

BE SAFE, STAY SAFE

Research
into
Community Safety and Disability

Commissioned by

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Contents

1. Introduction	2
2. Research Design and Methodology	8
3. Policy Context	13
4. Literature Review	16
5. Community Safety, Categories of Disability and Abuse	19
6. Community Safety and Daily Life	24
7. General Safety Themes	63
8. Conclusions: Safety and Capacity Building	79
9. References	87
Appendix	89

1. INTRODUCTION

In 2008, the Institute for Conflict Research undertook a partnership-based research project to consider perceptions of community safety, crime and of issues that cause concern and insecurity amongst people living with disabilities in Northern Ireland. The research was developed to ascertain the evidence and need for a five year community-led training intervention programme with a view to assessing what types of training and delivery mechanisms might be useful to address the issues and whose aims would be:

- An increased capacity for self-protection and reduced levels of fear of crime among participants;
- To build community capacity and community ownership of better and safer environments by providing opportunities to promote active citizenship;
- To develop strong community and voluntary and statutory relationships; and
- To increase opportunity for volunteering and engagement within and between communities – volunteer trainers will harmonise province-wide training and support.

Working with the guidance of a steering group comprising partnership members from Leonard Cheshire Disability, Mencap, Rethink, the Northern Ireland Office (NIO) and the Police Service of Northern Ireland (PSNI) to conduct the qualitative research project, consultations were held with these and other organisations representing the needs and rights of people living with disabilities and with their networks of advocates and service users. The organisational commitment of steering group members to community safety issues can be found at Appendix D

The findings presented here consider for the first time in Northern Ireland, what community safety issues arise across each of the three main categories of disability: physical (incorporating mobility, sensory and hidden), mental health and learning. In so doing it considers generic and specific issues relating to individuals who have one

or more form of disability and of those people who have had either disabilities from birth or who have acquired their disability in later life. Given that the political and social circumstances (including armed conflict) have impacted on all people in Northern Ireland and have further resulted in the acquisition of disabilities by some, the report reflects the uniqueness of living with impairments in Northern Ireland.

Many of those issues which arose during that consultation process do not fall within the immediate remit of community safety issues, for example, the extent to which access to services, employment opportunities and how successfully the requirements of the DDA are being met. However they have been included here at the beginning of the section entitled overarching themes as broad thematic issues. They have been incorporated in the first instance to honour the concerns of those who were consulted. Secondly as a general understanding of the fact that while Community Safety issues as defined by the NIO and which will be the focus of any training programme to be delivered focuses on tackling crime and anti-social behaviour, there are myriad factors including those related to poverty, environmental and social inclusion that impact negatively on perceptions and experiences of safety.

Consequently, the research works from an assumption that community safety is a quality of life issue which impacts differently on different people. The category of disability is a broad one and includes a diverse range of individuals who have varied experiences, perceptions, fears and concerns. It assumes that these are in part associated with their disability, but are also connected to other elements of their identity including gender, age, sexual orientation, ethnicity and faith, among others. It recognises that while some organisations, such as Disability Action refer to 'the community of disabled people'¹, others, also with extensive practical and policy-based experiences of the issues facing those with sensory, physical, cognitive, hidden or mental impairments, do not consider themselves to be disabled, nor to belong to any overarching community and some of those deaf people considered themselves to be part of a linguistic minority. There is little consensus between the disability sector and statutory service providers over an appropriate and standardised use of language

¹ Disability Action October 2003 Response to A Shared Future: Consultation Paper

with clear differentials evident between some government departments. For example, discrepancies between the Department of Health, Social Services and Public Safety and Department of Education's use of the words 'disabilities', 'difficulties' and 'needs' are based on different legislative frameworks that use diverse terminology when referring to the same individual's needs.

According to the Northern Ireland Survey Report on Activity Limitation and Disability (NISALD) more than 21 per cent of the population in Northern Ireland has some form of disability (NISRA 2007), and there are approximately 300 groups whose primary beneficiaries are disabled people. All those working in the Disability Sector have the aim of increasing the participation in society of people living with disabilities, to achieve this, two key archetypes, the social and the medical models, remain the principal perspectives through which organisations develop their practice. In Northern Ireland, the boundaries between the models are plastic in some instances and the overlaps are not always easy to define as no organisations follow an explicit and direct policy agenda in relation to their preferred mode of practice-based work. The choice of dominant model is often influenced by access to government funding streams: those working predominantly within a medical model, may perhaps find their working practices and strategic development particularly skewed in relation to rehabilitation routes. The British Medical Association for example, a body that advocates heavily on the part of those living with disabilities specifically, uses definitions drawn from the medical establishment and when working in Northern Ireland, this approach might also be considered true for organisations such as Arthritis Care and Diabetes UK. Conversely, organisations such as Leonard Cheshire and Mencap are clear that their remit is to work within a social model which recognises that disability is above all grounded in institutional discrimination and social exclusion as opposed to the physical differences between people.

The following report explores a range of views and experiences across a variety of settings and is associated with how states of security and insecurity are achieved. It considers what the factors are in achieving these conditions that directly impact upon the lives of people with disabilities. In so doing it focuses on the adult population and

did not seek to engage with or explore issues affecting those under the age of 18. The report acknowledges the impact of residential location on people's experiences and concerns and thus has engaged with people living in both urban and rural settings.

The research considers factors such as fear and safety in:

- the home environment, be that own, family or communal;
- open spaces near the home such as the street or municipal parks and gardens;
- other public environments including shopping centres, public transport and leisure facilities;
- different times of the day and seasons of the year;
- the company of others or when alone.

Although the research principally engages directly with disabled people, the process also involved discussions with a range of support workers and to staff of representative organisations, in relation to community safety across Northern Ireland. These discussions helped crystallise different organisational perspectives on the challenge between the rights of individuals to take calculated risks and that of organisations who have a duty of care for them in supporting them through the complexities of life. These conversations were thus used to provide a broad background and overview of themes and issues and to help inform the research team of issues related to the local context and changes that have occurred over time.

The thematic issues that were raised during the course of the fieldwork are presented with an overview of the topic supported where appropriate by anonymous quotations or case studies from the research participants. The layout of the report has been constructed so that where appropriate, reference is also made to these issues as they might relate to individuals who identify as having a specific category of disability.

The names of organisations that were commended by the participants for providing a helpful service have been included with a view to identifying further good practice in any potential partnership working and relationships.

When furthering the aims of people with impairments and who are disabled the Disabled Peoples' Movement has long debated the appropriate use of language (Clarke and Marsh 2002). This debate has been reflected in the language of official government policy (Office of the Prime Minister 2005) and the terminology used therein is incorporated into this report. The report attempts to avoid inappropriate use of medical labels at the risk of both promoting a view of disabled people as patients and of implying that any medical label is their over-riding identifier. It is understood that language and terminology are changeable and contested, their meanings can be subject to revision and can also change at a faster rate than any guidelines that have been issued by relevant bodies (British Sociological Association (2002)).

The Northern Ireland Context

'The biggest casualty of the Troubles is the Disability Discrimination Act. Here there is a lower level of disability awareness, of employment of disabled people and of physical accessibility - which really is a surprise for a place that has been touched by violence and so many people injured – you'd expect the opposite.' (Belfast man, permanent wheelchair user).

A combination of the social, political and economic focus in Northern Ireland, direct rule and the suspension of devolution has played a part in how what might be described as the Disability Sector in Northern Ireland has developed differently to those in other parts of Ireland and Britain. The focus in Northern Ireland has been and remains on service provision rather than the politics of disability. Here, the physical environment and practical services are concrete issues that have been grappled with in relation to day to day safety in advance of widening the debate as to how attitudinal change and a culture of inclusivity can contribute to the long-term safety of disabled people and the mainstreaming of disability matters into society as a whole. It has been suggested that these circumstances have disabled social movements to take hold in the development history of the Disability Sector. Consequently what has transpired in Northern Ireland is a measured and conservative sector where practical issues dominate in disability discourse compared to other places where tactical issues

prevail. This is in part due to there not yet having been an effective and sustained public argument about the politics and local politics of disability, of the use of language and the need for a sustained capacity building of disabled advocacy workers across the sector that has occurred elsewhere in Britain and Ireland.

Yet the unique circumstances brought about by the legacy of the conflict has dramatically increased the number of people living with disabilities both in Northern Ireland and more widely throughout Britain and Ireland particularly in relation to those who have served time in the security services. Disability Action (2003), estimate that 'approximately 30,000 people have acquired a disability as a direct result of the conflict' with many losing their jobs, families and homes all of which have concomitant safety issues as a direct result of changed circumstances.

Given the breadth of experiences of disability and the particular circumstances in which disabled people have lived and in some instances acquired their impairments, organisations representing those with disabilities has a pivotal role to play in filling a void and enabling the development of spaces and forums in which to further debates in relation to the politics of safety and service provision for disabled people in and outside Northern Ireland. This research will indicate that training by peer advocates has a key part in that process as there has been a need for such identified by disabled people who wish to play a role in the preparation and delivering of awareness about disability issues.

This report attempts to address the gap in the evidence based by drawing on primary research findings. The fieldwork of the research began at a time when the PSNI were launching their second poster campaign in relation to hate-Crime and consequently this particular aspect of community safety might have been evident to some of the participants and informed their awareness of the issues under consideration.

2. RESEARCH DESIGN AND METHODOLOGY

The research project was designed by the Institute for Conflict Research with the support of an advisory group made up of representatives of Leonard Cheshire Disability, Mencap, Rethink, PSNI and the Community Safety Unit. Qualitative research methods, including interviews and focus groups, were utilised for the purpose of the study. A topic guide (see Appendix A) was agreed and revised by members of the group which was used to inform the participants and their support workers, (sometimes in advance of their meetings with the researchers), of the issues to be considered. The topic guide was translated into a number of accessible formats including Braille and recorded onto CD by Visual Access Northern Ireland. A number of visuals were included both for information dissemination and illustrative purposes and as part of an informal formative evaluation of the research methodology the following comment was recorded by one participant with learning disabilities *'It's a good wee questionnaire there, I like the pictures.'*

Sample

Fieldwork was carried out with 213 people aged 18 and over who have experiences of living with impairments or physical disabilities. Table 1, below, indicates the numbers of individuals and the organisations representing them who participated in the research. They have been categorised according to the principal disabilities they experienced. Participants were informed that their contributions would remain anonymous unless they chose to be identified.

