* services involves financial advice both in general terms and in helping people understand their entitlement to benefits. The latter proves particularly useful for the community with welfare advice forming one of CCS's main services.[159] Some organisations also provide work-based training programmes.[160] SF and SDLP claim a role in this area through advice and capacity support, often acting as the bridge between people and the relevant service providers.[161] The SDLP raises its role in working with the community for better housing and in liaising with the police on behalf of those arrested and/or who have their houses searched. Both political parties note that they are also currently redeveloping their social policies.[162]

Three other *ad hoc* services are worth identifying because they focus on groups that could be considered vulnerable to poor mental health. The elderly are frequently forgotten in modern urban environments, it is therefore significant that CCS send a team of care assistants to the homes of elderly to provide general

150 For example, the WHC's "primary team" (for "more mild to moderate cases" such as abuse and trauma) refers to counselling (WHC Interview, 29 January 2007).
151 People seek counselling in Whiterock for several reasons, including, the perceived stigmatisation of their problems within their own community and also based on the reputation of a service itself through inter-organisation referrals and word-of-mouth.
152 CCS Counselling Service Interview, 26 January 2007.
153 TRC Interview, 6 March 2007.
154 TRC Interview, 6 March 2007; Springwell House Interview, 5 March 2007; Focus Group 1, 19 January 2007.
155 TRC Interview, 6 March 2007.
156 Focus Group 3, 19 January 2007.
157 WHC Interview, 29 January 2007.
158 Focus Group 1, 19 January 2007.
159 CCS Welfare Advice Service Interview, 19 January 2007.
160 CCS Counselling Service Interview, 26 January 2007.
161 SF Interview, 7 March 2007.
162 SF Interview, 7 March 2007; SDLP Interview, 19 January 2007.

support. It may be particularly important since the elderly have lived through *The Troubles* and share a history of deprivation. There is also a busy targeted service for the homeless, with several shelters in the community offering temporary accommodation. For example, Springhill House is funded by the North & West Housing Executive. It focuses on those suffering from addictions and prides itself in being "somewhat unique" with its "therapeutic component through "counselling, education and welfare" for a cross-community clientele.[163] A Housing Executive-owned hostel in Moyard district has a distinguished tradition for housing up to 16 families.[164] The third service, social justice, is delivered solely by Community Restorative Justice, which offers a non-violent approach to community conflict resolution through mediation and dialogue.[165]

Although not flagged at the beginning, patient/client referrals form a pivotal service among all the organisations and individuals that make up the response to mental health needs. The assessment returns to this important service below, since it is more an indicator of cooperation and coordination within the response.[166]

4.1.2 Trusted reputation

This assessment finds that the service providers at the local level have developed a trusted reputation with users and with residents in general. This finding was based on the household surveys, focus groups (service providers and CCS users) and individual interviews. Figure 16 below presents the first indicator of this. Household heads were asked who they considered to be the leaders and representatives of their community.

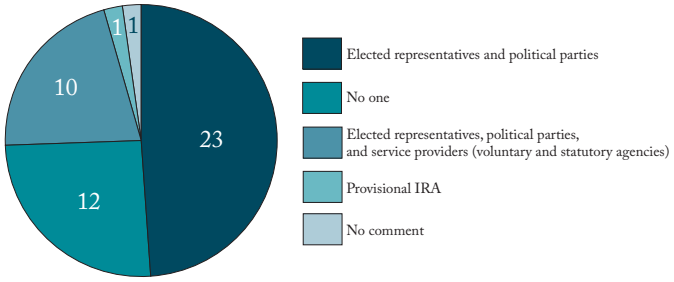

Figure 16. Perceptions of communtiy leadership

It is not surprising that the main political leaders (SF singled out in particular) prove the more common answer. However, it is revealing that 15 per cent (approx.) of household heads held community groups (by themselves and in tandem with the elected representatives, political parties, and statutory service providers) to be the leaders and representative of the community. In particular, it is a testament to the reputation and impact of the community groups in meeting needs. Among the users of the CCS Welfare Advice Service, trust was placed in "local community groups, the Upper Springfield Development Trust, GPs and schools."[167] Apart from the positive reasons, it is also clear for some that the community organisations are filling perceived gaps in community leadership that the politicians and the police are expected to fill.

All organisations refer to the trusted reputation that they have developed and add that the high-level of acceptance and respect has taken time to cultivate. Organisations believe that this rapport stems from their location within the community but is ultimately contingent on the quality of service. The latter is judged to depend on the solid experience, skills and commitment of staff.[168] For example, household heads consider CCS unique because of its reputation, which is based on trust, neutrality, confidentiality, friendliness in addition to its convenient location. CCS users echo these comments, adding the factor

163 Springwell House Interview, 5 March 2007.
164 Focus Group 5, 19 January 2007.
165 Focus Group 1, 19 January 2007.
166 Nearly all those interviewed raise the use of the referral system and the recurrence of this mechanism within their work.
167 Focus Group 7, 25 January 2007. Over half of the household heads (40 out of 68) indicate that they would use CCS in the long-term if they required their services. Twenty-three said that they 'did not know' and five said 'no'. CCS users state that they would like to be long-term users of the welfare advice and/or counselling. One user clarifies that this is not a preference: "I wish it was not so and it makes me feel guilty but that is the way it is" (Focus Group 7, 25 January 2007; Focus Group 6, 25 January 2007).
168 Focus Group 3, 19 January 2007; CCS Welfare Advice Service Interview, 19 January 2007; Focus Group 2, 19 January 2007; Focus Group 3, 19 January 2007; Youth and Community Worker Interview, 2 March 2007; WHC Interview, 29 January 2007; Springwell House Interview, 5 March 2007.

of 'staff skills and expertise'. Accordingly, all the household heads that have used CCS services and the sample of CCS users refer to positive impacts, from the alleviation of stress to a more general improvement in well-being.[169]

Interestingly, it seems that having a 'low profile' is key to this strength in relation to meeting mental health needs. While this is undoubtedly deliberate, based on the sensitivity to clients and their needs, it may also be unintentional in some ways. In other words, community organisations may maintain low profiles perhaps because of restrictions in funding and long-term planning but this is not to argue that the latter determinant is desirable, as outlined below.[170] Similarly, the GPs and CPNs interviewed also raise the importance of this characteristic in their work, which allows "good information, "close contact with patients" and a response "to all our patients' needs". Again, their relationship has taken many years to develop.[171] SF and SDLP also claim to enjoy a close relationship with the community based on trust and political outlook. SF considers its "direct contact with the people" as its main strength in addressing, managing, and tackling mental health needs within the community.[172]

The trusted reputation is a significant strength because it demonstrates a unique understanding and relationship that has matured over time. Moreover, it is difficult to not make direct links between this reputation and the perceived limited progress in de-stigmatising mental health needs that has occurred over recent years since it is reasonable to assume that trust is *the* precondition to seeking and maintaining assistance.

Alongside these strengths, it is important to consider weaknesses in the response, as defined by all those interviewed.

