# Analysing Baseline Data on Peace Walls (5): Exploring the Socio-economic, education and employment factors

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## Introduction

*The Together Building a United Community* (TBUC) 2016/17 Update Report highlighted the continued role of the Department for Justice's Interface Programme Board in supporting the Northern Ireland Executive commitment to remove all interface barriers[1] by 2023. The update report indicates that 'at the start of the process there were 59 structures, and that figure at the end of March 2017 was down to 50, with sections of five other structures removed'.

Moving forward, the Department is committed to developing a range of initiatives with communities that will create the conditions for the removal of the interface barriers. In order to understand the 'conditions' necessary for barrier removal, it is important to look beyond community safety and security issues, and explore the social, economic and health factors, which shape and impact upon communities' societal view.

The following policy brief draws on research conducted through an Economic and Social Research Council (ESRC) grant that looked at peace walls and public policy with the Department of Justice (2015), findings from a recent project which was developed through the Administrative Data Research Network (ADRN)  that explored 2001 and 2011 Census data specific to population areas which contained peace walks, and wider academic research. Broadly speaking, the work to date on peace walls in Northern Ireland has focused upon four key thematic areas: mapping and quantifying the type, number, location and ownership of the structures; the impact of the violence of the 'Troubles' and on-going residential segregation on the lives of residents including young people that live closest to the peace walls; analysis of the policy context on 'peace-walls', and the views of residents on the impact (and future) of the walls in terms of dismantling and transformation.

This policy brief shifts the focus of analysis to determine whether peace walls and communities in closest proximity to them *per se* are associated with differences in health, education and economic outcomes.

## What does the research tell us?

The wider international literature documents the explicit links between poverty, poor educational attainment, unemployment, social exclusion and mental health issues which tend to afflict urban working-class areas generally, regardless of the country in question (Browne and Dwyer, 2014).

But while facing a similar myriad of interlinked social problems, Northern Ireland also faces the added dynamic of widespread residential physical segregation and the legacy of an ethno-na-

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tional conflict. Hargie et al. (2006, 2011) have referred to this juxtaposition of 'ordinary' social and economic deprivation with segregation and sectarianism facing those who live in interface areas as a 'double penalty'. It is of little surprise therefore that:

**"The most socially deprived areas in Belfast are also areas where "peace walls" or interfaces between communities are prominent, are areas of lowest educational attainment with the fewest amount of children and young people progressing into third level education, and are places where youth unemployment runs highest"**
(Browne and Dwyer, 2014, p.800).

This social and economic deprivation appears to apply at both an individual/household and a communal level. In relation to the former, the 'Cost of the Troubles' study found that "The group with the highest intensity of violence (experience) was also characterised by households with extremely low incomes" (Morrissey et al., 1999, p.106).

More recently, Tomlinson (2016, p.111) has drawn upon data from the 2012 United Kingdom (UK) wide Poverty and Social Exclusion Survey, which showed that, "*there was a clear link between specific conflict experience and higher deprivation rates...*"

Respondents with 'high' levels of personal experience of the 'Troubles' were 1.85 times more likely to have lived in poverty in the past, 1.16 times more likely to state they are poor 'sometimes' or 'all the time', and 1.76 times more likely to lack three or more essential items most people take for granted as they 'cannot afford them' (Hillyard et al., 2005).

While this data relates to personal experience of the conflict and not to interfaces *per se*, given that 70% of all politically motivated murders in Belfast between 1996 and 2001 occurred within 500 metres of an interface barrier (Shirlow, 2003), it can be assumed that it is those individuals living in close proximity to a peace wall who are more likely to have had direct experience of

violence than their counterparts living elsewhere in Northern Ireland.

## The relationship between deprivation and peace walls

However, if many individuals and families living in communities dominated by peace walls tend to be amongst the most socially and economically deprived in Northern Ireland, then so too are the larger communities of which they are part.

For example, data from the Northern Ireland Multiple Deprivation Measure (NIMDM, 2010; NISRA 2010) indicates that communities living on an urban interface such as the Falls, Shankill, Ardoyne, Crumlin Road, New Lodge, Springfield Road and Duncairn (all of which are in North and West Belfast) comprise 14 of the 20 most deprived wards in Northern Ireland (70%).

Essentially, these statistics capture the challenge in attempting to interpret a relationship in the form of 'causation' between peace walls and increased rates of deprivation. There are major forms of inequity in those parts of Belfast where the peace walls are located. However, the evidence from the ADRC analysis strongly suggests that the driver for this is the by-now well-established epidemiological relationship between more generalised socio-economic disadvantage and adverse health outcomes, rather than any effect wrought by living in proximity to the walls *per se*.