Table 1. Research Participants

	Area	Physical		Learning	Mental Health
NA	Belfast	1			
DB	Belfast	1	Mobility		

Be Safe, Stay Safe: Community Safety and Disability

BC	Banbridge				1
SG	Belfast	1	Sensory		
PG	Ballygowan	1	Sensory		
MMc	Belfast				1
RS	Belfast	1	Mobility		
AS	Belfast	1	Mobility		
SG	Belfast	1	Sensory		
JH & GM	Omagh	1			1
JD	Belfast	1	Sensory		
PT, IR, MF	Omagh	3	Sensory		
NICRAS	Belfast				1
Mencap FG 1	Belfast			4	
Rethink FG 2	Belfast				7
Rethink FG 3	Carrick.				2
LCD FG 4	Belfast	4	Mobility/ Hidden		
Mencap FG 5&6	NI Wide			29	
SWC FG 7	Omagh			6	
LCD FG 8	Belfast	5	Mobility/ Hidden		
Rethink FG9	Ballyclare				11
LCD FG10	Omagh	8	Mobility/ Sensory		
Rethink FG11	Magherafelt				12
LCD FG12	Belfast	5			
Arth FG13	Randalstown N'ards Comber	3	Hidden		
LCD FG14	Derry	6	Mobility/ Sensory/		

			Hidden		
Rethink FG15	Banbridge				6
Disability Matters	North Down	10			
Ceder Foundation User Forum	Belfast	8			
Action MS	Belfast	8	Mobility/ Hidden		
Telling it Like It Is	Belfast			9	
Headway	Belfast	6			
Malone House Conflict	NI Wide	14			
Larne Adults' Centre	Larne			20	
Deaf Association NI	Belfast	3	Sensory		
The Centre	Belfast	1			
Total		93		78	42

The sample were contacted both by direct access facilitated by the advisory group and partner organisations and through the researchers' existing contacts within the disability sector. A process of snowballing enabled the research team to benefit further from the knowledge of participants wanting to engage further with the project by suggesting others whose experiences might also be of relevance.

Ethical Concerns and Informed Consent

Written consent was sought from individuals irrespective of whether they or another had identified them as willing to participate. It was agreed that if any aspects of their stories and experiences were to be included in the report, their names would be changed, but otherwise their comments would be verbatim and the accuracy of their verbatim comments was unquestioned. After agreeing to be involved, participants were offered a £10 payment to cover their expenses and by way of saying thank you. To meet the needs of those who might not otherwise have been able to take part,

transport and catering costs were covered when appropriate and childcare expenses were also available. Those participants who were accessed through organisations providing supported living accommodation, were often joined in the interviews by key workers, and all the participants were invited to have another adult present if they so desired.

Guidelines outlined by Connolly (2003) in relation to researching vulnerable groups were drawn on, as was the Statement of Ethical Practice for the British Sociological Association (2002), which informed the language used in the overall research. A list of local support groups was drawn up and was made available to participants.

In the course of the fieldwork, the researchers were aware that as well as agreeing parameters of confidentiality and consent with the participants, they would be required to report any information about crime against persons interviewed to the Police, specifically in relation to cases which had not been reported in the past. No such information came to light.

Community safety in family/home settings was a crucial issue to address, but it was recognised by the researchers and the steering group that this piece of research was neither structured nor had access to the necessary resources required to adequately prepare and support participants before and after their taking part in such a sensitive area. Consequently, it was agreed with Mencap that if, or when they were raised by participants, it would be inappropriate to unpack safety issues within the family setting due to the complexity of the dependency on and support given by family members to some people with impairments and who are disabled. Mencap provided examples of earlier research where participants were left particularly vulnerable and exposed after sharing experiences that they felt left them vulnerable and unsettled.

Data Collection

Material was collated using a variety of processes that were determined by the participants' preferences. These included face-to-face interviews, guided

conversations, discussions in small focus groups, telephone interviews and three workshops. Face to face interviews were conducted at a mutually agreed venue and took between an hour and a half and two hours. Participants were given the opportunity to contact the researchers again if they wished to discuss anything further or, when in a focus group, if they wished to postpone their input.

The research process also involved interviews and discussions with people working and volunteering with disability organisation, with Community Safety Partnerships throughout Northern Ireland and with the PSNI and other statutory bodies (see the Appendix for a full list) .

A small number of participants had English as a second language – in one instance this necessitated translating from a language for which services were unavailable in Northern Ireland and the translator had to be sourced by telephone from the Republic of Ireland.

Secondary Research

Secondary research included a review of relevant academic literature and social policy consultations alongside publications and oral input from the Centre for Disability Studies, University of Leeds.

3. POLICY CONTEXT

Government acknowledges that with regard to people living with disabilities, the requirements of the Human Rights Act 1998, Section 75 of the Northern Ireland Act 1998, the Disability Discrimination Act 1995, the Disability Discrimination (NI) Order 2006, Special Education Needs and Disability (NI) Order 2005 must govern all policy development in the provision of care, treatment and services in Northern Ireland as well as the duties required of bodies representing all those living in Northern Ireland.

Furthermore there has been growing awareness of the problems of violence and hostility towards people with disabilities, and the impact that such incidents have on a sense of safety, and in 2004 crimes against people with a disability has been included as a 'hate crime' in the Criminal Justice (No 2) (Northern Ireland) Order.

To further that end in relation to community safety, alongside the Department of Social Development 'Crime Reduction Policy' and the 'Criminal Justice Review Recommendations' guidance documents have been developed by the various departments in relation to disability issues. Furthermore, the Equality Commission has produced a range of materials to support current legislation that includes a series of Disability Codes of Practice and in 2000 the Northern Ireland Housing Executive (NIHE) launched its Community Safety and Community Relations Strategy.

The Northern Ireland Office's (NIO) Community Safety Unit (CSU) is the central co-ordinating body for community safety and has an overarching strategic role in its promotion which is outlined in the Northern Ireland Community Safety Strategy 'Creating a Safer Neighbourhood through Partnership'. This identifies three main strands to community safety, namely: tackling crime, tackling the fear of crime, and anti social behaviour.

At an operational level, strategic emphases are implemented through the Community Safety Partnerships of each council with an increasing commitment being made by the

NIO to developing partnerships within the community (NIO 2007). In addition to existing PSNI powers, legislation (not without its controversies) in the form of the Anti Social Behaviour (NI) Order 2004 and the Criminal Justice Review Recommendations are being used to address some areas of community safety.

Northern Ireland benefits from international policy advancements as it does from those in other British and Irish jurisdictions and these include both the UN Convention on the Rights of Persons with Disabilities (due to be ratified by the British Government by the end of 2008) and the Department for Work and Pensions Strategy Unit's Report, 'Improving the Life Chances of Disabled People'. This latter work focuses on four key and critical areas of disabled people's life chances including family and transition to adulthood highlighting the need for key workers to be put in place for families with needs in relation to caring for children and young people with a disability. It is the key policy document in use in Great Britain and was extensively drawn on by Northern Ireland in its devolved state to further local policy development and there is little reason to expect DHSSPS or the policies being developed by the NI Assembly to defer from the document's aims.

The implementation of recommendations of the Review of Public Administration provides government and the public sector in Northern Ireland with a unique opportunity to address the positive and active inclusion of vulnerable communities within new and reorganised structures for the planning, commissioning and delivery of public services. There is now an opportunity for this to be taken forward alongside a number of key policies developments impacting directly on the safety and lives of people with disabilities including:

- The formation of a Regional Adult Protection Forum in 2002 which had its production of regional procedures endorsed by the DHSSPS in 2006 (DHSSPS 2006).
- The five key areas outlined in the Promoting Social Inclusion (PSI) Document on Disability currently under development:
 - (a) access to employment,
 - (b) children, young people and families,

- (c) legislation, citizenship and attitudes,
 - (d) transport, access, housing and information and
 - (e) lifelong learning, culture arts and sport.
- The service models outlined in Bamford's review of Mental Health and Learning Disabilities, which aims to bring together interdisciplinary and departmental health and social care networks. However, it is noteworthy that there is no explicit reference made to the link between mental health problems, unemployment, social disadvantage and the Northern Ireland conflict, despite the well-acknowledged relationship between the impact of the conflict and its negative impact on mental well-being.
 - The Protect Life A Shared Vision (2006) Suicide Prevention Strategy with its aim to reduce overall suicide rate by 15% by 2011.
 - The 21/07 NIA Health and Social Care Reform Bill, August 2008.

When combined, applied cross-sectorally and with inter-departmental action plans, these developments might be expected to go some way to secure opportunities for more social inclusion of vulnerable groups within local communities.

4. LITERATURE REVIEW

According to Disability Action (2003:7) ‘the disability community has an extremely weak community infrastructure’ – which may in part be a reason why there currently exists little data across the sector in relation to the numbers of individuals living with impairments and disabilities in Northern Ireland. The 2007 NISALD survey indicates that one in five people in Northern Ireland have an impairment, with over a quarter of families having experience of living with a disability (NISRA 2007)). The Northern Ireland Health and Well-being survey for 2005 indicated that nineteen per cent of the population over the age of sixteen considered themselves to have mental-health problems and approximately 20,000 people are living with dementia, a figure expected to rise by thirty per cent by 2017 (DHSSPS 2008). But there is currently no register for people with disabilities and learning difficulties that might facilitate a more accurate quantification of knowledge. It is disputed that any ‘positives’ such a register would bring would be counterbalanced by a number of negative components including the labelling of individuals

The existing proxy indicators include the numbers of individuals accessing services, children with statements for special educational needs and membership of organisations and disability-related bodies. It is also noteworthy that the 2001 census data relating to the number of those declaring Limiting Long-term Illness (LLTI) indicated that 179,660 people stated that they were not in good health; with 343,107 declaring that they had the LLTI (NISRA 2004).

Little has been written about community safety issues and those related to the prejudice attached to disability locally, with ‘Living in Fear’ (Mencap 1999) an exception geared to raising awareness. However, recent research into the attitudes adults in England (TNS 2008) indicates high levels of stigma, discrimination and misunderstandings of the needs of people with ‘mental illness’. International research, which included perspectives from Northern Ireland was previously carried out on behalf of the Special Olympics to highlight the negative consequences and extent of stigma and prejudice attached to people with learning disabilities (Sipperstein 2003).

Despite a growing body of literature addressing the needs of those affected by the conflict in Northern Ireland, there is much speculation but no material that considers or questions any causal link between acquired physical impairments and mental health issues. This reflects a more general lack of material into the needs of disabled people who have both physical impairments and are mental health service users (Morris 2004).

Death and injury have been a principal cost of the conflict in Northern Ireland (Smyth and Hamilton 2002, Boydell et al. 2008) and one that people with physical impairments continue to address in the context of their being parents, partners, siblings and children as well as sometimes disabled themselves as a result of trauma and violent acts. Tomlinson (2007) suggests that the conflict ‘radically altered the nature and quality of relationships between state bodies and those communities and individuals now recognised as most affected by decades of various forms of violence’. This has particular risks and ramifications for people living with impairments and who have been disabled by these circumstances.

Bamford’s Promoting Social Inclusion (PSI) Report (2007) highlights the lack of understanding in society generally in relation to issues associated with mental health and learning disability. Restrictions in choice in relation to education, housing, and social life are all explored within the context of a society that is not yet equipped to enable people with disabilities to live as safely and independently as they could and should and Bamford’s review supports the view that “an informed community is an important outcome in its own right, but more significantly it is a step towards an involved community” (Para 3.7). However Mencap (2008 point 3.3) suggests that the PSI report should have explored the positive contribution that people with learning disabilities or mental health issues ‘can make to the design and modernisation of public services because of their experiences of using such services’, including identifying the most effective methods for engaging with and reaching excluded groups.