4.2 Perceived weaknesses

It is essential to explore the stark conclusion among the service providers that policy and practice ought to be refined. Therefore, towards protecting and advancing progress, the following analysis identifies and examines two distinctive weaknesses in the response: the need for more joined-up action; and limited capacity. First however, it is important to acknowledge that the service providers could not agree if the response had progressed, and to provide an explanation for this divided opinion.

Of the GPs reached by the assessment, a practice manager reflects that needs were "not met well" because the response is overwhelmed while one of the GPs assesses that "there has been no improvement".[173] Similarly, SF assess the impact and effectiveness as "not adequate" based on a combination of "weaknesses in the current response" and the "overwhelming need".[174]

Although the community organisations agree that mental health problems and needs have increased, at the same time they conclude that the response has achieved some success in keeping up with this increase in demand.[175] For example, CCS Welfare Advice Service argues that "[p]eople have benefited by having their pressures reduced, and are more informed and empowered".[176]

169 Focus Group 7, 25 January 2007; Focus Group 6, 25 January 2007. One of the CCS counselling clients emphasises the location of CCS (Focus Group 6, 25 January 2007).
170 The primary school representatives describe their institutions as "being at the centre of the community – very much part of it" and that "parents are very much part of the schools". The respondents note how their schools have an open door policy, and have become a "safe haven" during the past year of the dispute/feud (Focus Group 4, 19 January 2007).
171 GP 2 Interview, 23 February 2007; GP Manager Interview, 23 January 2007.
172 SF Interview, 7 March 2007; SDLP Interview, 19 January 2007.
173 GP Manager Interview, 23 January 2007; and GP 2 Interview, 23 February 2007, respectively.
174 SF Interview, 7 March 2007.
175 Youth and Community Worker Interview, 2 March 2007.
176 CCS Welfare Advice Service Interview, 19 January 2007.

The division above suggests two interrelated patterns. First, as this assessment finds, mental health problems and needs have increased but it ought to be remembered that some problems and needs have recently risen to the surface and become more discernible. In appreciating the second development, it is useful to consider an astute observation by WHC.

> We have found over the years that the level of trauma within this community has become far more complex with people presenting a greater variety of issues.

At the same time, WHC suggests that has been "a high-level of expectation from the community that we cannot always realistically meet."[177]

Therefore, the second development is that the service providers have gradually developed a more advanced understanding of mental health problems and needs in terms of grasping the profound impacts and the scope. When taken together, these two patterns suggest that mental health problems and needs have grown but actually fail to take account of the actual progress that has been made and the attendant increase in expectations among those affected and the service providers.

This pinpoints a central conclusion within the assessment but it should not cause the neglect of the main areas where the response feels that improvement was necessary.

4.2.1 A more integrated response

For several reasons, it is completely understandable that the response to mental health in Whiterock desires a more integrated or joined-up approach in the design and implementation of policy and practice. As detailed above, the needs are inherently complex, which means that any response will invariably be hampered by problems in accessing those affected, and/or overwhelmed trying to keeping up with demand since these needs are typically not prioritised by providers and donors during the early-to-mid stages of the post-conflict phase.[178] In considering these common pitfalls, the service provision structure in Whiterock is relatively developed but it is important to identify how greater integration could occur based on the 'rallying points' to date.

First, all the service providers claim a "holistic" and/or "multi-disciplinary" approach to understanding and addressing mental health.[179] While such a strategy is commendable, necessary and in-line with current best practice theory, the service providers (perhaps unintentionally) were divided on how to implement this holistic, multi-disciplinary approach. To varying degrees and with different results, all the organisations are pursuing a one-stop-shop model - offering a range of services tailored to the demands and needs of clients - and thus do not focus exclusively on mental health needs. Although the organisations interact and cooperate (see below), ironically it is each organisation's holistic approach that is hampering a more integrated response. In other words, each organisation considers their approach to be holistic and this is true for individual users but mental health needs at the community (and perhaps even familial) level ultimately demand a planned strategic integration of the organisations' services.

177 WHC Interview, 29 January 2007.
178 The latter is not contradictory considering that mental health problems and needs can be both manifested and dormant in the same post-conflict context based on the variables of when the trauma occurred, the type of trauma, and the desire of an individual to seek help, among other factors.
179 Sharon Campbell Interview, 16 March 2007; TRC Interview, 6 March 2007; CCS Welfare Advice Service Interview, 19 January 2007. For example, Springwell House works "holistically" through a "multiple-needs assessment on admission to the hostel" (Springwell House Interview, 5 March 2007). WHC prioritises needs based on their "urgency and duration" (WHC Interview, 29 January 2007). The TRC uses "a multi-disciplinary approach to working with multiple-complex trauma. This means that clients will receive psychological processing, exploration of functioning levels and investigation into somatic or pain experienced." (TRC Interview, 6 March 2007). SF (Interview, 7 March 2007) also assumes a "holistic" view of mental health, seeing it interlinked with the whole range of human needs, such as general health and well-being, education and schooling, and employment. Interconnections are also identified at the levels of: the household, community, and between the community and other communities.

Definitions of 'holistic' aside, it is the latter change that organisations prefer in order to advance the response and to keep up with the perceived increase in mental health problems and needs.

One of the specific reasons for the demand in improved integration is the importance of seeing the response more strategically – the *direction* of the response overall to mental needs, considering their complexity and the wide impacts. It was therefore not surprising that the response in this sense was characterised by "short-termism" and "nothing by way of strategy".[180] Overall, the providers themselves for different reasons refer to the fragmented nature of the response. One of the GPs explains their specific constraints: "the government has asked GPs to prioritise the severely mentally handicapped for example those with bi-polar disorder." Therefore, the GP concludes that while "we have a very good policy of care for such patients […] depression and anxiety disorders are not prioritised". In short, GPs are left with "little say" in such strategic decisions.[181]

Nevertheless, it is important and encouraging to acknowledge the current points of interaction. The three GPs all note their regular interactions with the other service providers, including community organisations, nurses, CPNs, and the two hospitals through "commissioning services from all agencies" and "practice-based learning sessions". However, a lot of these interactions rely on the patients' request for another service that the GP cannot provide.[182] The Neighbourhood Renewal Partnership, which includes the USDT among others, is significant but its creation is recent and thus it is difficult to ascertain its potential. Youth groups also network to form a "collective approach to community development" (for example, through the Youth Providers Forum) but of course this is limited to targeting youth.[183] CCS, Springwell House, WHC and the TRC all raise their regular interactions and communications between organisations and all service providers.[184] Some also refer to a positive impact from the dispute/feud, which has helped bring people together through the statutory agency task force in Upper Springfield.[185]

Similar processes are noted by the political parties. SF frames its response to needs overall as the networking with groups directly in general and through the partnership boards, operating on a one-to-one basis with individuals, and in acting as a link between voluntary and statutory agencies.[186] SF joins SDLP on a task force under the West Belfast Partnership Board.[187] As flagged above, referrals form a regular 'cooperating' mechanism through the sharing of information and resources. For example, the TRC "has set criteria of *Troubles*-related trauma with referrals coming from professional mental health practitioners" and with "cross referrals […] made on a regular basis to other organisation/community services providers."[188] A GP notes that they, "referred patients to the full range of providers including the public voluntary community and private sectors".[189] While this service/mechanism appears to be working well and forms a good foundation, there is clearly significant potential for this to be developed further.

