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Injured and disabled casualties of the Northern Ireland conflict: issues in immediate and long term treatment, care and support

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Abstract

Even though injury due to armed conflict is more commonly caused than death, research into injury due to Northern Ireland's four decades of otherwise exhaustively documented conflict is sparse. This article reports on a 2011 study based on interviews with 30 people seriously physically injured in the conflict and 20 of their carers and a self-administered questionnaire survey of a further 76 people injured in political violence in Northern Ireland. All injured respondents reported that emergency medical emergency treatment had been excellent. Those injured in the 1970s reported low expectations of their life expectancy and rehabilitation, a lack of psychological support and lack of help with chronic injury-related conditions. More recently injured people had psychological support and were more successfully rehabilitated but those injured earlier often saw it as 'too late' for psychological help. Influences on wellbeing seem to be: changing professional standards and awareness; policies acknowledging of the effects of conflict; anti-discrimination legislation; development of rehabilitation services; and the reform of disability benefits. *Inter alia*, health professionals' attitudes towards victims and their treatment of injury appear to have a significant influence on outcomes for injured people.

Key words: Northern Ireland; injury; civilians, armed conflict; rehabilitation, jus post bellum, trauma; victims.

Introduction

From 1969 to 1998, approximately 3,700 people were killed in the conflict known locally as 'the Troubles', putting the death rate[1] on a par with that in the Israeli-Palestinian conflict (Fay et al, 1999). The continuing lower level of violence beyond 1998 is largely a result of spoiler activities of dissident groups who do not support the Agreement, feuding amongst Loyalist paramilitary groups and Loyalist contests over flag displays (Steenkamp, 2008).

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The ceasefires and the 1998 Good Friday Agreement did not eradicate tensions between the Protestant and Catholic communities nor was there any significant improvement in the psychological wellbeing of the population (Cairns, Mallett, Lewis, & Wilson, 2003). On the contrary, amid the heightened expectations of the peace process of a better life, local support organisations reported an increased demand for their services. According to some perspectives (e.g. Mac Ginty et al, 2007), Northern Ireland illustrates the pessimistic analysis of Hoeffler and Reynal-Querol (2003) that post-conflict societies are usually not an improvement on what went before.

Northern Ireland was governed directly from Westminster by a succession of British politicians since 1972, until the faltering implementation of devolution and the 1998 peace agreement. Health and social policy (and law and order) has largely remained consistent with Roy Mason's 1970s pursuit of 'criminalisation, normalisation and Ulsterisation' (McGarry, 2012). In social policy terms, Northern Ireland was governed as if it were Finchley[2]. This included an almost complete policy silence about the existence of political violence and its consequences[3]. The increased prominence of voices of victims of the conflict and contests over the legitimacy of claims to victimhood (Breen-Smyth, 2011) is largely a feature of post-Agreement Northern Ireland.

As part of the government response to victims, the Commission for Victims and Survivors (CVSNI) was established in May 2008, as a Non-departmental Public Body (NDPB) of the Office of the First Minister and deputy First Minister (OFMDFM) and under the Victims and Survivors (Northern Ireland) Order 2006, as amended by the Commission for Victims and Survivors Act (Northern Ireland) 2008. The Commission was established to promote the interests of victims and survivors of the conflict. Its statutory duties under Article 6 of the 2006 Order include *inter alia*: the promotion of an awareness of the interests of victims and survivors and the safeguarding of those interests; and the review of the adequacy and effectiveness of services aimed at them.

In March 2011, WAVE Trauma Centre in Belfast, funded by the Community Relations Council and the OFMDFM, advertised a competitive tender for a research study of people injured in the Troubles, and the author won the tender. Until this study was conducted, there had been no comprehensive research on injury or disability as a result of the Troubles in

Northern Ireland. The study on which this article is based aimed to contribute to the establishment of a more complete, accurate and detailed picture of the issues facing injured people and their carers, to improve the recognition of the situation of injured people and their carers and to support the development of more effective and sensitive services.

Survivable injuries are inflicted more commonly than death is caused in armed conflict. Compared to death, the effects of these injuries are arguably more widespread, enduring and demanding on the public purse and health services. By the early 1900s, Whyte (1991) estimated that hundreds of books and thousands of articles had been published on the Troubles. A burgeoning literature has now developed on victims of the Troubles (see, for example the bibliography on the CAIN website). In such studies, the human consequences of conflict are most commonly reported in terms of the number of deaths. The severity of conflict is commonly assessed in terms of diminutions or increases in the numbers of fatalities in any period and loss of human life is regarded as the most grievous of impacts of armed conflict. Consequently, comparatively scant attention has been paid to those who survive critical injury. Yet these people often narrowly escape with their lives and often live with long term disabilities and life-limiting conditions.

Summary of the WAVE study

The study commissioned by WAVE Trauma Centre examined the needs of individuals injured in the Troubles and those of their families, with a particular focus on carers. The research was conducted using a participative methodology and was informed by an Advisory Committee composed of key stakeholders, formed at the outset, of all the key stakeholders, including injured individuals and representatives of the WAVE Injured group, various Victims Group representatives, the CVSNI, the OFMDFM, the Community Relations Council, professional health and social care providers and WAVE.

Definition

The difficulty of defining 'injury' was addressed at the first consultation with the Advisory Group and a working definition for the purposes of the study was adopted. The primary inclusion criterion for participants was that they had suffered: 'life threatening or disfiguring physical injury' in the Northern Ireland conflict. This definition was reviewed and refined as the study progressed. Given that a separate study on psychological injury had been commissioned (Commission for Victims and Survivors, 2011), psychological injury was not

the primary focus. However, where psychological injury had been suffered by those meeting the primary inclusion criterion, they were included, since many of those physically injured have also endured substantial psychological injury.