Given the changing demography of Northern Ireland and the body of literature attempting to show a correlation between mental well-being and those experiencing issues of loss compounded by racism as a result of migration, refugee and asylum-status, it is pertinent to recognise that effective communication as a prerequisite for being able to access appropriate service provision. This can be linked *de facto* to feeling safety within a number of settings and is discussed extensively by Tribe and Raval (2003) with a particular focus on people with mental health and learning disabilities who are working with the support of interpreters, advocates and link-workers. McNamee (2006) draws on both primary and secondary research when paying attention to the community safety and general well-being of same-sex attracted men with mental health needs in Northern Ireland.

Research carried out in Northern Ireland by young adults, (Educable 2000) addresses implicit community safety issues when highlighting the lack of choice experienced by participants with learning disabilities and physical disabilities in relation to acquiring independence skills in their social lives and with regard to public transport. Fearfulness and the anxiety of negotiating the built environment as a factor in the disabling and exclusion of people with physical impairments are explored by Keith (1994:62-3) as are the daily experiences and attitudes faced by disabled people:

'I'm always nervous about going somewhere newby the sheer physical concern about whether I can get out of the car straight on to the pavement, whether there will be kerbs. It's anxiety about asking a total stranger (if there is a total stranger to ask) to help me in some way. It's the fear that there will be some obstacle no one has told me about – a step a bollard, a pothole, a locked door....I telephone again. From the car I could see lights on, lots of people in the building. No reply. 'Don't cry', I said to myself firmly. 'Don't cry, you're not to cry.' It never works.'

5. COMMUNITY SAFETY, CATEGORIES OF DISABILITY AND ABUSE

At 45, Barry has had two nervous breakdowns since *'being pensioned off'* because of limb-loss. As an ex-serviceman, his rehabilitation to 'civilian' life was complicated by feelings of vulnerability and stress exacerbated by his being a former member of the state security forces and now living independently in Northern Ireland:

'I lived in barracks all my serving life, and now I am out living in the community again and for the first time in my life I don't feel safe. I'm not sure whether my house is being stoned and I'm being targeted because of my disability or because they know I was in the security services.'

Anthony, 50, was hit with a plastic bullet by the RUC when as a youth he was caught in crossfire outside his family flats in West Belfast flat. Partially sighted and epileptic, he now uses a wheelchair and finds himself targeted by youths in the community who in the past have been abusive and taunted him. Anthony no longer leaves the flat in the evenings to avoid running into them:

'My life is pretty restricted not because I've got a physical impairment, but because I'm disabled by it.'

Cathy acquired her brain injury as a result of a road traffic accident. She and her carers find it hard to find any activity outside the home that she feels comfortable participating in:

'I wouldn't go out in the town anymore, there's too many people I might be lost, or left behind or somebody might hurt me.'

The definition of Community Safety used in this report was drawn from the Northern Ireland Community Safety Office (www.communitysafetyni.gov.uk) where it is

defined as “preventing, reducing or containing the social, environmental and intimidatory factors which affect people’s right to live without fear of crime and of crime and which impact upon their quality of life. It includes preventative measures that contribute to crime reduction and tackle anti-social behaviour.”

Abuse or bullying in this instance are used here as terms which cover single or multiple incidents of physical abuse, sexual abuse, psychological abuse, financial or material abuse, neglect, discrimination and institutional abuse (including the inappropriate use of restraint or medication). These may have occurred intentionally or as result of negligence or ignorance.

The participants who contributed to the research live with a variety of impairments and were being closely monitored because of their needs. Others still talked of there being times when they are more heavily medicated and which can impact on their independence and engagement within wider community networks. One group of participants discussed how they all felt their needs as disabled people are increasing with age in relation to material and emotional support and to adaptations and other resources.

The research team recognises the distinction in the social model of disability between ‘impairment’ and ‘disability’ as described by Finklestein and French (1993) and as further outlined in Morris (2004) and further acknowledge the distinction between impairment and illness (Corker 2002). However crossovers between these distinctions were readily evident in the research sample. And, for example in the case of those living with multiple sclerosis, arthritis and HIV/AIDS, people living with a physical impairment are also to be found enduring distressing experiences that conflate impairment, illness and/or disability which includes both barriers and oppression.

Furthermore, it is pertinent to note that for some disabled people with multiple needs, their principal or first connection with DHSSPS in terms of developing a care package can impact on the services and equipment they are entitled or most readily able access. One man who was hospitalised and diagnosed with mental health needs found

that his profound deafness was considered to be a secondary matter in his care and rehabilitation rather than a core need to be addressed that impacted greatly on his sense of safety in the community:

‘It’s hard enough coming to terms with yourself in relation to other people after a breakdown – but when you can’t hear what people are saying you begin to imagine things, you misinterpret looks, gestures and this can all feed into how willing and able you are to engage with wider society and your sense of vulnerability and safety.’

Both pro and anti-state activists who acquired disabilities as a result of the conflict as well as those who were disabled by the actions of such activists, all recognise that their physical impairments can be complicated by depression, PTSD and other stress related anxieties that bring with them or exacerbate mental ill health and that these in turn impact on their feelings of safety within their networks and the wider community.

For the purposes of this report, and based on a DHSSPS model for the delivery of health and social care packages and pathways, participants are categorised as living with the following three discrete areas of needs and disabilities and were targeted and will in the main be described accordingly, namely, those people with

- Mental health and wellbeing needs;
- Those living with Learning Disabilities; and
- Individuals with Physical Disabilities (including sensory, mobility and hidden needs)

Some of the issues that arose in the fieldwork were of concern to members of each of the categories. For example, participants from across the spectrum all reported having high levels of anxiety about socialising in some pubs and clubs and their concern at being on poorly-lit roads as well as when using public transport on unfamiliar routes. Furthermore participants from all the categories were concerned that there was a need for further participation in decision-making about safety issues for people with disabilities.

The levels of concern in relation to some other issues that arose were specific to individuals' personal circumstances and levels of autonomy. For example, and at the risk of generalisation, those living with physical disabilities were more likely to consider issues relating to their built and natural environment than were those people with learning disabilities, who more often raised concerns about levels of safety in their interactions with other people whether in relationships, encounters with strangers or with individuals they came into contact with who they felt to be in positions of authority. Some of those participants living with mental health issues found it challenging to unravel where their feeling of safety was influenced by external events or by internal pressures. For example, one person diagnosed as living with paranoid schizophrenia discussed being disturbed from his sleep or when relaxing at night by people banging at his door and windows, *'but as soon as I get up, the culprits disappear'* and another with a similar diagnosis described his feelings at the onset of an anxiety attack:

'I stopped in my tracks because I didn't feel safe, and even someone is to come up to me and try and help me, I just don't feel safe and sometimes the police approaching me is very scary because I think I've done something wrong.'

It was less easy to ascertain general trends in the safety concerns of those people who have profound and multiple physical disabilities and whose lives and contributions were being especially mediated by carers. However, a number of those who took part in the research evidenced ways in which they looked after their personal possessions and the value they placed on the support they received from key workers. Some people with learning impairments were concerned about the level of support that they felt was a form of protectionism:

'People think they should keep us safe - they do not want us to take any risks'.

The following lists the main types of experiences in relation to community safety that participants reported, these can be broadly grouped into physical attacks on the

person, forms verbal harassment, damage to property, and difficulties that arise through use of public transport or public space:

- Opportunist physical attacks and beatings;
- Being pushed, jostled or bumped into when shopping;
- Increased likelihood of attacks/bullying/abuse when alcohol is consumed;
- Sexual assaults;
- Discrimination and Exclusion;
- Verbal Abuse;
- House attacked due to adaptations;
- Disabled Car Damaged;
- Theft (including bikes, money, mobile phones);
- Dog foul through letter box;
- Items ‘borrowed’ or given freely that are not returned;
- Insufficient information in appropriate formats on public transport.
- Bus drivers not telling when stop is or carrying on past requested stop;
- Buildings not compliant with DDA;
- Poorly lit streets and public areas; and
- Anxiety when in either over-crowded or under-populated public space.

The next section of the report explores a range of specific issues that affect people’s sense of safety, while the section following that (section 7) highlights a number of broader issues associated with concerns over safety and security.

6. COMMUNITY SAFETY IN DAILY LIFE

The following section sets out some of the core issues in relation to community safety that arose as a result of the primary research and which affect respondents' perceptions of their confidence and safety in the broadest sense. Many of the themes, have similar or interlinked characteristics, for example community safety issues which occur with inadequate signage is an issue that occurs in the context of transport and in buildings for public use. Where possible the authors have tried not to duplicate the information when flagging up the overlap.

While wishing to draw out similarities in experiences, the researchers also want to avoid generalisations across the categories of disabilities given the variations in the interpretations in definitions and conceptions of safety. To that end, the overarching themes, which were raised during interviews and focus groups, are sometimes subdivided into physical, learning and mental health when appropriate and sometimes the issues are illustrated by the experiences and needs of individuals. Some quotations are attributed to particular individuals, but if a quotation is similar to those made by a number of respondents they are not attributed.

Advocacy

'When you look on the ground you see your shadow, well that's me. That is what people treat me like sometimes. A lot of people are starting to stand up from the shadow thinking I'm not taking this no more - it's up to us to educate them.' Chris is a 25 year old man with learning disabilities, one of 150 participants in the Democracy 2 conference organised by a peer-based advocacy group supported by Mencap.

Disabled people are not at the forefront of policy making, and the restructuring taking place as a result of the Review of Public Administration (RPA) has resulted in there being fewer lay specialists than politically motivated councillors representing the interests of disabled people on trusts and boards. There are examples of good practice in the realm of Community Safety campaigns that impact on disability issues, such as

Causeway VIP's (Vulnerable Isolated People) and 'Your Key to Security', but it is noteworthy that representatives from disability forums are not formally represented on any of the community safety partnerships.

In Northern Ireland, there are still low levels of organisations that are run and controlled by people with disabilities and which are engaged in self-advocacy. Consequently, a 'protectionist' mentality remains.

'People think they should keep us safe – they do not want us to take risks, but when I see Ian, I feel at home', Craig, a participant in Mencap advocacy conference for and by people with learning disabilities, is commenting on a fellow advocate from the central England organisation People First, a campaign and advocacy group run for and by people with learning disabilities. Personal choice versus others' perceptions can play a significant part in (re)building confidence in relation to personal and community safety, for example, when people choose to live alone or in sheltered accommodation.

Many disabled people who participated in this research project are already-active in seeking out and disseminating information in relation to their impairments and see gaps that might easily be filled that would enable themselves and others with disabilities to feel safer. Suggestions provided as part of this research included:

- Having disability champions in public places such as shopping centres, and hospitals;
- Having telephone numbers for security in workplace/leisure facilities easily to hand;
- Installing panic buttons;
- Colour coding of floors and other visual stimuli; and
- Developing work with people convicted of drink driving.

One thing that transpired from the fieldwork was an evident commitment by people with disabilities to participate in advocacy, campaigning and the delivery of training through existing peer support networks. There was also a desire and perceived need to

deliver training to statutory agencies, private companies and members of the public in relation to the areas identified above. In each focus group and interview at least half of the participants indicated an interest to be involved in developing and participating in such activities and perceived there to be need to supplement any existing work being carried out on their behalf by other agencies.

Alison (57) was a nurse before she acquired a brain injury as a result of being a passenger in a car that was hit by a drunk driver. Now living in supported housing, she rarely sees her daughters because of the distance from where she lives and consequently has little opportunity to spend time with or care for her grandchildren:

'I've always taken care of people, my family, when I was in the hospital, so talking to people about drinking and driving and them seeing the damage they can do would be a good thing for me and for them.'