Overall, the relationship between the community organisations and the statutory agencies is raised consistently as a concern. The strategic level

180 Focus Group 1, 19 January 2007.
181 The GP manager explains that this selectiveness stemmed from the Quality Outcomes Framework first set up in 2004-2005 by the Department of Health. It is asserted that CPNs and social workers have to follow this approach (GP Manager Interview, 23 January 2007).
182 GP 2 Interview, 23 February 2007.
183 Youth and Community Worker Interview, 2 March 2007.
184 CCS Counselling Service Interview, 26 January 2007. Springwell House (Interview, 5 March 2007) notes various partnering outputs: networking, flyers, booklets and fund raising. It specifically works with health teams, GPs, the Community Psychiatric Nursing Service, the Community Nursing Service, the Shankill Housing Executive, and both the welfare and counselling arms of CCS. The TRC (Interview, 6 March 2007) notes that "all its members sit on the relevant committees and forums for networking purposes." The USDT, Ballymurphy Residents Association, Whiterock Community Centre, Springhill House, Corpus Christi Youth Club, Community Restorative Justice, and Whiterock/Westrock Residents all state that they meet every day for different reasons and under different forums (Focus Group 1, 19 January 2007).
185 Presentation of preliminary findings, 20 March 2007.
186 SF Interview, 7 March 2007.
187 SDLP Interview, 19 January 2007.
188 TRC Interview, 6 March 2007.
189 GP 2 Interview, 23 February 2007.

(policy direction and implementation) is noted as particularly weak. A representative of a community organisation reflects that there are "[n]o clear lines of communication between statutory and voluntary bodies" and "[n]o clear easily understood policies on say suicide".[190] Nevertheless, Sharon Campbell notes that TAPs "offer an opportunity for local groups to influence strategic planning and policy development for services addressing conflict-related needs." Also, through the referral service, EHSSB TAP "facilitates the process through supporting the services of its member organisations and addressing issues identified by them on a local, area or regional basis." Two constraints are noted though. Within the TAPs, there is only one worker operating in each HSS Board area across the region while there are ongoing efforts to relate to regional processes and bodies. Second, it is recognised that "there is much good work ongoing" but it is necessary "to overcome community divisions and political barriers in order to fully engage in an integrated, co-ordinated, locally effective system."[191]

Above all, some of the organisations themselves raise the need for a more joined-up approach towards "resolving problems or barriers" and the importance of "sharing information and not duplicating" since service provision ought to be "complementing" and "not about competition".[192] CCS adds that it has developed "a good relationship within Ballymurphy estate" but beyond Ballymurphy (that is, in other areas within Whiterock), it is presumed that "other organisations particularly statutory ones are not aware of what we provide." While CCS "do communicate with other organisations and service providers", the respondent considers that it is not sufficiently "systematic" across all projects within CCS. It is felt that there has been some progress in this type of interaction over "recent months" but ultimately more regular and planned follow ups are needed.[193] More generally, one of the GPs notes that the response at the community level "lacks an overall cohesive approach."[194] Sharon Campbell prioritises the need for "[b]etter co-ordination […] both to enhance service provision and to deter competition and 'territorialisation' in the sector."[195] The focus group of community youth workers concur, noting that there "[n]eeds to be a greater understanding within the partnership approach".[196] In strengthening this assertion, three sets of stakeholders emphasise the need to consult and involve users and residents in the decision-making processes, that is, the need to ensure services are "people-centred".[197]

In order to place this weakness in its context, it is essential to refer to the constraints to organisational capacity.

4.2.2 Capacity constraints

This final section on the community level response focuses on how the capacity of the service providers is constrained, focusing on: the access to resources (financial and human); skills-training for staff; and long-term planning.

All the service providers surveyed assert that they do not have access to sufficient resources overall to meet the demand in mental health problems and needs. In sum, there is a perceived lack of resources, with several definite indicators ranging from 'lengthy hospital waiting lists' to 'not having a treatment centre' within

190 CCS Counselling Service Interview, 26 January 2007.
191 TAP is an inter-agency, cross-sector forum hosted by the Eastern Health Board. Its executive group, the Trauma Implementation Group, is an inclusive implementation body comprising 18 representatives from statutory (health, education, social care), voluntary and community organisations, and includes service user representatives that reflect the range of impacts of the conflict on individuals. TAP raises a recent development whereby it was "facilitating transition planning for the Victims Unit with the local organisations with a view to having an influence on policy development with the incoming permanent Commissioner for Victims and Survivors" in addition to numerous initiatives, including "information sessions for organisations […] developing service level agreements, raising awareness of services" and a conference on "international practice"(Sharon Campbell Interview, 16 March 2007).
192 Youth and Community Worker Interview, 2 March 2007. WHC also raises the need to do more in this sense (WHC Interview, 29 January 2007).
193 CCS Counselling Service Interview, 26 January 2007.
194 GP 2 Interview, 23 February 2007.
195 Sharon Campbell Interview, 16 March 2007.
196 Focus Group 2, 19 January 2007. This is echoed by Focus Group 3 (19 January 2007).
197 Focus Group 4, 19 January 2007; TRC Interview, 6 March 2007; GP 2 Interview, 23 February 2007.

the community.[198] Springwell House provides a more balanced observation: "[r]esources have increased but so has the number of individuals who need them."[199] This suggests that mental health has started to be recognised as a salient developmental need within the community. Nevertheless, the TRC believes that it is still not a prioritised need.[200]

Respondents argue that donor funding results in four knock-on effects. First, the limited amount of funding means that an adequate response to mental health problems and needs is not possible. The scope of programmes etc is inherently restricted, are at risk of being donor and not needs-driven, and it is difficult to attain sufficient depth in services. For example, the GP manager feels that the current, "focus on severe mental health issues" is making "matters worse", as it "drains resources away from the larger need of those affected by *The Troubles*."[201] Connected to this, long-term planning is significantly restricted or simply not possible due to the brevity and non-recurrent nature of the funding cycle.[202] In particular, many of the community organisations are waiting to see if their core funding will be renewed after July 2007.[203] A GP notes that his fellow professionals have "tried to alter this but we get nowhere".[204] Together, this instability imposes a third layer of constraints, with staff in organisations forced to devote significant time to finding and bidding for new funding. One focus group states that, "[m]ost of their time is spent chasing funding."[205] Connected to this, another adds that the resultant job insecurity among the community organisations is itself a source of "a lot of stress".[206]

Maintaining adequate access to human resources is also difficult for some service providers though less critical compared to funding existing staff.[207] The GP manager notes the need for more CPNs.[208] The absence of an outreach facility is held as a particular barrier to meeting mental health needs while WHC notes that it is two crucial staff positions short.[209]

Inadequate specialist skills-training forms the second constraint and it affects two types of professionals.[210] The first type consists of those who have discovered suddenly that their job demands a guidance/support component because they have found themselves working with those who display mental health problems. This involves welfare guidance specialists, school staff (principals and teachers), the clergy, SF and SDLP.[211] Consequently, SF elaborates that it suffers from "a lack of training" with relevance to the "skills" needed to address the "stigma of mental health needs" within the community.[212]