Methods

A review of the literature was conducted and the evidence on the total numbers of injured people in Northern Ireland was reviewed. In-depth interviews with 30 seriously injured people and 20 of their carers and professional medical and support staff were conducted in the autumn and winter of 2011. These numbers were determined by the limited resources for the study, although a good spread of data was achieved through the use of a quota technique, recruiting interviewees to represent what was known about the total population's age, gender, location, date and type of injury. Interviewees were recruited using a snowball technique based on existing networks in both communities and a variety of support organisations for victims and survivors. Based on the key findings, a self-completion questionnaire was designed and included a Post-traumatic Stress Diagnostic Scale, referred to as the PDS (Foa, 1995) which is a commonly used screening measure for Post-Traumatic Stress. The questionnaire was distributed electronically and in hard copy by members of the Advisory Group and their organisations, and this was completed by a further 90 people injured in the political violence in Northern Ireland. In consultation with the Advisory Group, Northern Visions/NvTv, a community-based digital media centre based in Belfast that specialises in working in partnership with local people, made a 10 minute film and a 60 minute documentary film which documented the research (Northern Visions, 2012). An archive of video interviews with injured people and their carers is under construction and copies of the unedited footage were provided to interviewees who requested it. The study obtained Favourable Ethical Opinion Number 11/NI/0128 on 27 September 2011 from The Office of Research Ethics for Northern Ireland.

Literature Review

Where research on injury due to armed conflict exists at all, it focuses on specific injuries, such as limb or hearing loss from a surgical or triage perspective (see, for example: Armistead, 1977; Hadden, Rutherford and Merret, 1978; Graham and Parke, 2004). This is, however, overwhelmed by the psychological literature focused solely or primarily on the psychological effects of armed conflict and terror[4], and Post-Traumatic Stress Disorder

(PTSD) in particular, which largely treats traumatisation as a purely psychological and one-off phenomenon.

Size and characteristics of the population of injured people

Whilst death[5] is a relatively unequivocal event (although its causation may be disputed), what counts as injury due to conflict has never been definitively established. Thus, estimates are likely to vary depending on the definition applied. Whether or not counts include those who have endured bereavement, grief, incarceration, displacement, loss of employment and traumatisation by witnessing violent events will affect the size of the population. Early in the conflict, estimates suggested that 40,000 people were seriously injured (Daly, 1999); but there is no precise or agreed figure for the numbers of injured people. This study compared several estimates of the total numbers of injured, based on a further elaboration of a review by CVSNI, which is summarised in Table 1.

Table 1: Extrapolation of total population of injured people from previous research[6]

Survey/Research	**Year**	**Findings**	**Sample or study size**	**Survey/study extrapolated to current population***
Cost of the Troubles Study (COTTS)	2002	25.5% of survey experienced severe or very severe experience of the troubles	1,356	456,169
		36% indicated a severe or very severe impact of the troubles	1,356	644,004
Who are the Victims: Cairns and Mallet (NISRA 2003)	2003	16% of survey consider themselves direct victims	1,000	286,224
		30% of survey considered themselves indirect victims	1,000	536,670

Table 1: Extrapolation of total population of injured people from previous research[6]				
Survey/Research	**Year**	**Findings**	**Sample or study size**	**Survey/study extrapolated to current population***
The Legacy of the Troubles: Muldoon, O et al (2005)	2005	30% of the sample had direct experience of the troubles	3,000	536,670
CVSNI Omnibus Survey (NISRA) (2010)	2010	30% of survey had been directly affected by the conflict	1,179	536,670
CVSNI Omnibus Survey analysis (2010)	2010	Suffered physical injuries themselves as a result of the Troubles	1,179	107,334
Royal Ulster Constabulary /Police Service of Northern Ireland (cited in Breen-Smyth, 2012)	Summary to 30/6/2003	Persons injured due to the security situation in Northern Ireland	Census of all injured	47,541
Source: derived from data presented in Breen-Smyth, 2012				

Two sets of figures in Table 1 are lower than others: the CVSNI Omnibus Survey, which specified 'physical injury' and this accounts for the lower figure, and the police figures, which provides the lowest of all total population of injured people at 2003 of 47,541. The disaggregated police data, shown in the full technical report (Breen-Smyth, 2012), reveals that security force personnel account for 36.8% of all injuries, which is somewhat higher than their share of total deaths (30%) (Fay et al, 1999, p.159), suggesting some over-reporting of security forces injury in the police figures. Like all of the data, police data are not based on a specified definition of injury. Furthermore the police will obviously only record injuries known to the police. Police data are thus not likely to be comprehensive, since some people, especially in the Catholic community, went out of their way to avoid contact with the police,

who may also have tended to record local security forces injuries more comprehensively than civilian injuries. The higher figures in The Cost of the Troubles Study and Muldoon et al and Cairns and Mallet are a result of surveys of subjective assessments by respondents of the impact of the Troubles on them.

To summarise, whilst there is some convergence in the estimates of the numbers of people injured during the Troubles, the total size of the population is still a matter of estimation rather than calculation. Such estimates are hobbled by the lack of a commonly agreed definition. Even had government wished to develop policy for this cohort, the lack of even the most basic of data would have been an impediment. The various and ill-defined definitions of 'injury' notwithstanding, certain characteristics of the population such as gender, age, religion and occupational characteristics and their location in Northern Ireland are discernible from the available data.