Carers and Key Workers

'I still shudder when I think of her.' Deirdre lives with arthritis. She was a wheelchair user throughout her school-life during which she had a dedicated classroom assistant whom she feels was an unwelcome imposition placed on her.

'Given that this was the person I spent most time with at school, it would have been far more appropriate to have had myself at an interview panel to appoint the woman and then I could have let my feelings be known. As it was I spent nearly six years having my hair stroked by someone who tried to keep me wrapped in cotton wool. I was barely out of her sight so I never really had an opportunity to explore my own feelings about safety as everything I wanted to experience alone was seen as risk-taking behaviour. I was 17 and being patronised - I don't do sympathy.'

In contrast to Deidre's experiences, many of the individual carers and key workers were praised by those with whom they were working for their vigilance, long-term commitment and ability to engender independence in those with whom they worked

most closely. They were also frequently commended for their understanding of how forms of touch, the use of physical space, and violations of modesty and privacy can impact on people's feeling of safety. However, others reflected Deirdre's experiences and one woman who had limited mobility, but did not feel safe with her temporary carers, said:

'I'd rather wear a pad than ask for someone to help me to the toilet.'

It was more often than not reported that individual nurses and other workers made themselves familiar with the wider support networks of those for whom they care. When concerns about carers were raised, it was most often done within the context of temporary or agency staff. One recurring issue that arose was in relation to the language or dialect barriers that can exist with some migrant workers who are working as carers:

'I feel very safe when I'm with Terry, she always brings me to the club – but I really don't want to come when she's not there – it takes me a long time to trust someone and I don't like the way some other people lift me or can leave me or need to have me explain things to them. Sometimes it takes a while for people to understand what I'm saying and that can be even harder when they don't speak English very well.'
(Belfast woman, 28 years old, living with cerebral palsy in supported accommodation).

Consistency and continuity in carers recurred as a theme that helped to engender feelings of safety in the community. By way of addressing the challenges that having frequently changing key workers or staff can bring, nursing staff at the Craigavon Hospital were praised for having developed a 'passport' that incorporated hand held records and that is seen to '*go someway to addressing the lack of any standardised assessment forms*' for statutory services. The system, which has also been used with members of the Traveller community, enables the transfer of information between multiple departments and agencies to be within the gift of the service user and consequently ensures that there is no need for the duplication or repetition of

information, but rather a the process of information exchange becomes organic and dynamic.

People living with mental ill health tend to have relationships with key workers that may involve less physical proximity than some people who have mobility or learning disabilities. But that is not to say that the continuity of those relationships is any less connected, valued or necessary. Karen has been living in supported accommodation since leaving Holywell Hospital and relies on her close relationship with her key worker to rebuild her confidence in engaging with people:

'I would be very vulnerable to giving things away – sometimes if I go out and if someone asks me for something I want to be nice, I want people to like me and in the past I have just given away money and jewellery and things to people I don't really know – but with Geraldine, I know she likes me for who I am not what she can get off me.'

In 2008 a shared initiative by NIO, PSNI, DHSSPS and DE launched Access NI (to replace the former POCVA process), which is aimed at providing informed recruitment information about people (including ex-offenders) working in a paid or unpaid capacity with children and vulnerable adults. It does not, however hold or collate information on those who make an application from overseas or who may have recently moved to the UK. No participants discussed the benefits or challenges of the system, though organisations interviewed indicated a degree of frustration in some instances and some were cautious of placing demands on established and existing carer roles where new methods of disclosure might impact negatively on relationships with permanent and temporary workers providing support in the following areas: domiciliary support; crisis response; home treatment teams; Assertive Outreach Teams; and Supported Living.

The amount of time taken for clearance was flagged up by organisations that were concerned about the inherent risks in delays taken to appoint people to positions of employment. An example of a well-qualified night worker being lost to an

organisation due to the slowness in being able to award a contract, was provided as example of the unrealistic expectations employers were placing on potential staff, who might have to wait up to three months for a contract to be awarded.

Some participants were concerned that while supported accommodation brought with it some level of autonomy, relationships with staff could sometimes: *'be more controlling than they are helpful.'* The following examples were given to illustrate this perception:

- *'They try to take over your money tell you how much you can spend.'*
- *'They tried to stop us from getting engaged.'*
- *'(Oriel Supported Housing) It's like Fawlty Towers - they tried to stop my fiancé going on holiday with me and my mum.'*

Carers NI stress that when the carer is a family member, it is crucial to ensure that their respite and other needs are being met so as not to compromise the needs of those whom they are supporting. This will be visited further in the section on families. A number of participants commented on the reduction and closure of some respite facilities that cater specifically for people disabled people and their families, and which will impact negatively on opportunities for respite.

Education

Julia studied Fine Art at the University of Ulster while Caroline's degree was in Social Science at Queens University Belfast. Both were mature students when they enrolled, both are wheelchair users and both shared the experience of choosing to lobby hard for their educational establishments to address discrimination and health and safety protocols to be put in place to enable them to study in a safe and positive environment: *'To get to my lectures I had to travel down a wee dark alley, round the back of the physics building, navigate my way past the bins, and then a long wait till the security men would come to open the back door up'* explains Caroline, in contrast

Julia's negative experiences resulted in effective material resources to address the needs of others with disabilities:

'I went straight onto the Access Committee and at my request they put grab rails in the bathroom, installed automatic doors in place of revolving doors, ramps (eventually) and changed the fire evacuation plans so we made sure that all disabled students had the security number typed into their phone and then if the alarm went off we could phone security and tell them what part of the college we were in.'

Their experiences of safety in a higher educational environment though problematic, were ultimately more successful than those of David who *'had a breakdown at university'* in his early twenties and now in his thirties finds crowds and the prospect of returning to education in a *'high octane student environment too frightening to manage'*.

A number of colleges of further education were commended by students for their positive attitude to disability awareness training and for their role in promoting attitudinal change in the wider community:

'We need to all be able to go through the same gate, some may need to go to a different part of the building for some things, but we should all be together with teachers and other staff to understand the needs of disabled people and to have disability awareness training.' (Student with cerebral palsy, South West College, Omagh).

The South West College has a close collaboration with local day centres and is considered to deserve its 'centre of excellence' reputation by its disabled students because of its provision of training and development opportunities for disabled people in an environment, which actively promotes positive inclusion.

'The teachers in the Step Centre's like a family, they are able to crack jokes with you, they go above and beyond their duty, not moaning every five minutes, they talk with you because we're here not just for two years but for a long time.'

Disability awareness training, provided for all first year students as core to their induction, has heightened awareness of disability and is seen by senior management as *'one of the most important areas of training that we have – it's something that college will invest in each year.'*

The college provides extended educational opportunities for people with disabilities and stands as a good example of how a further education college, required by law to make adjustments for people with disabilities and to access mainstream courses, has developed its good practice. The college's rebuild, in line with the DDA, was designed to ensure that the Step Centre, catering exclusively for those with physical and learning disabilities, was moved from its previous temporary mobile classrooms adjacent to the old building *'where we only seen ourselves'* to become the heart of the college close to the front door, and also the canteen, on the ground floor:

'Everyone can see us and we're at the centre of everything. We are the heart of the college – the first port of call. We are the student body – we are a community.'

The research focuses on the safety issues facing an adult population and does not engage with or explore issues affecting those under the age of 18. However it is significant that much of the information spontaneously offered by respondents in relation to their safety referred to formative and highly negative experiences during their time in mainstream primary and post-primary schools. These included verbal and physical bullying as well as having to negotiate premises that were inadequately equipped for a variety of disabilities. The most extreme example of this was provided by Kiera, a 19 year old woman with a learning disability who talked of being *'threatened to be killed'* when she was 15 and 16 at a County Down High School:

'I went to the teachers and told them and they locked me in a room to keep me safe – I was locked in one dinner time because I was being threatened I told them and they said for your safety we'll lock you in the medical room and we'll come and let you out whenever dinner time's over. I was scared and nobody sat with me. Mummy and Daddy were upset and worried about me. I didn't feel safe at the school I wanted something to be done about it and I ran away'.

The severity of her experiences as a school girl still impact on her willingness to engage within the College she now attends: *'I feel OK here, but I don't like to be on my own in a classroom and won't go about on my own anymore'.*

In contrast experiences of bullying or of feeling unsafe because of a disability was not reported by any of those participants to the research who had attended a 'special school' such as Fleming Fulton, St Rosa's, St Gerard's or the Jordanstown Schools.

Many of those who wanted to focus discussions on their school experiences, felt that they would like to model their experiences for the benefit of pupils, educationalists and non-teaching staff as part of disability awareness training. This, they considered, would go some way to mainstreaming positive attitudes to disability and embedding a feeling of safety for disabled people through early peer support mechanisms. In line with the requirement of the Education and Libraries (NI) Order 2003 Article 17, children and young people with mental health problems and learning difficulties are entitled to be involved in the development of school anti-bullying policies. In June 2007 the Department of Education issued research and guidance on the scale and nature of bullying in schools – though there is limited material which relates explicitly to the bullying of disabled people. Given Bamford's concerns about the levels of bullying in schools, it might be surmised that a more effective anti-bias education is required to address diversity and engender positive attitudes towards people with disabilities, and this is promoted by the Northern Ireland Anti-Bullying Forum, co-ordinated by Save the Children.

Employment

A reluctance to disclose mental health issues in both a paid and voluntary work environment was common-place: *'I deny who I am – I rewrite my own history so that people do not find out that I live with a mental illness – I focus on the gay part of my identity and hope no-one finds out I'm 'mental'.* It was evident on a number of occasions that this was explicitly due to self-protectionism in an environment where participants might well be the targets of forms of abuse or hostility.

Jackie is diagnosed as bi-polar and works as a chef. He will never reveal that he has mental health problems at work because soon after beginning there he was shocked by the treatment of a trainee who had a learning disability. On Christmas Eve afternoon as the kitchen staff prepared through the afternoon for the evening opening, seven of the other kitchen workers were *'messaging him about'* and two carried him downstairs and put him into a half full black bin:

'He was vulnerable, an easy target and he told me himself he wanted to be a chef – but he disappeared after that – he never came back to work and I'll never forget that and that I didn't do anything to stop it.'

The principal issues that participants raised in relation to safety in the workplace related to their relationships with colleagues and others, health and safety, and the wider implications of employment discrimination, such as the awarding of short-term contracts, that impact on economic and social opportunities. One woman who is registered as blind carried out a 'mystery shop' on behalf of the RNIB with a number of recruitment agencies to see how well equipped they were to help place people with visual impairments in employment, and she concluded that *'there's some agencies I just wouldn't feel safe going to.'*

A number of people talked about witnessing the bullying of people with learning disabilities in a variety of workplaces, for example: *'There was one fella in the (names a supermarket) in Bloomfield who has learning disabilities he was always really slow*

and you could see his workmates were really putting this fella down in front of everyone else.'

However, no people with learning disabilities who were currently in employment reported feeling unsafe in the workplace, and those who had found work in supermarkets were both proud of their work and of the relationships with their colleagues and the public.