The second type of professionals consists of counsellors and GPs that need to broaden their expertise,

198 GP 2 Interview, 23 February 2007; Sharon Campbell Interview, 16 March 2007; Youth and Community Worker Interview, 2 March 2007; Focus Group 3, 19 January 2007.
199 Springwell House Interview, 5 March 2007.
200 TRC Interview, 6 March 2007.
201 GP Manager Interview, 23 January 2007.
202 GP 2 Interview, 23 February 2007; TRC Interview, 6 March 2007; CCS Counselling Service Interview, 26 January 2007; Focus Group 2, 19 January 2007; Springwell House Interview, 5 March 2007; Focus Group 4, 19 January 2007; Focus Group 3, 19 January 2007; CCS Welfare Advice Service Interview, 19 January 2007; Focus Group 1, 19 January 2007.
203 TRC funds are due to expire in 2008 (TRC Interview, 6 March 2007).
204 GP 1 Interview, 23 January 2007.
205 Focus Group 3, 19 January 2007.
206 Focus Group 1, 19 January 2007.
207 TRC Interview, 6 March 2007.
208 GP Manager Interview, 23 January 2007.
209 Youth and Community Worker Interview, 2 March 2007; and WHC Interview, 29 January 2007, respectively.
210 There is one exception, with a GP concluding that, "that there were no gaps in skills that limited the effectiveness of the service" (GP 2 Interview, 23 February 2007).
211 Representatives of the local primary and secondary schools feel that their traditional pastoral care structure and procedures are inadequate in responding to current needs (especially from the dispute/feud) (Focus Group 4, 19th January 2007). Similarly, a key respondent notes: "[p]riests were never trained to kneel and pray beside a murder victim and then go to say mass a few hours later." (Focus Group 5, 19 January 2007).
212 SF states that the party at the local-level has not received professional advice, information, training or any other forms of assistance and support on how to address, manage and meet mental health needs within the community but feels that there are "skilled individuals within the community organisations". In contrast, it has received ("on going") advice on "child protection" and "conflict resolution training". The representative reflects that skills-training would be useful for its party in addressing and meeting health needs, and calls for a "community-based training programme" (SF Interview, 7 March 2007).

considering the range of mental health problems and needs that have emerged. For example, a GP notes that while their CPNs are "geared up for the more serious mental health conditions", they are unable to "cope with depression and anxiety cases".[213] Dealing with "the increased complexity of our workload challenges" is how WHC refers to the impact and this comment is representative of the wider experiences of the service providers.[214] In appreciating this constraint fully, it is important to consider it a further indicator of the increased demands on the response to mental health. In other words, many of the service providers remind that their staff are already highly qualified with training processes ongoing.[215] Only one organisation assesses that training has declined due to a lack of funding.[216]

Barriers to long-term planning form the third strain in capacity for service providers. This is a product of the first two strains, in particular, the instability in donor funding. Ultimately, it is assessed that the aims and objectives of services are too time-bound or short-term. This is particularly problematic in addressing mental health because of the general *long-term* nature of the needs, and the specific prerequisite of stability for clients and providers in seeking solutions. In sum, 'short-termism' is not conducive to sustainable progress.[217] Furthermore, although the creation of new initiatives have been welcomed (for example, 'suicide prevention', and the 'intervention programme' for the dispute/feud in Ballymurphy); these are inherently reactive in nature and their long-term future is not guaranteed.

The capacity of providers to monitor and evaluate their services is a core component of planning. Several providers note that services are monitored regularly through updated assessments of user needs.[218] CCS, Springwell House and TRC use the Clinical Outcome of Routine Evaluation model to evaluate impact, involving the completion of questionnaires by users at the end of therapy.[219] In addition, service provision staff are subject to routine appraisals.

While these forms of monitoring and evaluation are possible, this assessment finds that the service providers have reached a critical stage in the need for community-wide planning, considering the wide and far-reaching impacts of mental ill-health and needs. While this shift is heavily dependent on the nature of funding, there is equally a need to integrate the findings from in-house evaluations and to look beyond immediate users to the community as a whole.[220] This ought to lead to a needs-driven approach and standardised methods for self-evaluation and further needs assessments.[221]

Respondents note their lack of capacity in this respect because of insufficient funding and the general lack of stability in programming.[222] There are several potential negative consequences of this strain. In particular, without such assessments and the

213 GP 1 Interview, 23 January 2007.
214 WHC Interview, 29 January 2007.
215 For instance, a GP notes that all relevant practice staff receive appropriate and ongoing training on addressing mental health needs (GP 2 Interview, 23 February 2007). This main finding is also supported by TRC (Interview, 6 March 2007); CCS Counselling Service Interview, 26 January 2007; GP Manager Interview, 23 January 2007; GP 1 Interview, 23 January 2007; Springwell House Interview, 5 March 2007.
216 TRC Interview, 6 March 2007.
217 Focus Group 3, 19 January 2007.
218 A GP describes how "the programme was planned after 'a practice-needs assessment' and it is integrated with the wider work of the practice, and controlled and funded by the partnership" (GP 2 Interview, 23 February 2007). Springwell House (Interview, 5 March 2007) notes that its programme "was planned in response to residents' needs through meetings, a survey and research."
219 CCS Counselling Service Interview, 26 January 2007; TRC Interview, 6 March 2007; Springwell House Interview, 5 March 2007.
220 A particular indicator of this is the recurring comment among the household surveys when asked about CCS: 'I know where to find them if I need help'. This suggests that ideally CCS and other organisations could be more proactive.
221 Sharon Campbell (Interview, 16 March 2007) notes that the relative absence of accountability standards and evidence-bases stems from the rush of efforts and funds at the very start of the post-conflict stage.
222 For example, the GP manager notes that "[w]e do not assess the wider impact of mental health needs, we just react to them" (GP Manager Interview, 23 January 2007). Sharon Campbell states that "[a]s yet we have no meaningful and comprehensive assessment of needs across the region" although adds that "the collection of such data was being planned". Furthermore, the respondent reminds that "the Commissioner for Victims had recommended that needs assessments migrate to the local community planning bodies associated with the new councils after devolution […] to facilitate grass roots engagement." Nevertheless: "[w]ithout a clear idea of the needs arising from the conflict, the sector remains in disarray regarding future funding potential." (Sharon Campbell Interview, 16 March 2007).

ability to plan for the medium-to-long-term, there is a risk that needs are inaccurately prioritised.[223] This may compel a ranking of vulnerable groups and the potential risks of a tiered approach to mental health needs have already been outlined above.

In conclusion, analysing the self-review of the response at the community level is integral to the assessment of mental health. There is no doubt that the diverse range of services and the trusted reputation of the providers form unique strengths. At the same time, policy and practice urgently needs to be refined at this level through significantly greater integration and capacity development in terms of the access to human and financial resources, skills-training for staff and long-term planning. While these weaknesses verify that mental health problems and needs have increased, they equally reflect the recent ripening in assistance seeking and the progression in the service providers' understanding of mental health.

Based on these findings, the prospects for change ought to be regarded.

223 A CCS counsellor indicates that "[w]e tend to prioritise needs, as 'first-come first-serve', however in the Counselling Team priority would be given to anyone in danger of ending their life" (CCS Counselling Service Interview, 26 January 2007).