Patterns of injury

Due to the intensity of violence in the 1970s, there is likely to be a concentration of injured and traumatised people aged from 50 upwards. Particular groups (for example, males) and particular neighbourhoods (those of high intensity of violence) were most likely to be exposed to political violence and its negative consequences in terms of both physical and mental health (Fay, Morrissey, Smyth, & Wong, 1999, p. 77). Communities that have suffered a disproportionate number of deaths also tend to have high levels of poverty and ill health (Campbell, n.d.: 57-58; Fay, Morrissey, Smyth and Wong, 1999; Smyth, Hamilton and Thomson, 2002).

The literature does provide some insight into the effects of specific weaponry on the Northern Ireland population. Hadden, Rutherford and Merrett (1978: pp. 525–531) examined bomb injuries in 1,532 patients in the 1970s in Northern Ireland. They found a total 1,532 explosion victims 9 of whom died in hospital. They included a cohort of patients who suffered from emotional shock. Most of these had no physical injury, and 82% of this cohort without physical injury was female. Amongst those with physical injury, the prevalence of injury to the chest or abdominal organs was comparatively low (10 patients of whom 5 died) as was primary blast injury to the lung (2 patients). A further 16 patients underwent major limb amputations, 4 of whom died. They found 50 patients with burns severe enough to require skin grafts, none of whom died. Burn injuries were predominantly suffered on the head, neck

and limbs, indicating the protective effect of clothing. Hadden, Rutherford and Merrett's study pointed to a pattern that remained more or less consistent, with limb loss being the most frequent serious physical injury due to bombs (Hadden, Rutherford, and Merrett 1978: p 50). However, the IRA bombing campaign, where large city and town-centre bombs were deployed, was largely limited to the 1970s. Thus, limb loss due to such attacks was more frequent in that period, and survivors with limb loss from that era had reached their late fifties and more by 2012 when this study was conducted.

Available literature and the experience of service providers has confirmed that limb loss is one of the most common serious physical injuries due to the Troubles, with hearing loss being the most common. Graham and Parke's (2004) retrospective study of limb loss due to the Troubles analysed demographics of the 129 patients who suffered limb amputations due to the Troubles between 1969 and 2003 (Graham and Parke, 2004: 255). Of this total number of people using their services in Northern Ireland with limb loss due to the Troubles, they found that 9 had died in the period 1969- 2003 (35 years) which gives a death rate of .0069 over a period of 35 years. Using this rate, one could anticipate a further 2 deaths since 2003, leaving a total of 118 people who have suffered limb loss using their services, five of whom have left Northern Ireland.

Table 2 shows extrapolations for total populations sustaining specific categories of injury. A more detailed explanation of these studies and the method of extrapolation is contained in the full technical report of the study (Breen-Smyth, 2012). Again, the results are less than satisfactory since two of the studies (Cost of the Troubles Study Survey, 1999; and Hadden, Rutherford and Merret, 1978) report more general 'damage to health' or 'bomb injuries' without indications of the severity or longevity of such injuries, and these studies produce the highest extrapolated population figures. However, the re-analysis of the Northern Ireland Survey of people with Activity Limitations and Disabilities (NISALD) survey elicited a figure of 8,383 people in the population suffering from hearing loss[7] due to the Troubles, and Graham and Park's 2004 study produced a figure of 113 people in the population living with limb loss due to the Troubles. These latter figures are likely to be more useful to policy makers, but represent a much larger number than that known to the various support services in the victims' sector in Northern Ireland. This points to a hidden population of people injured in the Troubles.

Table 2:
Extrapolation of total population of people with specific categories of injury from previous studies or analysis of patients[8]

Survey/Research	Year	Findings	Sample or study size	Survey/study extrapolated to current population*
Re-analysis of NISALD survey[9]	2007	Persons suffering from damage to sight or hearing only as a result of the Troubles	3,543	8,383
Cost of the Troubles Study Survey (Fay et al)	1999	Persons specifically reporting damage to health or injury	1,356	52,153
Graham and Parke	2004	Limb loss due to the Troubles based on service users from 1969-2003	129	113
Hadden, Rutherford and Merrett	1978	Bomb injuries based on analysis of patients	1,532	20,305

Source: derived from data presented in Breen-Smyth, 2012

Psycho-physiological health

The relationship between physical injury, psychological state, and functional capacity is complex and interdependent. Physical injury will impact on functional capacity, reducing the person’s ability to use their body. This in turn, affects morale and psychological state. Functional capacity similarly impacts on psychological state, and can lead to depression or conversely can give rise to a determination to recover lost functioning due to the injury. Psychological state will influence how the person functions physically and a determination to maximise functioning and live life to the full can greatly improve general wellbeing.

A recent study conducted by the University of Ulster, the Northern Ireland Centre for Trauma and Transformation and Compass working in partnership with the Commission for Victims and Survivors (2011) addressed the relationship between conflict-related trauma and mental health issues in Northern Ireland. They cite the Northern Ireland Study of Health and Stress which found that 23% of Northern Ireland's adult population met the criteria for a mental health disorder in the 12 months preceding interview (Commission for Victims & Survivors, 2011, p. 70). They delineate the key mental health issues with a view to the development of relevant services and training across different sectors (p. 3). They argue for a 'better identification of trauma related needs' and for a 'routine and readily available access to effective specialist trauma services' (p.71)

Research that quantifies the human cost of injury to families and communities is scant nor are the demands on the public purse estimated in the short, medium or long-term. The Commission for Victims & Survivors is one of the few studies focussing on the 'economic burden' and focused on PTSD, its prevalence and effective treatment, and the economic and social impacts of PTSD, as an example of a trauma related disorder. The study, which did not include traumatic experiences due to traumatic bereavement concluded that, since the needs of those affected by the conflict 'are increasingly chronic and complicated' (p.58), current estimates of the impact of the conflict are likely to be conservative.