People living with physical impairments sometimes spent some considerable time during the research process disguising their needs and conditions with regard to their fear of discrimination. Ria has recently returned to employment after a prolonged sickness and she is reluctant to 'out' her disability to colleagues:

'Given the stigma that can attach to having a disability, there can be a tendency to conceal it in the workplace in case people think you can't do the job or for fear of people's responses. Last week I consciously left my stick in the car despite knowing that I can't stand for long without it.'

This masking of needs can prove to place people in unsafe situations. Harry, a 57 year old man who worked as a hod-carrier before he registered as blind, told of an experience when working on the renovation of the second floor of a terrace of nineteenth century houses in Duncairn Gardens. He opened the door to a room where the floorboards had been removed and would have *'gone down through the joists if a workmate hadn't have held me back. I shouldn't have been working because of my sight, but it was a mixture things, I wanted to carry on and provide for my family, you feel part of the community when you're working.'*

Family Safety

Leanne is 26. She and her partner are blind and parents to their lively two year old Miranda. Leanne suggests that she would: *'tend to be very cautious when I'm out with my daughter, I'd keep her in the buggy over and above when other mothers might and*

I only use parks that have gates or are fenced spaces. Mistakes are easy to make as a parent especially if you have a visual impairment. There's another blind girl I know from the nursery who was so embarrassed because when she went to pick up her daughter she hugged the wrong child.'

While one of the principal aims of this study was to ascertain the community safety needs of people with disabilities, the research also revealed that the participants wanted to extend the remit so that the experiences of the safety of family members could also be incorporated. This concern is also identified as important by Carers Northern Ireland who are clear that community safety issues exist for some young carers suggesting that 'They can find themselves being bullied at school in relation to caring for an adult with mental health problems and this can increase if the adult also has substance and alcohol-related issues that leaves them and the young carer more vulnerable and their own feelings of safety compromised. Community safety and hate crime against disabled people is also flagged up to us as being of concern to the parents of young adults who have learning disabilities'.²

Leanne's parental concerns were replicated by other participants living in different circumstances and with other needs. Gillian comes from North Down, she is a Re-Think service user and is concerned not just for her own safety but that of her 16 year old son Andy. *'It's not easy to admit it, but he's sometimes at risk from me and because of me from other people because of my illness. He has seen me being violent to myself and he's seen me being violently abused, especially when there's been alcohol related incidents up where we are in Bangor. Now I'd never lay a hand on him, but when something kicks off, he's going to jump into in the thick of it if I'm involved.'*

As individuals move from or into supported accommodation and more independent living circumstances, family support and transitional arrangements are two key principle areas of life that are required but often inadequately therapeutically supported in Northern Ireland. David is registered blind and has recently moved out from his family home. His sister's children are important to him but he regrets and

² Helen Ferguson, interviewed 9 May 2008.

resents that fact that: *'I'm not trusted to take the kids out alone in case anything were to happen - they are aged three and eighteen months.'* The lack of family therapy as an integral part of any care or rehabilitation programme is in part based on the shortage of any dedicated posts, as well as being situated in a medical culture of care that does not privilege the wider family context. Furthermore, the lack of such family support can compromise feelings of safety within the family.

Darren's family life altered dramatically as a result of his mental ill health. After a period in hospital, he was subject to a court order that meant he was no longer able to see his children from a first marriage and has subsequently spent some months in marriage guidance with his second wife to work on their relationship:

'After I stopped work I took a breakdown which really impacted on my family. My first wife used it against me and in the early stages of my breakdown my second wife didn't understand what was happening and she was taking some things I was saying personally.'

Finance

Stuart is 67 and living in supported accommodation: *'I couldn't save until I came to live in Ballyclare, people always used to be taking things away from me and people were picking on me if I didn't give them things – my pockets were always empty'*.

When the management of personal finances is focussed on security and personal safety, this can require particular attention and caution on the part of some disabled people.

'I've never used the (ATM) machines before, I'd always be going into the bank with my brother and they'd give it to me from my book so I would be nervous of doing anything different now' (Peter, 22 year old man registered blind).

Familiarity plays an important part in creating a safe and secure environment for people in terms of financial management. Geraldine, who is 30 and registered blind, is clear about what works for her:

'I look after my own money and like it that way - but I would not use an ATM. Usually go to the post office. I am ok in local places. In my wee town they all know me. I would never move away born and raised here.'

A number of the research participants felt that ATM machines outside banks are spaces that induce heightened feelings of insecurity irrespective of what kind of impairment or disability people are living with. The researchers frequently heard versions of the following statement: *'I look all around me from left to right, when using the cash card.'* Some people considered that there were big safety and security benefits to be reaped when headphones at ATM machines were used inside the bank, but this was not so when if they were being used on the street *'like the Northern Bank do'*.

Joan regularly uses the same taxi service to go to the bank in Comber near where she lives:

'One day the bank machine was not doing as it should have been and the driver got out of the car to help me. A woman who was standing behind me in the queue asked me if I was ok as she realised I was putting the card in and no money was coming out, and started giving out to the driver when he offered to help me. It's hard to refuse help when you need it and that might leave you vulnerable to giving your pin number out in some circumstances.'

In addition to the provision of benefits, including Incapacity Benefits and Severe Disablement Allowance, the government have initiated a personalised system to enable people to manage their own care through individual budgets by way of a Direct Payment Scheme. This has been available since 1996 and currently has 753 individuals accessing it. It is the aim of government to increase the number of

recipients to 1,500 by March 2011. The scheme has significant implications for disabled people and their management of finances as well as their relationships with those who currently administer their money and savings. Many of those people who participated in the research did not use banks or the post office directly. They discussed having given power of attorney to, or having good-will relationships with members of their families in relation to their finances and the day-to-day accessing of funds. None felt concerned about this in relation to their financial security and were pleased to relationships built on trust and mutual respect.

The use of internet banking, has proved to be liberating for some people with physical impairments, however, it can also be particularly challenging for some with visual impairments who in turn may use telephone banking as a preferred option. For those people who were more autonomous in their financial dealings, awareness about internet scams played a crucial part in their perception of their on-line safety and this will be explored further in the section on IT and New Media. Others made the conscious decision not to carry cash around and to rely on chip and pin numbers. One woman who has begun to use sticks to walk described her feelings of concern when making a trip to the bank:

'Last week I had a reason to be carrying a large amount of cash from the bank to the car and even though I was parked close by, I was scared shitless – that had never happened to me before. As an independent businesswoman I'm used to handling large amounts of money, but as an independent businesswoman with a mobility problem, I become a different person in my own and other people's eyes.'

For some people with chronic mental ill-health, inappropriate financial management has the potential to impact severely on individuals sense of safety and wellbeing. Stephen is diagnosed schizophrenic and is described by his family as being *'more vulnerable and less rehabilitated than most other people in his circumstances'*. Mismanagement of his finances began with the Community Psychiatric Nurse who omitted to tell anyone that she had not completed and submitted his benefits claim. The hostel staff where he lived and his family were unaware that no money was paid

into his account for about three months and during that time he was verbally abused for not paying bills and assumptions were made that he was:

'Drinking away his money when in fact he was lifting cigarette butts off the streets because I had been told to 'tough love him' and refuse him money. This time that was seriously devastating and frightening for him and was when regular episodes of psychoses developed.'

Home and Housing

Safety issues that impact on the homes and housing of disabled people appear to fall principally into two distinct categories: (i) design and facilities and (ii) relationships. The first is associated to the interior and exterior design of premises and the availability of adaptations and equipment in and about the accommodation. The second relates not just to the relationships between individuals living together or sharing some facilities and to those providing support within sheltered accommodation, but also to friends, neighbours and strangers.

1. Design and Facilities

Individuals' preference of one style or design of building over another is not determined or restricted by any particular impairment they might have. Some people with physical impairments demonstrated a preference to live on ground floor accommodation because of ease of access, whilst others with similar needs voiced concern about being on the ground floor because they felt more vulnerable to being burgled. A number of people signalled no preference for the level on which they lived, but rather wanted to live in single or multi story accommodation that had been designed in a horseshoe shape with interconnecting walkways which they suggested promoted neighbourliness and *'an opportunity to look out for one another'*. One tenant, living in supported accommodation in an urban area with high levels of deprivation and criminal activity, was concerned about the level of anti-social behaviour he encountered as a resident and wanted to discuss the frequency with which local (and identified) youths *'get on roof and throw in snooker balls and eggs*

through skylight' of his house which is at the end of an L-shaped complex. Staff who were present at the interview were keen to point out to the tenant that there was a forum where such an issue might be raised, but he had no recollection about previously being made aware of the forum.

Good lighting, including the incorporation of dimmer switches both inside and outside accommodation, was seen as crucial by all participants who commented on housing. Top floor apartments or houses with low ceilings and those where the eaves have been incorporated into buildings as a design feature can mean poorer lighting than other places because of the angle or shape of the windows: *'the nooks and crannies where shadows can lurk can be dangerous for people with visual impairments - give me open plan and skylights anytime'*.

People from across the region who were living in supported accommodation were keen to discuss the benefits of aids such as buzzers, door openers and the process by which staff lock, check and carry out observations on residents. Intercom cameras linked up to the TV and door opening devices were commended as being useful and providing a feeling of well-being and safety for some people. However, a number of those participants who were diagnosed with mental health conditions explained that watching television was not a pastime that they enjoyed and to have a familiar face appearing on the screen could be quite alarming and reduce their feelings of safety within their home or residence.

The adaptations that are necessary for some to achieve the level of independent living that people desire can also make them feel vulnerable and visible. Some people felt that organisations responsible for the maintenance of their accommodation are unwilling to make security adjustments for fear of them becoming further targets or becoming ghettoised. Despite its commitment to develop and support community safety, the criticism was levelled at members of the Housing Community Network, which comprises over five hundred Housing Associations. Asif, for example, has been living with diagnosed schizophrenia for a number of years and reports young people throwing stones at his window every day. He has asked the Housing Association to

install metal screens on his windows but they were reluctant to do so, suggesting instead that they would help Asif secure other accommodation, which he did not want.

The Northern Ireland Housing Executive (NIHE) are proactive in addressing safety concerns and have introduced a range of housing management services to address community safety issues with regard to anti-social behaviour both through their community safety strategy (NIHE 2008) and in partnership with other agencies. This includes: Acceptable Behaviour Contracts (ABCs), mediation and warning letters as part of a programme of pre-emptive early intervention mechanisms. Its programme of planned environmental and physical improvement schemes is outlined in NIHE (2008:15) and the executive works closely with the PSNI Architectural Liaison Officers to pursue ‘Designing Out Crime’ standards when addressing:

- Improved lighting to public areas;
- The provision of multi point locks on all external doors;
- The rationalisation of rear entries and controlled access to them;
- The reduction, or elimination where possible, of shared access to entrances of flatted blocks;
- The creation of better defined private external spaces and the removal of “left over” spaces;
- Rationalisation of hard and soft landscaping;
- Securing boundary fencing; and
- Traffic safety measures and provision of car parking spaces.

However, existing issues for some NIHE tenants that were raised as part of the research process included:

- Appropriateness of accommodation;
- The speed and willingness with which adaptations are carried out;
- The challenge of mixed tenure; and
- A recognition by housing organisations of the need for housing for homeless couples with impairments.