5. Future Directions for the Community Level Response

> Any immediate crisis has to be dealt with – now is the time to do it.[224]

It is appropriate to complete the main assessment findings with a look to the different directions that the response to mental health in Whiterock could take in the future. This brief analysis is deliberately restricted to the possible structural arrangements and changes to the composition of the response. It also intentionally avoids framing the future in terms of defined 'options' since such clear and comfortable boundaries are a post-conflict rarity. In other words, the assessment appreciates that the directions below may actually incrementally overlap and even interchange.

Three scenarios emerge from the field data: the continuation of the status quo; increased and more direct intervention by the state; or, a more integrated response involving the current service providers. This section closes by conveying a concern raised frequently during the assessment - that the response ought to be shaped and driven by, not simply based on, the mental health problems and needs within the community.

5.1 Continuation of the status quo (Direction No. 1)

The first possible direction demands little explanation since it would involve the continuation of the current arrangements, approach and composition of the service providers. In this way, community organisations would maintain a mixture of services centring on counselling, alternative therapies, general mental health awareness, and welfare advice. The various partnerships and coordination initiatives would continue but remain understated, with the referral system and informal sharing of information acting as the main links between the service providers. Community organisations would continue to work alongside the relevant statutory agencies, local schools and civil society groups.

As this assessment finds, such a scenario has its merits. Mental health problems and needs would proceed to be addressed based on both the trusted reputation of the local organisations coupled with the expertise and dedicated work of GPs and the social welfare agencies and bodies. However, as raised above, this direction is far from optimal based on the scale and depth of needs, and the consensus that the response does not have the capacity to work proactively and in an integrated fashion. Accordingly, this direction is not a preference among those interviewed. Furthermore, the continuation of the status quo (in its strictest sense) is premised on the community organisations receiving a complete renewal of government funding, which many fear would not happen.

5.2 Increased and more direct state intervention (Direction No. 2)

In this scenario, statutory agencies would assume a more active role and greater responsibilities, which would in turn increase their visibility among the community. In this way, the response to mental health needs would witness an increase in the capacities of GPs, CPNs, hospitals, and social welfare agencies. Accordingly, with less government funding available and other donors perhaps reluctant to engage, it is logical to assume that the current role of community organisations would be forced to move away from mental health concerns, especially in terms of counselling and alternative therapies, with their involvement limited purely to referrals through its other services.

224 Focus Group 4, 19 January 2007.

This direction in its entirety does not attract support among respondents but there is considerable support for the state to assume an increased role and to intervene more directly.

In particular, several respondents would prefer to see a single one-stop-shop facility within the community that would specialise in targeting and addressing mental health problems and needs through targeting vulnerable groups.[225] Consequently, the response to mental health would be delivered by a single provider, with GPs and community organisations referring users to this medical centre or hospice.[226]

Although a specialised centre could improve the response in several important ways, without the active support of community organisations it would be constrained by the lack of flexibility that often affects large (state-run) institutions. There is then the risk that it would be grounded in an ethos of prioritising certain groups and subgroups, and this report has already illustrated how this could strengthen the stigmatisation of mental health needs at this stage. Second and connected to the former, as argued above, one of the main strengths of the community organisations has been the development of a trusted reputation. Instead, a specialised facility (hospice, centre, hospital wing etc) might find it difficult to develop such a rapport, considering that residents tend not to identity the state as a source of trust. This scenario would then leave considerable gaps in the response if it was charged to take over from community organisations. Third, such a dramatic shift would represent a complete change in how the government has approached and funded developmental needs over the past 20 years. This direction would also depend first upon a stable and fully operational local executive and assembly.

Nevertheless, the co-existence of a specialised state-run facility working alongside community organisations is perhaps more likely, which takes us to the third possible new direction.

5.3 A more integrated approach by current providers (Direction No. 3)

As the wording suggests, community organisations and the statutory agencies would continue to work as they have been doing and based on similar levels and patterns of funding. Noted above, this scenario could also involve the phasing in of a specialist facility. Whether the latter is introduced or not, this direction would be new because it would entail significant changes to the professional relationships and arrangements between all the service providers. In essence, a more integrated approach would demand a concerted effort to develop a joined-up strategy at all levels of policy and practice relevant to the community. Partnership boards and panels would need to be inclusive, empowered, and entrenched though supported by the existing forms of cooperation, such as information sharing and cross-referrals.

Further to the renewal of government funding, two key interdependent factors would determine the efficacy of this new direction: the capacity of a state/non-state body to take an appropriate lead in coordination while not compromising the unique flexibility and reputation of the response at the community level; and the nature of the incentives for service providers to adapt to this arrangement. That is, this direction would not simply involve 'the same story with a new title' - the continuation of the status quo with some extra 'token coordination'. Fundamental changes would be required to enable a more robust response. Within this scenario, there

225 GP 2 Interview, 23 February 2007; and GP Manager Interview, 23 January 2007. Springwell House (Interview, 5 March 2007) calls for a "dedicated day hospital for mental health patients" and a "mental health unit in the Royal Victoria Hospital." SF proposes that the medical centre would be a suitable provider while also emphasising the need for a specific community-wide suicide prevention policy (SF Interview, 7 March 2007). CCS raises the vulnerability of young mothers (CCS Counselling Service Interview, 26 January 2007), and a GP emphasises that child psychiatry was particularly under-resourced within the hospitals (GP 1 Interview, 23 January 2007).

226 The idea of a one-stop-shop model was proposed by the Victims Unit in 2005 (Sharon Campbell Interview, 16 March 2007).

are several possible trajectories for service providers. Some may decide to specialise in counselling, which would allow others to extend and focus more on the provision of alternative therapies, and welfare advice. Alternatively, providers might follow the one-stop-shop model but with closer and formal links to the other service providers. Ultimately, these decisions and such a transformation overall ought to be grounded in further needs assessments and impact evaluations of current services.

The majority of respondents prefer this third direction, which made sense considering the widespread recognition that the response needs to become more systematic and cohesive, not forgetting the perceptions that demands have increased. More specifically, some welcomed greater integration as it promises a more "streamlined" relationship between voluntary and statutory agencies while also establishing "clear lines of best practice and action […] in regard to depression anxiety and suicide" and the creation of "an accountable body in Northern Ireland to ensure a standard of practice."[227] Sharon Campbell agrees but went further because of the scope and impacts of poor mental health. Looking within and to the structural conditions of the community, the respondent argues that a truly integrated response would need to connect with school curricula in order to strengthen education and general awareness on mental health and thereby attempt "to break the conspiracy of silence that has persisted here".[228]

5.4 From needs-based to community-driven

Regardless of its future structure and composition, there is broad support for the response not to be simply based on needs but *driven* by the community and its needs.[229] The latter represents an important shift because it involves the community playing a participatory and proactive role in meeting its own needs, which includes making the key decision on how these needs ought to be met. The core appeal of a community-driven response is empowerment, which itself could form the foundation to long-term recovery and may also have many positive knock-on effects on developmental needs overall. Within a community-driven response, voluntary organisations and statutory agencies would be restricted to a facilitating role and the provision of emergency assistance.