## The relationship with education

If poor socio-economic conditions are intimately associated with living beside a peace wall because of where it is located, then it follows that this will impact upon the educational attainment of residents. In their analysis of data on 'school leavers' from 2013/2014, Borooah and Knox (2017) found that where a pupil lives in terms of Super Output Areas (SOAs) could significantly impact upon the chances of passing General Certficate of Secondary Education (GCSE) examinations. They found that in 2013/2014,

school leavers from areas in the highest deprivation quintile had a 53.5% chance of obtaining good GCSE passes, and a 28.9% chance of getting good A-level passes, compared to 68.6% and 40.7%, respectively, for school leavers from areas in the lowest deprivation quintile.

Similarly, the Northern Ireland Executive and Department of Education have noted that, "*social disadvantage* (defined as Free School Meal/FSM status) *has the greatest single impact upon* (educational) *attainment*" (NIE, 2016, p.56). In 2015, only 41.3% of school leavers with FSM's attained five GCSE's A*- C grade, compared to 73.7% of those without FSM status (ibid.).

Horgan (2009) has argued that these statistics with regards to socio-economic indicators and academic performance at secondary level are not surprising; but crucially, suggests that family poverty impacts on every aspect of a child's experience of school from the earliest years of primary school.

Horgan also suggests that children from poorer backgrounds (including working-class interface communities), essentially get used to the fact of their social position from a very early age; the children seem to accept that this will be reflected in their experience of school; that they are not going to get the same quality of schooling, or of outcomes as better off children.

Thus, while lower levels of educational attainment invariably depend upon wider socio-economic and structural inequalities, it can also develop from the 'cultural transmission' of values from parents to children. Children from more affluent homes tend to be taught to place a greater emphasis and value on education, while those from poorer backgrounds tend to 'know their place' in society (Scherger and Savage, 2010).

In their study of the 'social ecological risks' to educational achievement in Northern Ireland, Goeke-Morey et al. (2012, p.249) drew upon data on 770 adolescents that found,

**"A family environment high in-conflict and low-in-cohesion was the sole environmental predictor of poorer academic achievement."**

They suggest that,

**"A peaceful home environment may provide youth both the instrumental and emotional support necessary for academic success, including emotional and biopsychological regulation, adaptive sleep patterns, a sense of emotional security, self-confidence, and a culture of achievement"**

These 'external' (structural inequalities) and 'internal' (culturally transmitted) barriers are also apparent in tertiary education. The Administration Data Resource Centre (ADRC, 2015) found that 'household social class' and housing tenure/value were those factors most strongly associated with enrolling in third level education (with those in rented accommodation approximately 70% less likely to enrol than their counterparts in the most expensive houses). Area level deprivation was also a significant factor in discouraging enrolment in third level education (ibid.).

As a result of all of these factors, Northern Ireland tends to have the highest number of young people not in education, employment or training in the UK (NEETs). In 2013, 22.6% of young people in Northern Ireland were deemed to be NEETs, 2% higher than the UK average (Browne and Dwyer, 2014, p.800). Given the multiple levels of deprivation facing interface communities it is more than likely that a significant proportion of these young people come from 'working-class' interface communities.

Indeed, in two studies of young people living in interface communities in Belfast (Hargie et al., 2006) and Derry Londonderry (Roche, 2008), unemployment and sectarianism were the two most important (and at times inter-linked) issues facing young adults. Hargie et al. found that young people were reluctant to venture outside of their own community due to a fear of what lay 'beyond the wall'. This led to a 'bubble syndrome' where unemployment passed from generation to generation in interface communities, and for many young people was viewed as the 'norm' (Hargie et al., 2006, 2011).

## What about Physical and psychological wellbeing?

The Northern Ireland population generally has been significantly impacted upon by the violence of the 'Troubles' (Kelleher, 2003), with estimates suggesting that 39% have experienced a conflict-related traumatic event and 16.9% witnessed a death or serious injury (O'Neill et al., 2014).

Given the scale of the conflict (more than 3,600 deaths and 40,000 injured) it is perhaps unsurprising that the population at large tends to have poorer levels of mental health and higher levels of 'psychological discomfort' than both the rest of the UK and the Republic of Ireland (O'Reilly and Stevenson, 2003; Murphy and Lloyd, 2007; Murphy, 2008; Bunting et al., 2011, 2013; Wang et al., 2011).

Perhaps even more surprisingly, levels of mental health in Northern Ireland appear to be even poorer than in other countries also emerging from protracted ethnic and political conflict (O'Neill et al., 2014; O'Connor and O'Neill, 2015). Furthermore, Mahedy et al. (2012, p.646) have contended that, "…*it could be hypothesized that an underlying continuum dimension (sic) of anxiety and depression is present in the Northern Irish population.*"

If one looks more specifically at the conditions facing residents of urban interface communities (given the socio-economic deprivation and legacy of a conflict where, as previously noted, 70% of all killings in Belfast took place within 500 metres of a 'peace-wall' [Shirlow, 2003]), it is apparent that there are likely to be even poorer levels of health for those living closer to the peace walls (Myers et al., 2009; Browne and Dwyer, 2014).