Participants were further keen to have incorporated into the research to general issues of concerns: first that planners, architects and those involved in building control should consider the design and aesthetics of adaptations to houses and external areas, rather than merely the functionality; and second housing organisations tend to see homeless people as single persons and do not envisage them as being in relationships or having partners.

2. Relationships

As previously outlined in Section 2 (Ethical Considerations) the steering group felt that this research was an inappropriate mechanism to unpack safety issues within the family setting due to the complexity of the dependency on, and support given by, family members to some people. But it was considered proper to flag up concerns if they were raised by participants.

Feelings of insecurity in the home because of a fear of neighbours and strangers were noticeably more prevalent amongst people living with mental health issues than other people who participated in the research. Two ReThink service users talked about sleeping with knives and/or cleavers under their beds in case they are disturbed in the night. Another man talked of having four locks on his door in the North Belfast block of flats where he lived and another of being:

‘terrorised by school children looking in at the window and putting excrement through the letter box – in a world where there is little human value – living together is good!’

The stress of moving home and changing relationships was found to be particularly acute for people with poor mental health and the process of relocating people into appropriate housing does not appear to take into consideration the sensitivities of the religious and political geography of Northern Ireland.

Simon lives with schizophrenia and when he left hospital at 19 he was placed in a rehabilitation trust hostel, which allowed people a maximum two year stay. When the

time for relocation came, he didn't want any of the places he was being offered, which included spaces provided the Salvation Army and in older people's homes. But the threat of homelessness or being located far from the family meant that he accepted a place in a hostel near to his former school. However this proved to be a negative experience which fed into feelings of paranoia and isolation as in the first instance it brought back memories of bullying and isolation at the school.

One male wheelchair user, who has been broken into on a number of occasions, talked with a humour that only partially disguised his lack of feelings of safe in his house and neighbourhood. He describes one such incident when he was taking a bath:

'I could hear there was someone moving about in the flat and so I put on a gruff voice to scare them away, which I did, but in retrospect I'm not sure what I'd have done if they had come into the bathroom cos I wouldn't have been able to get out of the bath. I'd just have had to splash them I suppose!'

It is noteworthy there was little information available about perceptions of increased safety or a reduction in anti-social activity since the introduction of community safety wardens in areas of high density accommodation with houses of multiple occupancy in Belfast and Derry/Londonderry. These posts are managed by respective city councils with the involvement of both NIHE and PSNI and an assessment of their potential impact on the safety of people with disabilities could be a useful exercise.

Hospitals

Those statutory services that tend to focus on accident and emergency, restraining, detaining, and prison are often least best equipped to deal with the safety of disabled people and this was particularly evident in the experiences of those on mixed gender psychiatric wards. People are often at their most defenceless and least autonomous when caught up within a medical world and system which they perceive renders them passive and reactive. Hospitals can epitomise this process and exacerbate feelings of exposure and vulnerability. This perspective was perhaps made most evident to the

researchers by one deaf participant who had been having dialysis in a renal unit for a number of years and who spoke about having had to lobby long and hard for her interpreter to be allowed into the theatre.

While the majority of participants who had spent time as inpatients in hospitals saw them as safe spaces where they and their possessions could be secure, a significant number of comments were made by women who do not feel safe when on mixed gender wards:

'It's not that I think I'm going to be attacked or anything everytime I come out of the bathroom or get into bed, it's just that I don't want that level of intimacy with men I don't know'.

The cut off period between being placed on a children's ward or being moved onto an adult ward was blurred for some vulnerable young people and this too had implications for feelings of safety:

'The hospital wouldn't find me a bed in sick children's (Royal) because I was over 15 but that meant that I was put on a medical ward with old men and everything and I'm in my pyjamas – it was horrible.'

A number of patients reported being abused verbally by staff on psychiatric units or in psychiatric hospitals where it was suggested that *'sometimes the nurses were not great'*. Many anecdotes were given of patients feeling vulnerable in relation to their exposure and engagement with other patients:

'I felt scared all the time when I was in XX - I laughed when a woman set herself on fire one time, and then she beat me up.'

and

'I remember there was a fella one time and he just lost it and put the chair out the window – you have to watch for people who aren't really well and maybe not coping as well as you're doing.'

It was considered that large communal wards and common-rooms are often not conducive to recovery and rehabilitation:

'There's no way you can even try and get better on (XX ward mentioned) in a place like that – it's impossible, it's worse than prison – sure there's graffiti on the walls of people hanging themselves – why are you not surprised that people with demons can't let them go in there?'

Lighting

Participants views on lighting feature earlier in this section and later in relation to Housing, Streets and Socialising in pubs, clubs and restaurants.

New Media, Communication and Information Technology

Some forms of communication, new media and information technology were seen as life-lines that provided an essential service and set of connections both for communication and surveillance purposes. Mobile phones bring many people the opportunity to access emergency numbers or to contact friends or family immediately in times of fear or uncertainty. Deirdre has Down's Syndrome. She is 21 and lives with her family: *'My phone is great, I can keep in touch with everyone and if I am frightened or think I might be lost, I know I can be in touch with someone.'* But the safety benefits of using them can come with a caveat for others:

John self describes as a Paranoid Schizophrenic with obsessive-compulsive disorder. On a number of occasions when alone and in town, he has *'stopped in my tracks and I don't feel safe, even if someone is to come up to me and try and help me, I just don't feel safe and sometimes the police approaching me is very scary because I think I've*

done something wrong.’ At a time like that he thinks that the theory and practice of having a phone are poles apart:

‘It would be good at one level to have the phone, you would think, to help to reach home safely. But a mobile can be too intrusive for me at a time like that.’

The potential for the misuse of new mobile phone technology, was described by one participant in a Special Olympics football team at Lisburn:

‘Sometimes people bully you using their phones. One of our players had his bike tyres slashed and that made him fearful and mistrustful. And what is worse, it wasn’t just dangerous because he couldn’t get home, but he was being filmed and pictures uploaded onto You Tube.’

The accessibility of data held on computers, was of concern to some people who reported being worried about the confidentiality of personal information including the security of their pin numbers.

‘I simply wouldn’t give details to places online unless big companies such as Argos, Amazon and that of course reduced my opportunities of where and how I shop around – but it’s the only way I can be sure of being safe.’

While software for IT equipment is designed to aid visually impaired people, the reduced print size of security caveats are often missed or inaccessible which leaves some people concerned that they might *‘sign off on something and regret it later’*.

For some people, this caution is extended to their use on the internet: *‘Being blind, I’m ten times slower on the internet than anyone else and you never know what it could be that I have opened - porn, getting in touch with credit agencies, everything.’*

Social engagement rules are changing and this in part is being advanced by social networking sites bringing with them opportunities as well as challenges. It was

suggested by one participant that it allows for a space in the home that support workers can't control.

'Older nursing staff can sometimes be less skilled than younger staff in IT and that might mean that as carers they may not always be tuned into essential areas of safety you might have.'

Internet and other computer use also raises concerns for some autism charities that have suggested that it encourages repetitive behaviour and an unsafe view of the world.

Police Service of Northern Ireland and Criminal Justice System

'When my nephew was alive, he lived with us. He was profoundly disabled. He was blind and had no way of communicating with us at all. He had no control over his limbs, and because he needed fresh air in the room we would keep the window open about six inches by the bed. I noticed that he had cuts and bruises over one side of his body and couldn't work out where they came from. One day when I came in, I saw that he was being poked and prodded by a big stick by kids. It was actually a piece of skirting board that was outside the house. We called the police, and their response was "they'll be gone by now". I remember we were told to put extra bars on the window.'

As a result of a restructuring of the PSNI, district command units dictate their own priorities and the concomitant budgetary expenses. In all areas, the remit of Minority Liaison Officers (MLOs) includes specialist work on community and personal safety, crime prevention and reporting in relation to people living with disabilities. However the focus of the MLOs in different units can be dependent on personal connections and some areas have better contacts than others with some disabled people and groups representing their interests.

One area where Disabled People felt that the MLO was particularly engaged with their Day Centre, was in Larne. There, 'Jim the Policeman' was commended for coming out regularly and spending time with the centre users and talking about safety issues. A number of organisations representing people with learning disabilities had a regular engagement with the PSNI that was both proactive and reactive in terms of preventative and safety awareness work. For example, following an internal community safety training programme, Gateway arranged for a group of their members to attend the local PSNI stations where they were able to learn about the process of an arrest by taking part in activities and role play.

The PSNI were commended by a number of people for their use of SMS text messaging when communicating with deaf people but criticised for their use of interpreters and signers whom were not always appropriately accredited. There were concerns raised by a number of people in relation to how PSNI feedback to those who have contacted them and a number of people reported they do not report concerns about their safety to the PSNI as they fear that their concerns are *'too trivial'* and are *'not sure what the police response should be'*.

For people with mobility issues, an increase in the number of privatised traffic wardens was seen as unwelcome as they are perceived to be less flexible than PSNI when issuing tickets or allowing people to park in towns and non-designated areas.

It is noteworthy that the official response to the Bamford Review states that 'individuals with a personality disorders are significantly overrepresented in the criminal justice system' (DHSSPS 2008:78), and that 'mental health is a particular issue within prisons.' None of the participants spoken to in the fieldwork reported having spent time in prison, however a number of people with mental ill health talked about having been cautioned or spent time in police custody which they felt was often directly related to their state of mind which some described as them *'when I'm being psychotic'* or *'I was a bit manic and all over the place at the time'*.

Few respondents had experienced house thefts or burglaries. Those who had been victims of such crimes rarely considered that they had been targeted because of their

impairments. Rather, they felt they were the victims of opportunism. They reached this conclusion based on the fact that other houses in the street or apartments in the same block had also been broken into either the same day or within a close time period.

Rurality

There can be additional community safety concerns for people with impairments who live in rural areas, which may not impact as significantly on those living in urban areas. Key issues for concern include the risks that come with: isolation, limited transport, restricted lighting, reduced policing, and limited dedicated services and facilities.

Sectarianism

Alan is a 50 year old traditional musician and basketball player from a Republican background. He is a paraplegic who acquired his paralysis as a result of a sectarian-motivated shooting at the age of 19. He works as an arts activist and as a driver.

'I think it would be wrong for me to use words like scared or afraid, but my fight or flight instincts are always on though, and that's why I'd always check whose at the door before I'd open it. There's always 5 per cent of me that never relaxes but I would happily go up the Shankill to pick up a guy who I play basketball with.'

A number of people interviewed for the research had acquired their physical and mental health impairments as a result of the conflict. One of the principal issues that they feel is a legacy of this is their anxiety about being in unfamiliar situations. Gerard was shot by loyalist paramilitaries when walking through a Republican area of North Belfast, now whenever he sees a large crowd he feels anxious and he has flashbacks of that experience:

‘That fear’s always there, and my disability plays a big part in that - 36 years of trauma and of feeling vulnerable can’t be undone tomorrow. Every invitation you receive to go out you consider it in the light of these fears.’