A community-driven approach should certainly not seem far-fetched. As noted above, the assessment unearths popular support; beyond Whiterock and Northern Ireland it is now the sought after strategy for tackling mental health and post-conflict needs in general. Moreover, there is evidence that at least one voluntary organisation has already started to facilitate the empowerment of users. Springwell House describes: "[r]esidents are part of the process and this enables them to take responsibility for day-to-day living".[230] A GP also reminds that the recent action on "suicide prevention" came from families and had in turn "galvanised the community".[231] Figure 17 below indicates the response from household heads when asked who they would approach in order to improve their needs.

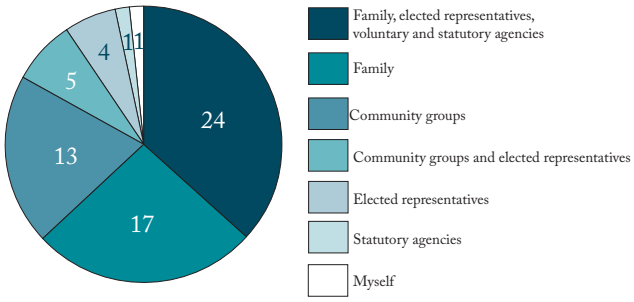

Figure 17. Getting needs resolved

227 CCS Counselling Service Interview, 26 January 2007. Also in agreement: TRC Interview, 6 March 2007; WHC Interview, 29 January 2007; Youth and Community Worker Interview, 2 March 2007; GP 2 Interview, 23 February 2007; Focus Group 3, 19 January 2007; and CCS Welfare Advice Service Interview, 19 January 2007.
228 Sharon Campbell Interview, 16 March 2007.
229 For example: "[c]hanges and ideas need to come from the bottom up - not statutory-led" (Focus Group 1, 19 January 2007). One of the GPs stresses that those with mental health needs and their families "needed to be consulted", and felt that community organisations ought "to empower patients" In sum: "[p]eople need to be listened to" (GP 2 Interview, 23 February 2007).
230 Springwell House Interview, 5 March 2007.
231 GP 2 Interview, 23 February 2007.

Figure 17 is insightful because it shows that the family unit, despite the evidence above for its erosion over the past ten years, continues to be the first preferred source of assistance.[232] Those that chose a combination placed their family first in the list. In sum, household heads suggest a preference for a bottom-up response to their needs, which is further confirmed by the weak support for statutory agencies acting alone. Figure 18 below also demonstrates that over two-third of households look to the future optimistically – a basic though illustrative indicator of self-drive.[233]

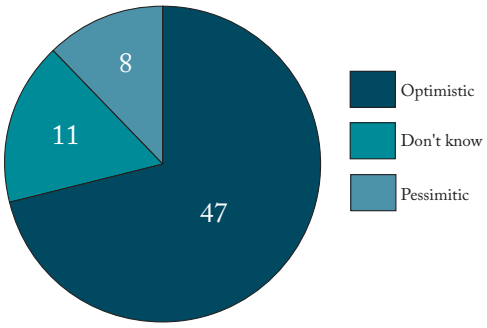

Figure 18. Hopes for the future

At the same time, there is no doubt that a community-driven response would face at least three main barriers. First, residents would need to be willing or able to adapt to such a change. Of course, some of those with mental health needs may not be ready to participate in this way.[234] For example, a different interpretation of Figure 17 would note that only one household head believes that they could meet their needs unaided.[235] Furthermore, statutory agencies and community organisations could consider the transformation too risky, and donors may be equally sceptical, believing accountability measures to be unenforceable. Nevertheless, it would be foolish to completely discount the importance of a community-driven response. In principle at least, it directly seeks sustainable solutions through empowerment and prevention by tackling the root causes, and avoiding long-term dependency. Perhaps these core aims serve as clearer and more instructive signposts for the response when it comes to thinking about future directions.

232 Three households did not answer this question.

233 The CCS users are divided equally. The two that are pessimistic blame the social deprivation while the other points to general anxiety and the primary trauma: "I wish I could feel better about the future every time I get a phone call it is like a bullet or bomb going off" (Focus Group 6, 25 January 2007; Focus Group 7, 25 January 2007).

234 CCS Counselling Service Interview, 26 January 2007.

235 All relevant household heads and CCS users overall could not think of other services that CCS could provide to meet current and future needs, or other approaches that it could take, apart from the continuation of its current services. Only a few respondents suggest that more should be done for the youth. It is also perhaps worrying that one-fifth of household heads feel that the community does not have leaders or representatives (see Figure 16).

6. Conclusions and Recommendations

This assessment finds that overall Whiterock has reached a juncture in terms of the developmental needs of its residents, with focus on mental health. It is a particularly critical stage because the community has managed partially to move out of *The Troubles* but at the same time has not experienced stability and the many other important peace dividends. Accordingly, it stands tenuously and dangerously somewhere in between and thus joins a number of other precarious post-conflict communities in Northern Ireland and across the world. In tackling this long-term uncertainty and to prevent backsliding, the significant improvement in the mental health and other developmental needs of the community is essential. Furthermore, while not advocating a prioritisation of developmental needs, there is no doubt that mental health is especially crucial, in part because the response has been relatively delayed and remains overwhelmed. It is this latter overarching lesson that helps explain the deficiencies in the post-conflict peace so far and therefore deserves full consideration when it comes to the funding, design and delivery of all further services within the community.

In reaching its conclusions, this assessment has employed an in-depth qualitative methodology. The study was small-scale, which entailed inevitable constraints in scope. Nevertheless and more importantly, the limited scope reflected the need for a concentrated focus in relation to mental health and with close reference to the seven other developmental needs at the community level. Accordingly, the rationale was to test and refine practice-based evidence, and to bring together for the first time the dispersed knowledge and expertise of the complete range of service providers at this level. In recognising the challenges posed to gathering sensitive data in post-conflict environments and on mental health, a flexible and reflective approach has been used, involving multiple and interrelated participatory techniques: focus groups; semi-structured interviews; and the household survey. Through this composition of methods, it has been possible to triangulate the data in several ways, which has ultimately produced a verifiable body of evidence. The reviews of the relevant academic and policy-based literatures in turn have verified and strengthened the findings of this systematic investigation. In addition, the robustness of the conclusions stems from the multi-levelled nature of the assessment, which incorporates households, CCS service users, and service providers. Last, the sampling strategies were non-random though strategic, which enabled representativeness at each level, and tentative generalisations can be made to other comparable communities.

In completing this report, it is essential to detail the main conclusions and to provide recommendations, which will hopefully contribute to the design and delivery of long-term solutions in Whiterock.

6.1 Developmental needs

In taking a multidimensional and integrated approach to understanding mental health, this assessment has investigated seven other sets of core developmental needs. The findings are based on a comparison of the perceptions of household heads, the service providers and the 2005 NIMDM. Undoubtedly, all these needs continue to reflect severe and extensive deprivation, with particular deficits in the areas of employment, mobility, and skills training. Nevertheless, higher levels of satisfaction and slight improvements are noted in the areas of health, housing and schooling, which are stated to have occurred slowly over the past ten years and thus mark the first trend. The second correlative trend is that a significant minority of residents believe that one or more of their core developmental needs have remained the same or deteriorated during this time. Accordingly, this assessment finds that a division within the community has emerged since the ceasefires and *The Agreement*. In considering this division and towards refining the meeting of the developmental needs:

Recommendation 1: To determine how the delivery of services can be adapted in order to close the gaps within and between services in order to target those who do not have their developmental needs fulfilled.