The WAVE Sample

The study reported here, conducted in 2011, undertook in-depth interviews with 30 seriously physically injured people and 20 of their carers and a questionnaire survey of a further 90 people injured in the political violence in Northern Ireland. There were limitations in the composition of the sample due to the lack of a sampling frame, the scale of the study, recruitment strategies, low response rates to the survey and the participation of particular networks in recruiting participants. These limitations are discussed at length in the full technical report (Breen-Smyth, 2012). Nonetheless, there is a substantial convergence in the findings across these cohorts.

Significantly, in spite of using a quota for recruiting interviewees, the sample contained disproportionate numbers of injured people from particular victims' groups, for example 39 respondents associated with WAVE, or occupational groups, such as disabled former

members of the security forces. Some 56.6% of the sample is perceived as Catholic and 43.3% as Protestant, in line with the distribution of deaths in the population. In all, 15 respondents (19.7% of total sample) identified themselves as members of the security forces, a further 2 respondents identified themselves as civil servants, one described his occupation as 'MOD' (Ministry of Defence) and 5 did not respond, so it is possible that the share of respondents who were members of the security forces is even higher. Table 3 shows the gender and status of the sample on injured people.

Table 3: INJURED SAMPLE: Status and gender			
INJURED STATUS BY GENDER	**Male**	**Female**	**Total**
Civilian	14	8	22 (73%)
Former RUC	4	1	5 (17%)
Former UDR	1	0	1 (3%)
Former political activist	2	0	2 (7%)
Total	21	9	30(100%)

The sample is concentrated in three age ranges: 41-50 years old; 51-60 year old; and the largest age which is the 61-70 age group. Political violence was particularly intense in the 1970s, so the age profile of the injured and traumatised population is likely to show a concentration in the age range from 50 upwards. Consequently, respondents were recruited on a quota basis in order to reflect that age distribution. Half of the sample was between the ages of 11 and 30 at the time of their injury. The age demographic is likely to be broadly reflective of the pattern of injury in the general population, although this cannot be stated definitively due to limitations in the sample. Table 4 shows the date of injury and gender of the sample.

Table 4: INJURED SAMPLE: Date of injury by cause of injury					
CAUSE OF INJURY by DATE OF INJURY	**1970s**	**1980s**	**1990s**	**2000 onward**	**TOTAL**
PREMISES BOMBS	6	1	1	0	**8**

Table 4: INJURED SAMPLE: Date of injury by cause of injury					
CAUSE OF INJURY by DATE OF INJURY	**1970s**	**1980s**	**1990s**	**2000 onward**	**TOTAL**
GUNSHOTS	7		1	0	**8**
GUN / ROCKET ATTACK ON PERSON	6	1	0	0	**7**
BOMB ATTACK ON PERSON	1	1	0	0	**2**
PLASTIC BULLET	0	2	0	0	**2**
PUNISHMENT ATTACK/GUN	0	0	1	1	**2**
ARMY VEHICLE	1	0	0	0	**1**
TOTAL	**21**	**5**	**3**	**1**	**30**

The majority of respondents were married (56.6%) with a further 14 (18.4%) being divorced, 7 (9.2%) widowed, 9 (11.8%) single and 1 co-habiting, and the research showed that most injured people were cared for by their spouse or other member of their immediate family.

Nature, effect and impact of the injuries

Table 5 summarises severe injury amongst interviewees. The most common injury was partial loss of hearing (33 participants, 43.4%), with 28 interviewees (36.8%) reporting disfigurement other than facial (damages at hands, legs etc). A further 11 interviewees (14.5%) mentioned facial disfigurement, with smaller numbers reporting triple limb loss, double limb loss, loss of one eye, partial loss of sight, total loss of sight, total loss of hearing. 6 interviewees (8%) reported multiple injuries as a result, for example of being in a bomb explosion.

Table 5: INJURED SAMPLE: Extent of injury			
INJURED TYPE OF INJURY BY GENDER	**MALE**	**FEMALE**	**TOTAL**
LOSS OF ONE LIMB	1	2	3
LOSS OF TWO LIMBS	4	1	5

LOSS OF MORE THAN TWO LIMBS	0	1	1
PARTIAL LOSS OF SIGHT	1	0	1
SEVERE LOSS OF HEARING	1	1	2
GUNSHOT WOUNDS	6	2	8
DISFIGUREMENT	0	1	1
WHEELCHAIR BOUND / PARALYSIS	4	0	4
BRAIN INJURY	1	1	2
PARALYSIS OF ONE LIMB	2	0	2
PARALYSIS OF TWO LIMBS	1	0	1
TOTAL	21	9	30

As a result of their injuries, 23 respondents to the survey (30.3%) cannot not walk; 15 (19.7%) experience constant pain; 6 respondents (7.9%) reported brain damage, depression, anxiety and/or panic attacks; 4 (5.3%) are paraplegic; and 2 (2.6%) experience paralysis in one limb.

Less than half of survey respondents, 31 (40.8%) reported a total recovery, with exactly half, 38 (50%) reporting a partial recovery and 5 (6.6%) reporting no recovery since injury. Many reported severe or moderate mental health issues and the highest proportion (61 survey respondents; 80.3%) reported multiple health problems. Most participants expressed concerns about the impact of ageing on their already diminished health.