Several participants had only become aware of or concerned about sectarian geography since acquiring their disability irrespective of whether or not that was conflict related:

‘Because I have a Southern twang in my voice, I realise that I have become more conscious of the areas where I no longer feel comfortable walking in since I have had to begin using the sticks or the wheelchair. For example, last week I was carrying out a community based mediation in a run-down loyalist area in East Belfast and for the first time in my life, I thought, I can’t run away here, there’s no way that I can escape if something goes wrong whereas previously I’d wandered around those streets quite happily.’

Similarly, a number of ex-service men and women from both the PSNI and British Army referred to their avoidance of or reluctance to go into areas that were perceived to have a history of committed Republicanism:

‘No matter what your training in equality, or human rights or community relations, there’s always going to be a part of you that says ‘that’s a no go area – it’s always been a no go area and it always will be – and my prosthetics prove that.’

Many of the respondents who are living with diagnosed mental health needs talked about how the Northern Ireland conflict and the flags and memorabilia associated with paramilitarism could both trigger and exacerbate feelings of insecurity. One mother of a schizophrenic youth from a nationalist background spoke about her son having:

‘a fear of the loyalist paramilitarism and associated regalia and that was evident in the area where his hostel was and the fact that staff members had been dismissed for activities related to paramilitary involvement did nothing to make him feel safe’.

Workers in both a drop-in centre and in a residence providing supported accommodation residence talked about how it was not uncommon for a large number of their users or residents, irrespective of their religious, cultural or ethnic background to refer to sectarianism if they were going through episodes when they were at their most unsettled or unmedicated.

Self Harm and Suicide

Geordie is a 67-year old farmer living in an isolated rural area with his wife who does not drive. They have one adult daughter who is currently at University. Geordie has been diagnosed as suffering with depression and has received two periods of extended inpatient treatment over the past six years in relation to his condition. He recognises that the autumn and winter months are particularly hard times of year for him and are the seasons when he has previously attempted suicide. In our interview he talks a lot about his fear for his daughter's mental well-being and of not being able to discuss his concerns with his wife, as he is mindful of the taboo and stigma in his own family already attached to issues of mental health. He does not want to put any more pressure on their relationship. He ends our conversation with the caution that :

'To help people feel safe, it's important that stigma about mental health is addressed through training and advertising, but I don't think that anyone would want to be publicly identified for fear of how other people react to them.'

Statistics from the General Registrar Office shows a sizeable (21 per cent) increase in deaths that are attributed to suicide in the period between 2001-2006 with a 34 per cent rise in those by women, with around 4,500 admissions to hospital for self-harming. In the 2006-2007 period, the Standardised Admission Rates for self-harming in deprived areas was almost double that of the overall Northern Ireland rate (Stewart et al 2008:35-6). No direct link is been made to the mental well-being of those who attempt or complete suicide.

Three of the participants with a physical impairment discussed self-harm or suicide, while a very high number of those who self described as being diagnosed or living

with mental health issues raised suicide and self-harming as something that was exacerbated by their feelings of vulnerability in the community and several women presented with cuts and scars to their arms that they spontaneously discussed. For example, in a focus group discussion about experiences of work and volunteering the contribution of one young woman in Belfast was:

'I want to volunteer, but when I went for an induction with a crowd, I felt unsafe. What makes me afraid is the fact that not everyone likes being around a mentally ill person. So I feel like cutting myself and I do still sometimes.'

Organisations named by participants as being helpful in addressing self-harming and suicidal thoughts included Samaritans, Cruse, Carlisle House, Alcoholics Anonymous and ReThink. A focus group comprising employees representing organisations providing services to disabled people voiced concern that all disabled people have at some time considered themselves a burden and therefore it should be considered that some people may be at risk of self-harm or suicide.

Sexual Safety

Sexual safety for people with impairments is an issue that can occur in a specific set of circumstances that do not present for non-disabled people. In the first instance, the life experiences and the expectations that have been internalised by some people can impact on their confidence and opportunities to develop and conduct themselves equally within sexual relationships.

'People like me with a learning disability can't have children, they're told they're not fit to look after the child.'

A desire for sexual awareness training by people with learning disabilities was revealed on a number of occasions during the fieldwork. Many people felt that a wider process of 'protection' by carers and what was also referred to as 'wrapping us in cotton wool', was that they had never had the opportunity or had been discouraged from having sexual awareness training. One woman said she would like to learn 'How

to be safe, not to be easily led by boys.’ A 24 year old man whose girlfriend, like him, also has a learning disability talked about his dreams for the future saying:

I’d like us to get married one day and learn how to love her safely.’

Organisations representing the needs of people with impairments highlighted the fact that that issues of intimidation and coercion in relation to sexual safety can present as a challenges for some people with learning disabilities and vulnerable adults. There is no way of assessing whether any such training might have averted any of the following examples which are given to demonstrate the range of ways in which people with learning disabilities raised concern about their sexual safety:

- *‘When I was seventeen, I was in Lurgan Park with a friend and he forced me to have sex in the toilets but my parents didn’t believe me.’*
- *‘I was raped in the toilets at college’.*
- *‘A girl I knew fixed me up with an older man from Donaghcloney and my parents didn’t like it because he was in his 20s or 30s and I was only 18. He was really dirty and he weed over me and hit me - he tried to choke me when I was kissing him, he’d put his hands on the back of my neck and I couldn’t breathe I was frightened of him and I don’t know whether he done it because I was disabled too. I was too scared to tell the police in case he would harm me.’*

The link between sexual vulnerability and other aspects of safety was highlighted by two woman both of whom were wheelchair users and who felt that their desire to be involved in a sexual relationship had left them vulnerable to exploitation on other levels:

‘Now I trust Stephen, but it took me a long time to trust another guy after my first ‘boyfriend’. I thought I could trust everyone before – but he set me up and was just using me so I gave out my bank account and other personal details.’

'I suppose my guard was down because I wanted a boyfriend – but when I caught him with my granny's wedding ring that she give me when she died, I knew he wasn't for me.'

Some women with mental health problems also reported experiencing high levels of sexual activity and promiscuity, which they felt, was linked to their diagnosed conditions and which left them vulnerable to being abused in a variety of ways:

Karen is a single 40 year old woman with two children in their twenties. She has lived independently for five years after being in a psychiatric hospital for ten years. She is now involved in a relationship with another former inpatient, but still finds herself *'easy prey particularly if I haven't taken my medication'*, she and her support worker discuss how Karen often goes to the pub and is *'passed around'* a group of men who go there often leaving with one or another of them.

One deaf participant to the research commented on the need for Women's Aid and other organisations with telephone helplines representing the interests of women under threat of or experiencing abuse to address their accessibility issues and commit to becoming *'deaf friendly'*.

Shopping

'I like shopping where people know me. I never worry about getting stuff stolen 'cos I take my time and I go to shops where people know that I have to take my time and that I'm not allowed to be pushed or anything. The shop keeper actually knows me and what clothes I would be after, so anytime I be looking clothes he knows what clothes to pick out' (Philip is a 25 year old man with cerebral palsy living in the Ballygawley area).

'I'm now blind and a wheelchair user I really don't get any pleasure only concern about going into town' (Eric, a 50 year old wheelchair user with acquired brain injury).

Shopping is an everyday activity that provides many people with an opportunity to socialise and to assert independence and autonomy. For many it is an enjoyable experience, for others it can bring anxieties and trigger feelings of uncertainty and this can be particularly so at busy times and with seasonal variations. In particular crowds and the physical danger as well as the threat of loss of money that they bring cause particular concern. Christine is a young woman who has been an arthritis sufferer since childhood:

'I remember had a breakdown in Tesco's one Christmas eve. I needed to leave and told my mother that I couldn't cope with the large crowds of people. I just went into complete melt down. I spent that Christmas on Prozac. I don't like being in tight spaces where there are things like prams and trolleys that knock you in the back of the legs or on the hips and ankles.'

Her experiences were echoed many times by participants with a variety of physical impairments:

'People in the shops would just barge into you – so I wouldn't go into the town on a busy day and I certainly wouldn't go in at Christmas time – I start my shopping early.'

Some people with epilepsy were particularly cautious about how other shoppers might respond:

'I take seizures, I don't get any warning and if you were a stranger and saw me in an attack you mightn't look after me. I can't shout help, I would fall and hit the deck and if you seen me in one, you might think I was drunk and then ignore me and walk on, you know, because I can't speak when that happens.'

Another respondent with epilepsy suggested *'Everyone should learn how to prop me up and put me in a sitting position.'* The need for people to carry identification as to any medical condition or treatment they might require was discussed frequently and

while many people made sure they had a recognised form of identification on them, for some it was not always possible:

'I do carry a card – but I don't wear the bangle like because I'm allergic to metal and I can only wear pure gold, so sometimes people don't know to look for the card.'

No respondents who had learning disabilities voiced a concern about shopping and people tended to be proud of their skills at handling their finances in shops and markets. Conversely, a number of the participants with mental health issues avoided shopping at all costs: *'I would still be wary of people and I get worried when you have to ask for something - I remember times when I would have walked back out of a shop rather than leave myself feeling exposed, vulnerable and anxious'.*

Socialising in pubs, clubs and restaurant

On 7 May 2008, the Black Box, a Belfast music venue, hosted the debut of the Barracuda Club, Northern Ireland's first nightclub for people over the age of 18 with learning disabilities. DJs and VJs with learning disabilities came from the London-based Heart and Soul organisation and using the model of their Octopus club, trained local people to perform on the night while other people with learning disabilities provided the art work for the 'chill-out' room. Brought together by a steering committee of eight Mencap peer advocates and supported by the Arts Council, Awards for All and Open Arts, the Barracuda Club provided a dedicated space for adults with learning disabilities to socialise with a focus on music, dance.

There are a large number of disincentives to people with impairments wanting to socialise in pubs and clubs that are based specifically on their feelings of safety. As with other barriers evidenced in this report, some are attitudinal, others based on physical and material resources and facilities. The use of strobe lighting in pubs and clubs is a significant deterrent for epilepsy sufferers. Fintan, a 29 year old man from Lisburn explains:

'If I have a bad day I can have between ten and twelve seizures – at my very worst I had 110 seizures over a weekend. Now can you imagine how you might feel if that happened to you when you were out with your friends or even with someone you didn't know that well – they wouldn't know how to help you.'

Bouncers and bar staff frequently came in for criticism by people with physical impairments for their lack of insight into the needs of people with disabilities and for interpreting an unsteady gait or speech stoppage as drunkenness. Examples were given of bouncers regularly excluding people with these disabilities in Belfast at a number of bars and, at an unnamed Lisburn Road Restaurant, bouncers were reported to have *'thrown out'* someone who lived nearby in supported accommodation and who lost her balance and fell over. Joanne has cerebral palsy, which affects both her mobility and speech:

'I understand now why they represent bouncers as gorillas in cartoons. I was going out to a club one night in Tyrone, near where I live, I was all dressed up, make up on, looking the business – and the bouncers wouldn't let me through the door "no love, you've had too much to drink", now I would be sick before I would be drunk because of the medication I am on so people calling me drunk is particularly offensive to me and to my family – but it was also downright dangerous and left me stranded and alone at night.'