Executive Summary

Recommendation 2: To ensure also that the progress made so far is maintained and protected in each of the developmental needs.

The division among households was particularly acute for the developmental need of social relations. The particular reason consists of a perceived dismantling of the community as a consequence of the dispute/feud in Ballymurphy and the rise in crime among other social disorders over the past ten years. CCS service users and senior representatives of the service providers have concurred.

Recommendation 3: To continue the funding and delivery of the intervention programme in Ballymurphy but also to realise the need for a similar though more extensive programme to address the wider forms of social decay and destruction. Such a strategy ought to seek greater integration of the key services and their providers through, for example, the current partnership boards. At the same time it needs to be preventive, address root causes, and be driven by the participation of residents.

Deeply connected to the latter finding was the third stark trend that involved two-thirds of households claiming a range of stress-related needs as a direct result of where they lived. These cut across all six areas of the community and supported the main practice-based claim that mental health problems and needs are prevalent and far-reaching within Whiterock.

6.2 Mental health problems

There is overwhelming evidence for a range of mental health problems in the community. Diagnosis is undoubtedly complicated. The types of problems can be acute or chronic or both depending on the individual's circumstances. Indicators vary involving psychological and physical signs and manifestations. Furthermore, the nature of the two root causes poses unique challenges to residents and service providers. That is, the protracted nature of *The Troubles* and the intergenerational deprivation have each had direct and indirect effects but it is the interplay of these two factors that makes the mental health problems complex. Moreover, the continued cycle of violence through the dispute/feud and the post-conflict forms of social deprivation add new types of less accessible trauma for both those that have and have not suffered primary trauma during *The Troubles*. Consequently, a self-perpetuating cycle of mental ill-health has emerged.

It is also concluded that all of the above mental health problems reside at the level of the family and the community. While the wider ripple effects of *The Troubles* are commonly acknowledged, there appear to be weaknesses in designing and delivering practical strategies to address communal loss and damage.

Alternatively, this report finds that the current strategy of targeting vulnerable groups and subgroups is risky. Although the logic and limited value of this strategy is appreciated, ultimately such an approach is highly subjective and threatens to over-simplify the causes and impacts of mental ill-health. Moreover, it is asserted that targeting and categorisation at this early stage in recovery risks adding to the stigmatisation of mental health within the community. The latter is particularly significant as it forms the main challenge to access and progress.

Recommendation 4: To maintain the current treatment of mental health problems for individuals based on actual needs.

Recommendation 5: For the reactive treatment approach to develop a more systematic and ongoing community-wide assessment of trends in individualised mental ill-health types and manifestations, in particular, if positive and negative changes have occurred and the reasons for the alleviation/deterioration. This form of reflective information sharing ought to complement the public health approach recommended below.

The weaknesses in the strategies for collective mental ill-health and the targeting of vulnerable groups and subgroups are further addressed below.

6.3 Mental health needs

As discussed in Section 1, a sustainable approach to mental health also ought to involve concentrating on promotion, and the appreciation that mental health has positive as well as negative dimensions. This entails the active realisation that everyone in a given community has mental health needs, otherwise known as the public health approach. It is considered best practice in any type of society but this report argues that it is particularly useful in post-conflict contexts such as Whiterock where mental health problems are profound in scale and depth, and with the stigmatisation of problems forming an intractable barrier to access. Accordingly, a public health approach may be the only way to address the trauma and damage at the familial and community levels, thereby ensuring the inclusion though not the targeting of vulnerable groups and subgroups. As emphasised above, this approach would need to work in tandem with mental ill-health treatment at the individual level.

Recommendation 6: For service providers at the community level to work with all statutory agencies, elected representatives, and political parties in designing a tailored integrated public health strategy for the community based on the multidimensional notion of well-being, and through using the existing mental health promotion initiatives as a starting point. Such a strategy and approach ought to operate through the structures of the community, including, schools, colleges, work places and civil society groups.

Recommendation 7: For all the relevant statutory agencies, elected representatives, and political parties to support and guide the community level service providers in the design and implementation of a tailored public health strategy, and to provide leadership and expertise in making sure such a strategy can work at the structural level while feeding into the wider top-down processes of reform under the peace process.

Further starting points and initiatives can also be found in the Health Promotion Agency for Northern Ireland (1999: 138 - 141).

6.4 The community level response to mental health

While not evaluating the performance and impacts of service provision in Whiterock, this assessment has investigated the roles of the service providers since their working needs are integral to the well-being of the community. In considering the diversity in services and activities, it is concluded that the providers have developed a uniquely close professional relationship with users and residents. Evidence suggests that this stems from the development of a reputable standard of services, which has created a vital layer of trust. The latter is in turn responsible for the slight progress perceived in reducing the stigmatisation of mental health problems.

Recommendation 8: Considering the achievements, it is recommended that service provision at the community level by voluntary organisations is strengthened and developed both in terms of the treatment of mental ill-health and as the core component of a tailored public health approach. This demands renewed willingness from the service providers, in addition to the active recognition by statutory agencies, EHSSB TAP, political leaders, and donors that the providers at the local level are hindered by significant capacity constraints, in particular the areas of: access to financial and human resources; skills training for staff; long-term planning; and community-wide monitoring and evaluation.

Therefore, as Recommendation 8 states, there is no doubt that the current weaknesses in the community level response have been determined by the misguided pace and non-recurrent nature of funding coupled with the limited level and type of support from the state and political leaders. Nevertheless, the service providers themselves also have an important role to play in correcting these weaknesses.

Recommendation 9: In complementing Recommendations No. 3, No. 6 and No. 7, there ought to be more concerted and sophisticated integration among all the service providers at the community level in terms of information sharing, the design and coordinated implementation of the response to mental health, and the removal of professional boundaries in general. Possible ways forward include a network of inter-organisational and cross-sectoral working groups on all the key issues, followed by the formulation of a shared strategic vision for mental health within the community. Such a process ought to be inherently participatory, with residents playing a central role in shaping and driving the strategy in line with actual needs. Here, standard popular consultation methods would be useful but more innovative and contextualised methods are encouraged to ensure the needs of all residents are included.

Last, towards the continuation of an evidence-based response:

Recommendation 10: In strengthening Recommendation No. 5, it is advised that further community-wide assessments and ongoing evaluations are supported by donors and service providers. These would add a formal component to the other more informal processes of continuous learning noted above. Possible starting points include a synthesis (meta-evaluation) of the providers' in-house programme evaluations to assess impact, feasibility studies to feed into the design of the strategy and approach, and an audit of codes of practice to gauge relevance, adherence and consistency.

In sum, the future fulfilment of mental health and other developmental needs in Whiterock faces significant challenges. The two root causes are complex, occur on three main levels and continue to create new needs while scratching at old wounds. It is evident that all the developmental needs are interlinked but the exact connections and causal relationships are difficult to discern. Mental health brings its own barriers in terms of restricted access and insufficient recognition. At the same time, the response at the community level is forced to work within a limited professional framework.