The most common response among survey respondents to the question about the impact of their injuries was that it had totally changed their lives. Restricted mobility had severe impacts on respondents' lives and self-perception. Respondents also reported that their injuries had led to loss of employment and the often the loss of their home. The impact of injury had caused *inter alia* family stress, relationship breakdown, loss of educational opportunity, restricted social life, and mental health problems. A number of respondents attributed their alcohol abuse to the result of their injury.

Medical care, pain management and aids

Respondents reported that emergency medical treatment was excellent, and acute hospital care was of a high standard. However, medical care for chronic health issues was less satisfactory. Those who lost legs reported chronic problems with their stumps such as abscesses, need for surgical re-sectioning of stumps and so on. Injured people who were severely wounded or who carry shrapnel in their bodies report continuing problems with wounds or scars re-opening or shrapnel travelling to the surface of the skin and breaking through, sometimes many years after the injury.

For some people with embedded shrapnel or gunshot wounds, those who lost limbs and suffer phantom pain and severe itch, or those who lost mobility or sustained neurological damage, pain management is a chronic problem. Some described a sense of not having their pain taken seriously, difficulty in accessing pain management and of having to learn to live with pain. According to service providers interviewed, pain management continues to be an unrecognised and under-resourced issue and the psychological aspect of pain management is not always understood by family doctors and health professionals outside the specialism.

Many of those who had lost lower limbs reported that prosthetics were not always suitable for use over longer periods, since some need elbow crutches with prosthetics, which ties up their hands. Prosthetics also become more difficult to use as the person gets older. As a result some decide to use a wheelchair in preference. Some respondents who lost both legs had stability and safety problems using prostheses leading them to use wheelchairs for safety reasons as they get older or experience falls. This group of respondents reported a difficulty in accessing longer-term provision, including difficulty in accessing help for circulation problems, pressure sores, muscular-skeletal problems and chronic pain. These problems were particularly acute in the past. One Belfast woman, now in her 60s, who lost a leg in a no warning bomb in 1971 described how, following her discharge from hospital, her family were left to their own devices to cope. Her father had to improvise bathing arrangements for her:

> He went out in the Castlereagh Road looking for a farmer to get a barrel that I could use to shower. Because we had 10 minutes with a social worker who said, "I don't think you need anything" and went away. So we had to look for things ourselves.

Michael Patterson, who lost both his arms in a rocket attack on his Land Rover when he was serving in the Royal Ulster Constabulary, attracts attention and stares, which he has had to learn to deal with:

> I remember the week after I got out of hospital, I hadn't got my set of artificial arms at this point … so the sleeves of my jacket were dangling, just flopping about. I was in a cast brace so I was hopping across the road. People were standing at a bus stop staring.

Expectations of life expectancy and rehabilitation

A limited amount of physical rehabilitation was provided to injured people in the 1970s and those provisions were consistent with standards at the time. However, little consideration was given to occupational or other forms of rehabilitation, and in many cases none was offered. Consequently, those injured in the early period of the conflict (1970s) reported comparatively low expectations of their life expectancy, recovery and rehabilitation. They spoke of 'not being expected to live this long' and that past attitudes to disability had shaped their social access, their expectations and self-image. Their achievements and life chances were considerably limited by these factors. Most were economically inactive and finding work, even if they were physically or mentally capable of doing so, would have almost impossible. Past and current barriers of discrimination against disabled people, long absence from the workplace and current high unemployment rates makes current economic activity impossible for many people injured in the 1970s and 80s. Yet they are subject to the government's cuts in disability benefits.

Those more recently injured were more likely to return to work and also to consider themselves 'survivors'. Some respondents were able to work for a period of time after their immediate recovery, but reported that deteriorating health forced them to stop work well before retirement age. The impact of injury on employability has implications, not only for physical and psychological wellbeing, but for economic status and future pension entitlements.

Finance, poverty, benefit dependence, pensions and threats to benefits

Campbell (n.d.) points out that the communities that have suffered a disproportionate number of deaths also have high levels of poverty and ill health. By March 1995, the British

government had paid a total of £1,119,585,000 in compensation for the Troubles, £300,516,000 in damages to property and £814,219,000 in personal injuries. Expensive though this provision was, many of those affected did not qualify for compensation and there were obvious inequities in the compensation scheme. Most of those interviewed had long since exhausted any compensation they were awarded. Most of respondents were benefit dependents and derive their income from pensions, disability and welfare benefits. Thus, injured people are particularly fearful of the consequences of benefit reform. Annette Creelman, a welfare rights expert, explained:

> There are a number of changes [which]… will continue in the next 3-4 years. The main [change] which is a big cause of concern, is the transfer of clients from Incapacity Benefits over to Employment Support Allowance [ESA].… It will affect all our clients apart from those who are three years from the state pension age. The test for ESA is very different from Incapacity Allowance... As a result I do expect now that a lot of people will fail the test. … Now you have to weigh this up with the possibility for these people to be able to get a job, realistically in the real world. I think that the government went too far. (Creelman, cited in Breen-Smyth, 2012)

Injured people are also concerned about their families and carers. For Linda Bunting's husband Alec, there is no pension for Linda to collect if he predeceases her, as he was a self-employed taxi driver when he lost his leg. Alec worries about Linda's future if anything should happen to him, as they spent his compensation, as many others did, in buying a house. However, Linda's financial security, if widowed, living without the carer's allowance and without Alec's benefits, is a big worry for Alec.