Tomlinson (2016) found that those individuals with high experience of the 'Troubles' were 2.65 times more likely to be at risk of mental illness than those with no such direct experience. The risk of Post-Traumatic Stress Disorder (PTSD) in particular is higher for those exposed to a conflict related traumatic event, as opposed to those individuals only exposed to a non-conflict related traumatic event (O'Neill et al., 2014).

Indeed, Ferry et al. (2014) found that events that were characteristic of a violent conflict, including the unexpected death of a family member/loved one, witnessing a death or a dead body or someone being seriously injured, accounted for the highest proportion of the overall public health burden of PTSD (18.6, 9.4 and 7.8 %, respectively). This built upon the findings of the 'Cost of the Troubles' study, which documented that approximately 30% of the 1,300 participants in the research suffered from the symptoms of PTSD (Morrissey et al., 1999).

This included disturbed sleep, upsetting memories, overconsumption of alcohol and higher than average use of prescription drugs, all of which were more readily apparent amongst those residents who lived in areas where the violence was of a 'high-intensity'. While anyone can suffer from PTSD regardless of where they live and depending upon their individual experience; given that much of the violence and most of the killings occurred within interface communities, it is plausible to surmise that those living in these communities are at greater risk of suffering from mental ill-health and/or PTSD.

This would appear to be borne out in a recent large-scale study, which aimed to explicitly assess the potential for poor levels of mental health based upon residential proximity to interface barriers (see Maguire et al., 2016).

The study assessed health record data on 1.3 million individuals living in Northern Ireland and found that living in a neighbourhood segregated by a 'peace-line' increased the likelihood of using anti-depressants by 19%, and of anxiolytic medication by 39%. While a previous study (French, 2009) had suggested that it was segregation in and of itself which had an adverse effect on mental health, Maguire et al. in fact suggest that it is the proximity to an interface structure which is the much more significant factor in the use of prescription medicine and poorer levels of mental health.

They suggest that this is a crucial point to understand, as "*Individuals living in areas with a*

*segregation barrier are without doubt segregated, but it may be the built environment and the segregation infrastructure, not population composition per se, that is affecting mental health in these areas*" (ibid., p.7).

Paradoxically therefore, while peace walls may provide local residents with a sense of security (Byrne et al., 2015), on another level they may also be impacting negatively upon their mental health.

There are two added issues to consider with regards to mental (ill)health, particularly relating to trauma. Firstly, poor mental health and trauma can often be transmitted inter-generationally (McAllister et al., 2009; Taylor et al., 2013), with the children of parents who had conflict related trauma more likely to display 'emotionality' and 'hyper-activity' in terms of their behaviour (Fargas-Malet and Dillenburger, 2016).

Secondly, poor mental health and conflict related trauma is related to higher levels of self-harm, suicide ideation and the act of suicide itself (O'Neill et al., 2014).

Perhaps more significantly, once again socio-economic status plays a significant role in increasing the likelihood of self-harm or suicide. Data indicates that between 2010-14, there were 8.4 deaths by suicide per 100,000 population for 0-19 year olds in the most socially and economically deprived areas in Northern Ireland. In the least deprived areas, the figure was 2.2 (NIE, 2016, p.44).

In addition, between 2010/11 and 2014/15, there were 50.6 hospital admissions due to self-harm per 100,000 population for 0-19 year olds from the most deprived areas. For the least deprived areas, once more, the corresponding statistic was 22.4 (id.).

Building upon these statistics, Cummings et al. (2016, p.16) have argued that:

**"Children and young people growing up in the participating interface areas were aware of and perhaps were more vulnerable to severe mental health issues. This in turn may be related to the risk for self-harm, such as self-mutilation, cutting, burning or purging. Thus, an increasing risk that youth must attempt to deal with is risk for higher levels of self-harm and/or suicide than may be the case in other types of neighbourhoods."**

## What are the policy implications?

The data suggests that peace walls do not specifically account for differences in social, educational and health variables in areas close to peace walls. However, the evidence does confirm a measurably higher demographic concentration of people residing in areas characterised by high deprivation levels, when compared to the rest of Greater Belfast and Northern Ireland. Therefore:

• Understanding the 'conditions' necessary for removing peace walls requires a broader focus than one which is framed around community safety and security;

• The evidence suggests that simply removing the peace walls will not address the range of inequalities experienced by residents that reside in the most socially deprived SOAs in Northern Ireland. Therefore, it is crucial that residents understand the relationship between the peace walls and 'quality of life issues', and that any process around barrier removal incorporates broader health, employment and education strategies;

• Communications and messaging on 'barrier removal' are important, especially around rationale, impact and benefits. There is a risk that residents assume an immediate transformation in their 'quality of life' upon the removal of a peace wall;

• The overwhelming majority of peace walls are located within the most socially and economically disadvantaged communities in Greater Belfast. Although, the success of any peace walls programme will ultimately be measured by the removal of physical structures, the legacy of any interventions must also be measured in terms of an improvement in deprivation scores.

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[1]Interface barriers also referred to as peace walls in this policy brief