Notwithstanding, this assessment also finds numerous indicators of progress and significant opportunities to develop a more equitable share of the peace dividends. In particular, there has been a recent ripening in the willingness of many residents to seek assistance for their mental health needs. Overall, the changes introduced during post-conflict have been difficult to accept but residents now have had ten years to adjust and are undoubtedly resilient. Moreover, it is concluded that the service providers have evidently developed a more advanced and nuanced understanding of problems and needs. Above all, it will be only through a community-wide tackling of these challenges and opportunities that mental health can be adequately addressed, which will allow the community of Whiterock to leave behind its conflict and post-conflict status.

Appendix A. Interviews Completed

Focus groups:

Focus Group 1, 19 January 2007 (7 community organisations and resident associations and a local leader)

Focus Group 2, 19 January 2007 (3 community organisations and a youth worker)

Focus Group 3, 19 January 2007 (4 local organisations)

Focus Group 4, 19 January 2007 (3 schools)

Focus Group 5, 19 January 2007 (Local representatives of the Catholic Church)

Focus Group 6, 25 January 2007 (Corpus Christi Services Counselling Service users)

Focus Group 7, 25 January 2007 (Corpus Christi Services Welfare Advice Service users)

Individual interviews:

Social Democratic and Labour Party Interview, 19 January 2007

Corpus Christi Services Welfare Advice Service Interview, 19 January 2007

General Practitioner 1 Interview, 23 January 2007

General Practice Manager Interview, 23 January 2007

Corpus Christi Services Counselling Service Interview, 26 January 2007

Whiterock Health Centre Interview, 29 January 2007

General Practitioner 2 Interview, 23 February 2007

Youth and Community Worker Interview, 2 March 2007

Springwell House Interview, 5 March 2007

North and West Belfast Trauma Resource Centre Interview, 6 March 2007

Sinn Féin Interview, 7 March 2007

Sharon Campbell Interview (Coordinator of EHSSB TAP), 16 March 2007 (by email)

Appendix B. Terms of Reference

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Director: PJ Connolly LL.M

Following receipt of the researcher's profile and his discussion paper: 'Key Considerations in Approaching a Community Needs Assessment', Corpus Christi Services (CCS) has invited Dr David Connolly, researcher at the Post-war Reconstruction & Development Unit (PRDU), the University of York, to carry out a needs assessment in the local government ward of Whiterock situated in West Belfast. The following details set out the terms of reference.

Description of Project

The Post-war Reconstruction and Development Unit (PRDU) is contracted by Corpus Christi Services (CCS) to undertake and complete an assessment of community needs in the local government ward of Whiterock, West Belfast, Northern Ireland. The ward is made up of a number of inner city housing developments that include: Ballymurphy, Whiterock, New Barnsley/Moyard and Springhill, hereafter referred to as the designated area.[236]

Dr David Connolly, researcher at the PRDU, has been hired as the lead investigator but will draw upon the wider experience and expertise of the PRDU in order to complete this needs assessment.

The assessment will investigate the type and level of general needs, particularly mental health needs, experienced by victims of the Northern Ireland conflict within the designated community as a result of that conflict and related social deprivation. The assessment will be purely qualitative in nature and will incorporate:

- A literature review including current and statutory reports, statistical evidence etc;
- focus group sessions with a representative sample of community and elected representatives; and
- household surveys with a small though representative sample within the designated area.

Dr Connolly will design all of the above interviews and survey questions and select the samples of respondents in consultation with CCS. Dr Connolly will also participate in leading the focus group sessions and will conduct the training of those hired to conduct the household surveys. CCS is responsible for hiring the staff to conduct the household surveys.

Upon completion of the above field research, Dr Connolly will complete the analysis of the findings and conclusions, and will make recommendations where relevant. These will be disseminated through a presentation for all community stakeholders in the designated area, including the Community Relations Council for Northern Ireland (CRC), and in a written final project report to CCS and CRC.

Duration of the Project

The project overall will take place between 5th January 2007 and 30th March 2007. During this time, Dr Connolly will complete 10 full days of work. Four of these 10 days will be spent in Belfast in order to consult with CCS and complete the focus group sessions. The final project report will be submitted to CCS on or before 30th March 2007. Dr Connolly has been made aware that CCS is contracted to the Community Relations Council for Northern Ireland to complete this report by 31 March 2007.

236 This was later revised to include the more representative areas of: Ballymurphy, Whiterock, Springhill, New Barnsley/Springfield, Sliabh Dubh, and the Falls.

Appendix C. Profiles of Lead Investigator and Research Institution

Dr David Connolly is a researcher at the PRDU, Department of Politics at the University of York, UK. From 2000, he has completed several internationally-commissioned needs assessments and programme evaluations in post-war contexts, with concentrated field experience in Afghanistan, Indonesia and Northern Ireland.

Alongside publishing for both practitioner and academic audiences, Dr Connolly teaches on the PRDU's Masters in *Post-war Recovery Studies*, coordinates the annual *Chevening Programme on Conflict Resolution*, and is an associate lecturer at the Department of Social Policy and Social Work.

The PRDU was established at the University of York in 1993 and is an international centre of excellence in post-war reconstruction and development. The PRDU's philosophy is premised on the understanding that post-war reconstruction requires an interdisciplinary, multidimensional problem-solving approach in order to address the integrated complexities of recovery and development. With a central role in providing outstanding strategic guidance and technical assistance to the complete range of reconstruction and development actors, the Unit emphasises the importance of fostering strong linkages between theory and best practice through the generation of high-quality, field-grounded assessments, planning initiatives, and training workshops. The Unit is also distinctive in its emphasis on post-war/disaster recovery studies, which sets it apart from other centres that specialise solely in the adjacent areas of development or peace studies.

At the forefront of post-war reconstruction for 15 years, the PRDU has developed an extensive track record of innovative commissioned consultancies through the successful completion of numerous (short and long-term) projects for all the relevant United Nations agencies, the European Union, the World Bank, a number of national governments, the Red Cross, and many (international and indigenous) nongovernmental organisations. Through these outputs, the PRDU has secured and managed over £1m in external funding, and gained in-depth field experience in Northern Ireland, in addition to the diverse post-war contexts of Afghanistan, Bosnia-Herzegovina, Colombia, Croatia, Egypt, Indonesia (Aceh), Iran, Iraq, Kosovo, Jordan, Lebanon, Former Yugoslav Republic of Macedonia, Nepal, Palestinian Territories, Philippines (Mindanao), Somalia (Puntland), Somaliland, Sri Lanka, Sudan, Syria, Turkey, UAE, Uganda, Vietnam, and Yemen.

The work of the PRDU and its founding director, Professor Sultan Barakat, has received media attention on many occasions.[237] Further information can also be attained from its website: http://www.york.ac.uk/depts/poli/prdu/

237 For example, see the BBC Radio 4 programme, *Thinking Allowed*, 5 February 2003, http://www.bbc.co.uk/radio4/factual/thinkingallowed_20030205.shtml

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