The services most appreciated by the injured people we interviewed was, beyond doubt, that provided by the Northern Ireland Memorial Fund, which provides direct financial support to victims. The Fund is an independent charity established by government in 1998 to provide financial support for victims of the Troubles in Northern Ireland. This includes people who are bereaved, those who were injured, either physically, psychologically or both and carers of injured people. The Fund's budget is approximately £3.5 million per year allocated to their 5,000 active clients and they had assisted 11,500 people by 2012. However, the long term future of the Fund is not certain.

There is a widespread consensus that individual financial support for those injured in the conflict and their families and carers is centrally important, but varies widely varied and is often inequitable. The issue of lost pension entitlement is currently the focus of lobbying by some victims groups.

Carers

Spouses and immediate family members provide the majority of care for injured people, many at the expense of their own careers and wellbeing. Carers deal with both the physical and psychological needs of the injured person, and there is little recognition or support for this dual role. Recently, there has been some attempt to provide 'care for carers'. The stress that family members endured, coping with the injured person as well as their own personal trauma has, on occasion, been lethal. Peter Heathwood, shot by the UVF in front of his family in 1979, is a wheelchair user. His wife Ann opened the door to the men who shot and almost succeeded in killing him:

> My wife developed problems with her mental health. She never forgave herself for opening the door that night. I would have told her 'it wasn't your fault – they'd have kicked the door in!' But seeing me gunned down and seeing her father-in-law die [Peter's father dropped dead at the scene] she felt to blame for it. She did try at one time to overdose and was in the City Hospital… She started drinking a lot – an alcoholic basically – being dry a lot of the time, but then something would set it off. I could tell this mood. It was like you were looking at a stone with nothing behind the eyes. She was in … all those places that help people – but at the end of the day it ended her life. She died, at only 51, upstairs here… They did an autopsy … she had basically taken a heart attack – but she'd been warned by all the doctors, 'you're taking years off your life'. And God love her … when she was sober and talking about it she said she hated doing it – just something drove her to it to get the pain out of her head… She couldn't get rid of this guilt thing, 'if I hadn't opened the door none of this would have happened'. In many ways Ann suffered more than me. I acknowledge that. My mental health is strong. I'm a fighter. But it destroyed my wife. And she's not even a statistic.

Some carer spouses married their partner after they were injured, knowing the extent of care they needed, whilst others were already married when the injury occurred. In several of these

latter cases the relationship broke down. Carers' psychological and emotional needs may be substantial, but tend to be subsumed in those of the injured person. Carers may also have been witnesses to the traumatic circumstances of the injury, as in the case of R who saw his brother shot. R said:

> I tend not to think about it. … What's the point – it happened. I look at it from the point of view 'What's the point, you might as well just get on with it.' … I have to deal with the real issue which is coping with S every day … I'm not indulging myself.

Nonetheless, in the immediate aftermath, R "was drinking quite heavily after it – to sleep – 'cos I was quite angry and feeling quite hateful". Carers live under considerable pressure and restrictions. Janine McCann, who specialises in the needs of carers, pointed out, "There are key problems with levels of isolation, and rates of depression and ill-health being very high among carers." Other injured people reported their carers suffering strokes, poor physical health, isolation and loss of income. Even when respite is available to carers to give them a break, WAVE welfare worker Annette Creelman said:

> My experience is that some carers wouldn't take respite because the person who they are caring for has nobody else. They are the ones who are kind of stuck. I think that if respite could be more flexible... Maybe it would help them more.

Psychological support

More recently injured people have better access to psychological support, whereas some of those injured in the 1970s and 1980s had none and saw it as 'too late' for psychological help at this point, even though several have significant problems with traumatic memories, sleep disturbance and depression.

Long waiting lists for psychological help with trauma has meant that some injured people were receiving less appropriate general counselling rather than trauma-focused treatment. Several respondents reported having significant problems with alcohol which they use to manage emotional issues. None reported having had help with alcohol misuse, although one man reported that religious practice helped him manage his. Appropriate trauma-focussed mental health services in many areas are over-subscribed or non-existent. Unmet mental health needs can be seen as a public health problem, argues David Bolton, of NICTT:

> The need is of public health dimensions and will for some years to come require public funding to be applied to it in both the voluntary and the statutory sector. (Bolton, cited in Breen-Smyth, 2012: 207)

Social stigma, identity management and life in the community

Northern Ireland continues to be a divided, and at times violent, society and injured people have had to manage their identity as a person injured due to the Troubles. Some people who experienced traumatic injuries due to the Troubles described continuing fear, distrust, and isolation and some reported feelings of resentment and bitterness that intensified after the Good Friday Agreement and subsequent broken promises of help for injured people. Several injured people described a sense that peace has come too late for them and their difficulties were compounded by a lack of acknowledgment for their suffering.

Injured people also face significant identity management challenges. Some injured people with no visible disability but, for example, carrying shrapnel as a result of gunshot wounds say they are suspected of malingering, and they sometimes feel a lack of sympathy with their condition, since it is invisible. Others describe having to manage the prurient interest of strangers in what happened to them.

Others describe encountering suspicion that that 'there is no smoke without fire' and that they were injured because they were "involved" in paramilitary groups. Significant numbers of injured people, especially former members of the security forces, reported on-going concerns about their own personal security even decades later. These fears have an isolating effect and many injured people chose to stay within their own local communities because of such fears. Other injured people pass off their injuries as non-Troubles related in order to avoid being drawn into awkward, invasive or anxiety provoking conversations. One injured civilian had chance encounters with those who had attacked him and the attacker jeered at the injured man.

Those who live in rural areas face particular problems of isolation, making it very difficult in some cases to avail themselves of suitable services. The segregated nature of services means that some victims services in rural areas focus on particular groups such as former members of the security forces and are thus not available to civilians. There is almost complete

segregation between disability organisations which have little involvement with victims of the conflict. Conversely, victims' organisations have little contact with disability groups. Injured respondents who wish to avail of services in the voluntary sector must choose either to attend a victims' group where their disability is not the primary focus of services, or disability groups where their victim identity may not be acknowledged. In addition, victims' organisations, with some notable exceptions such as WAVE, have operated in silos – bereaved families and people injured in the Troubles are segregated into organisations that separately serve the armed forces, civilians, Republican communities, and Loyalist communities.

Truth and justice

Very few injured people have seen the perpetrator of the attack on them successfully apprehended and punished. Peter Heathwood has tried and failed to have his case, which involves alleged collusion with the police, re-examined by the Historical Enquiries Team, who only look at cases where someone was killed, and Peter survived. The death of his father at the scene of the shooting does not count and Peter continues to feel that justice is denied.

Brendan Curran, a republican who was shot by the British Army in 1989, is less focussed on these issues:

> My attitude and belief is that at that stage there wasn't a police RUC but a quasi-military force operating here. There was a war going on. I didn't expect anything different. I was on the other side of the war.

Others achieve some kind of solace from their religious faith. For Florence Stewart, whose husband Jim was seriously injured in the Abercorn bomb in 1972, justice is a matter for her maker and not a matter of earthly retribution:

> We just never think about it. They will stand before the Lord to be judged if they don't repent for what they have done. That's the way we leave it.

Other injured people and their carers feel strongly that they have been denied justice when the perpetrators have not been convicted. Many feel forgotten, relegated to insignificance in comparison to bereaved families. Yet in the wider society, there is also impatience in some

quarters with the persistent demands for truth, justice, investigation and inquiries and a desire to ‘ put the past behind us.’

Gilligan asserts that the language of ‘healing’ or ‘forgiveness’ is preferable in some quarters as it steers away from challenges to the status quo. In 1998, Victims Commissioner Ken Bloomfield noted that those who had relatives killed directly by state forces, or by alleged state collusion, held a ‘firm view that revelation of the full truth of [these] controversial events was far more important for the victims they represented than any other consideration’ (Bloomfield, 1998: 36 cited in Gilligan, 2006). Gilligan argues that healing can be achieved through obtaining justice rather than undergoing therapy.

The influence of professional attitudes

As the peace process took hold, as victims’ voices became more coherent as part of that process, some professionals and policy makers in the statutory services began to reflect on the invisibility of victims of the conflict in their practice. Social worker Arlene Healey has documented how the silence operated:

> On several occasions the stories I heard had such ramifications that I was unable to record them in my notes. Yet in the midst of all this, I seemed to carry on as ‘normal’ with my work, only reflecting on the awfulness of the situation in which I live and work when something ‘very traumatic’ happened like the deaths of several people or the death of a child… The resulting silence… echoed the silence among the ‘caring professions’ in Northern Ireland. At that time I had worked in Belfast for fifteen years, and rarely had I heard these issues discussed in a professional context. It seems that in order to carry out our work we accept this situation, maintaining the ‘status quo’, and remain silent. (Healey, 1996 p 69)

Healey (1996) then began talking to her clients about what they had been through:

> When I really started to look at my work and take into account the effect of the ‘Troubles’. I found myself overwhelmed at times by what I now saw yet had failed to see in the past. .. It is this failure to include the political conflict in our thinking that is central to the problem for those involved in therapy. Maybe questions are not asked because therapists do not want to hear the answers. /Silence is the safest position to

> adopt in Northern Ireland. If you ask questions about the effects of the Troubles and hear the answers, you become involved. You become involved with a problem with no clear answers… The problem and the solution did not just lie within the family system but included a much bigger political system. They had no control over that system and neither did we. We shared their frustration and sense of powerless (sic)… Is this why no one has written or talked about how to help? …

Healey reflects on the causes of this silence:

> Perhaps it is because the conflict is called the 'Troubles' and not a civil war … Another possible explanation is that the majority of people involved with therapy in Northern Ireland are employed by the state… The Department of Health in Northern Ireland has Government guidelines for most situations including rarer phenomena such as organized sexual abuse. There are no such guidelines for working with victims of the Troubles; or young people at risk of being knee-capped; or children whose fathers have been killed etc. The Department of Health has been silent about these issues. (Healey, 83-84)

Buhmann et al (2010) have pointed to the significance of health care workers being 'insiders' in a soceity, but here Healey shows how, even with 'insider' knowledge, workers are silenced and disabled from addressing need. With the advent of devolution and the establishment of the Northern Ireland Assembly it is at least theoretically possible to develop appropriate policies, for victims and survivors in general and for injured people in particular, in spite of the intense politicisation of these issues (see Breen-Smyth, 2011). A number of factors combine to indicate the need for a root and branch reassessment of provision for those injured in the Northern Ireland conflict. At the level of provision for disabled people in general, the world has moved on since the 1970s. Changes in public health, such as increased longevity (NISRA, 2011) together with changes in standards of practice and patient expectations in rehabilitative care[10], the 'discovery' of PTSD and psychological trauma counselling (Summerfield, 1999), anti-discrimination legislation in the form of the Disability Discrimination Act 1995; The Disability Discrimination Act 2005; the Equality Act 2010; and the heightened profile of disability issues (Grey-Thompson, 2012) has meant that those more recently injured have a substantially different experience from those injured early in the Troubles.

It is clear from this study that the absence of rehabilitation and psychological support at an early stage in recovery increases the level of disability. Furthermore, it is not only painful for those denied such help to watch others get it nowadays, but it raises the issue of the obligations of a society to those damaged through what can now be acknowledged to have been political conflict. International Humanitarian Law[11] (ICRC, 1988) sets out an obligation to protect and treat humanely persons *hors de combat* and those not taking part in hostilities and the obligation on the part of the party on whose care they depend to provide care for the wounded and sick. This particularly applies to civilians, who seem to have been least well served to date.

Conclusions and way forward

The availability of services and health professionals' attitudes towards serious injury due to political violence have had a definitive influence on outcomes for injured people and their carers. While initial hospital treatment was seen as good, on-going services and treatment are seen by injured people as inadequate, including limitations in current NHS access to new technological developments in prosthesis and remedial treatment, especially for civilians. The multiple health problems experienced by many injured people requires access to multiple medical and social services. This often results in the injured person or carer having to coordinate and manage multiple health and social care needs. This is a complex and demanding process, which becomes more difficult with age. Many injured people described high levels of anxiety about their future ability to manage their healthcare needs and the welfare of their carers as they get older.

Most immediately pressing are the financial issues for a largely benefit-dependent population who face cuts in disability benefits and expectations of return to workplaces they left in the 1970s and are ill equipped to return to, even if they did still exist. The loss of pension rights for civilians who were injured as a result of the Troubles is another issue of justice and fairness and prospects for special pension provision should be explored. Injured members of the security forces have pension entitlements, but they have been unable to earn additional pension rights in the interim.

The lack of contact between injured civilians and injured former security forces compounds misunderstandings about different treatment through available services, compensation and

financial support. This ensures that division and misunderstandings between the two sectors persist and can be construed as a community relations problem. In the same way, segregation of disability organisations from victims groups is, in many ways, also matter of societal reconciliation.

The need to establish protocols to describe, monitor and analyse the effects of conflict on civilian populations is an unmet challenge to scholars, policy makers, practitioner and parties to conflict alike (Taback and Coupland, 2005). What to do about the human consequences of conflict is an issue of *jus post bellum* (Clifford, 2012), and raises issues of social justice and fairness. The UK government will be ill placed to pronounce on how other nations perform if they preside over failure on this issue domestically. With the advent of devolution and the establishment of the Northern Ireland Assembly the development of appropriate health, social care and social security issues could benchmark such provision elsewhere. Local social and health care professionals are similarly challenged to review their past practices and orient themselves to what Buhmann et al (2010) call ‘whole sector change’, which will be a crucial factor in successful work with injured victims and their families.

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[1] This is calculated on a per capita basis thus this number of deaths rate highly in a population as small as that of Northern Ireland, which varied between 1.54 million in 1971 towards the beginning of the current conflict up to 1.811million in 2011.

[2] Margaret Thatcher is wrongly credited with saying that 'Northern Ireland is as British as Finchley." What she actually said in a Commons speech on 10th November 1981 was "Northern Ireland is part of the United Kingdom; as much as my constituency is."

[3] The Northern Ireland Multiple Deprivation Measure 2010, (NIMDM) the so-called "Noble Indicators" report includes only one mention of the Troubles or political violence, thus: "Mental health indicators were first included in the NIMDM 2001 after consultation showed that it was viewed as an important aspect of health deprivation, particularly as it may capture some of the long-term psychological costs of the Troubles." The physical or economic effects are still not taken into account in spite of the issue being raised by the Cost of the Troubles Study from the 1990s onward.

[4] An exception is Hume and Summerfield (1994), who studied wounded ex-combatants in Nicaragua, which recognised both physical and psychological injury. Studies focus on veterans of Vietnam, the Falklands and other conflicts but rarely on injured civilians.

[5] Sutton (1994) compiled one of the first databases of Troubles-related deaths followed by The Cost of the Troubles Study / Fay, Morrissey and Smyth, 1998; McKeown (2001; 2009) and the work of the Deramore Group (McKitterick et al, 1999). Melaugh / INCORE maintains a list of deaths to date (Melaugh, 2013). The

consensus view is that there have been approximately 3,700 deaths due to the Troubles, about 3,500 of which occurred in Northern Ireland.

[6] A detailed description of how this table was compiled is available in the full technical report of the study, Breen-Smyth (2012).

[7] There is no indication in these data of severity of hearing loss.

[8] A detailed description of how this table was compiled is available in the full technical report of the study, Breen-Smyth (2012).

[9] The 2007 Northern Ireland Survey of Activity Limitations and Disability (NISALD) survey was a comprehensive survey on the prevalence of disability in Northern Ireland and the experiences and socio-economic circumstances of people with disabilities. The full dataset for the NISALD survey was acquired and re-analysed.

[10] See, for example, the National Service Framework (NSF) for Long Term Conditions (2005)

[11] The British government has resisted attempts to apply international law of armed conflict to the Northern Ireland conflict. See para 58 of UN General Assembly Fifty-eighth session Agenda item 113, which states "…Northern Ireland… is not an armed conflict within the meaning of the Geneva Conventions and the Additional Protocols thereto…" However, this argument has been considerably weakened since the Belfast Agreement is made up of two interlocking documents, one of which, the British-Irish Agreement has the status of an international peace agreement.