Even when door security staff were credited with having a desire to accommodate people, it was often reported that they were bound by discriminatory health and safety regulations imposed by management. Damian is a wheelchair user who likes to attend 'metal nights' in bars and clubs. The first and second times he visited Belfast's Auntie Annies:

'The bouncers gave me a lift up the stairs, but the owner came down the third week and after I'd went up he came up and said you can't come in because we don't have access. I asked him to get in a lift and he said sorry mate, you're a fire hazard.'

Knowledge of escape routes and designated places of refuge were important issues for participants who were regular pub/club goers. *'Access issues always impact on how safe you feel.'*

A number of visually impaired people discussed the inadequate lighting they generally experienced in pubs, clubs and restaurants:

'It would take me a couple of minutes to adjust to lighting in restaurants, by which time I've either fallen down the stairs between the front door and the dining area that nobody bothered to point out or because everyone behind me's started pushing me forward.'

The lack of foresight by planners and designers was noted on a number of occasions:

'There's really no reason why it shouldn't be standard practice to provide the same lighting along the steps in restaurants and bars as they do in cinemas.'

Six people with visual impairments suggested the benefits of dimmer switches in restaurants. People with visual impairments also raised the issue that if all menus were produced at 28 point type face it would be easier for clients to read allergy information.

Street and Road Safety

Brid used to cycle each day to pick up a paper for her father from their local paper shop. But she no longer does so since being teased about having a learning disability and called names by boys aged 12 or 13 who then threw her bike down on the ground after she parked it outside the paper shop. *'No-one stopped to help me even though there were other people about'*. She was encouraged to talk about the incident and to carry on cycling to the shop by her father who is a former police officer, but has lost her confidence to do so.

The lack of attention paid to the needs of disabled people and the abuse they can experience particularly when unaccompanied on the street was a prevalent complaint. Sometimes this could result in feelings of vulnerability and a lack of safety when in certain neighbourhoods, as Ria explains:

'I really like to walk a lot at Holywood on the shore – but young people there call me names – and when I walk on the Shore Road in Belfast - I had a breakdown ten years ago and everytime I pass a pub where I like to walk they shout out schizo'.

Several people with visual impairments commended organisations with which they were associated for supporting them with road safety training – and one man in the Omagh area spoke highly of the tandem club for visually impaired people that he was attached to, which gave him confidence to be around traffic and to develop his independence.

Despite the increased use of both audible and vibratory traffic signals and of illuminated road signs, the safety of sensorily impaired people rose as an issue on a number of occasions. Sam, who is 26 and has degenerative blindness which had a late onset, was knocked down by a car crossing at lights and broke his foot after he followed on the tail end of others crossing after the green man had 'gone' – the driver drove off, and Sam was left in the road by other passers by.

Mary who is 68 and blind recounts being shouted at and told to 'F. off and to get glasses' by a driver as the car drove straight across over the zebra crossing she stepped out into. A number of participants indicated that as their vision decreased, so they felt increasingly visible and vulnerable in terms of their levels of community safety and this impacted on how they approached their:

'I wouldn't have a dog for a long time, I found it really hard to start using a stick even, it wasn't that I didn't accept being becoming blind, but that I didn't want other people to see how vulnerable I had become.'

Anxiety about knife crimes and anti-social behaviour, exacerbated by media news stories, was a concern for some people: *'There used be honour among thieves but now it's different - I was so scared about getting attacked that my doctor suggested I get a dog and that would mean I'd have more independence'*. It is noteworthy that one participant to the research who is a ReThink service user talked about previously carrying a knife with him to protect himself on the streets.

Participants made choices about what items they would take out with them because of their impairments. People reported not wanting to have their I-pods, phones or bags visible because they felt that this left them more vulnerable than they would like to be. Julie has cerebral palsy and always keeps her purse in a bag around her neck so she can't drop it since an occasion when:

'I was rushing to get the bus one day on the Lisburn Road, at Surrey Street, you know the bus stop outside Roast and Zip. I dropped my purse in middle of road, and a lorry driver who was loading up told me to go across road and he'd pick up the purse for me. But in the meantime a car pulled up, the passenger got out, picked up the purse and drove away and then the lorry driver and I went into the shop and phoned the police'

And finally, the general inadequacies of street lighting in rural areas was also a constant refrain, but it also occurred in urban areas where people found that they were having to rely on the lights in fast food cafes or shops to navigate safely.

Transport

Angela is 48 and lives with her parents she has learning disability and currently works in a children's charity shop where she irons clothes, having previously worked at Sainsbury's and B&Q. *'My worst time was once when it was winter and I felt sleepy on the bus, and I think it was that I was going to ask him to stop but he just went onto the next stop and that was on the North Circular Road near Jordanstown and I*

thought I was going to end up in Belfast. So when I go off at the next stop it was dark and I had to walk all the way back on my own and I didn't have my mobile with me'.

Some Translink and Ulsterbus drivers and Northern Ireland railway station staff were commended for being patient when passengers have particular needs that may take more time to accommodate than others. For example, Philip who is registered blind, has travelled alone each week by bus from Omagh to attend his church in Templepatrick. He spent several journeys learning the route, how to change in Belfast identifying landmarks to aid the process and was well supported by drivers and depot staff in the early days of his journey. However, the overall impression given by the majority of participants was that the facilities, drivers and station and depot supervisors have some way to go to engender feelings of safety in users with impairments.

Irrespective of whether a transport facility was being provided privately or under the auspices of a community or charitable organisations, the key recurring issue for individuals was that the driver's attitude was key to feelings of safety. This was highlighted in a number of ways:

- *'He's always mindful if mum has hung the bag on the back of the wheelchair and makes sure I have it in my hand or round my neck'.*
- *'I always give him my card and he knows not to ask for money and that I'll bring it next time if I forget'.*
- *'When I'm on the bus with people that I don't know they always make sure I'm OK before they leave off'.*
- *'... good, but buses not escorted, e.g. mum or dad picking you up, there are things to be mindful off, mum might have hung bag on back of wheelchair'.*

Fear of encountering anti-social behaviour on buses was commented on frequently with one twenty year old woman person with cerebral palsy explaining that her travel times were dictated by other bus users:

'I always avoid the quarter to four bus because that's the one the school kids get on – you don't go looking for places to get bullied or attacked and as I know well from my own school days, the bus is the one sure place that's going to happen.'

Travelling when school children were likely to be using the service was also seen as a deterrent for some train travellers: *'the young ones just take it over, pushing and barging'* and one participant with a learning disability never likes travelling by bus as it brings back an experience of travelling by bus to school when *'boys from Downshire High set my blazer pocket on fire.'*

People living with mental health issues reported high levels of anxiety when dealing with public transport systems:

'When I get depressed I can also get agitated and my anxiety and all builds up – so I don't use public transport – I don't know how I'll be or how others will be around me.'

Conclusions

This section has identified a wide range of areas of routine daily life in which people with some form of disability have been subject to behaviour, attitudes, facilities, services and elements of the built environment that disrupts their sense of safety. Some of these issues can or could be readily addressed through the provision of appropriate advice, assistance or training, while others will require more strategic interventions in order to have an impact over the longer term. The report situates some of the broad themes cross cutting safety themes within the context of the four main aims of the research in section 8, below. The next section however raises a number of broad issues that are more loosely connected to issues of safety, but which can nevertheless have an impact on an individuals confidence and well-being.

7. GENERAL SAFETY THEMES

People with disabilities are most often in contact with a variety of social service agencies that do not consider issues of community safety as core to their working. For example, the DHSSPS like the PSNI they may have safety as a core objective, but in reality their practices are considered to be *'more about having the client fit into an existing system or services than working from a client-based system'*. And when people are dependant on accessing services in systems in which, as they suggested in this research, they find themselves marginalised, infantilised and which exacerbate their feelings of already being a burden to organisations *'that don't lend themselves to honouring their commitments'*, there is a general reluctance to feed into the any existing complaints system which might help them address areas of community and personal safety.

Existing and developing organisational protocols concerning the treatment of people living with a variety of impairments can tend to focus on disability checklists that register practices in relation to health and safety, language and access to services and equipment but do not directly address perceptions of vulnerability and safety. The research evidenced a significant gap between the expectations of employers, health care workers and those providing services and the disabled people they are allegedly servicing. Despite the rhetoric of 'whole person-care' that prevails throughout the public and private sector health service, service providers are not necessarily in tune with their patients' emotional needs and consequently a number of respondents talked about feeling unsafe when in communal settings. The research found there to be limited evidence of practitioners attempting to develop forms of communication that bridge the emotional gap presenting between themselves and those from different backgrounds, and attempts to demonstrate professionalism through clinical distancing was interpreted by some service users as a lack of empathy and a barrier to communication.

A number of other recurring themes that arose did not fit neatly into any community safety rubric when using the NIO definition of community safety with its focus on

tackling the effects and experiences of crime and anti-social behaviour. The themes consider community safety in its broadest sense and the extent to which the barriers and discrimination faced by disabled people relate to wider issues of social exclusion and are accompanied by indirect safety issues. They tend to fall within four principal areas: access to services and employment; the built and natural environment; transport; and media representation.

Access to Services and Employment

‘There can be a difference between feeling unsafe and feeling vulnerable – and while I might be vulnerable all the time, it would sometimes be at the back of my mind that would be really very unsafe when I am in places that don’t have ramps or people working there that don’t understand what it means to be in a wheelchair.’ (Male 25, living with Cerebral Palsy in Omagh).

The researchers understand the expression ‘access to services’ to have two meanings. In the first instance it relates to the provision of services directly related to the health needs of disabled people, for examples aids, adaptations, supports and assistive technology. But more generally, it refers to a culture and process of inclusion that enables people to carry out day-to-day activities including the pursuit of leisure, employment, training and education in situations without fear of exclusion or discrimination occurring.

Access to services and service provision were not probed or prompted by researchers. However, the issue of access was frequently raised by the participants and some were concerned that in line with the increased life expectancy of all people, the accessibility needs of people living with disabilities are increasing along with their age. The report does not record or focus on these contributions except for where the lack might directly impact on the contributor’s safety.

Systems used by statutory agencies to evaluate people's eligibility for particular benefits or entitlements were criticised as being deterrents to people entitled to access resources that could enable them to live their lives more safely:

'The NHS is like an old lorry rolling along without a handbrake! And as for the DHSS - it is insulting and hurtful to have to answer stupid questions. For example, I was asked to describe how my disability affects me – and how do I envisage my situation improving/deteriorating in the next 6 months? - well I don't have an arm on my right side - I doubt that it is going to grow back in the next six months.'

Given the inherent safety implications for disabled people in not being able to access medical and social services, it is noteworthy that while 80 per cent of the Northern Ireland population live within fifteen minutes access time of *most* of the different types of health and social care facilities, this excludes A&E Departments, maternity services, hospitals providing in and outpatient services for people with mental health and inpatient services for people with learning disabilities. For those in rural areas, the travelling time for these services is more than 40 per cent longer than Northern Ireland in general (Stewart et al 2007) and the Northern Ireland census indicates that just over one third of the population live in rural areas.

It is further noteworthy that there is a cultural shift away from a former focus and reliance on the provision of Adult and Day Centres as the principal option of daily activity for some people with disabilities. With this change comes more of a focus on integration into the non-disabled world through participation in further education, vocational training and supported employment, befriending and leisure schemes as well as advocacy and voluntary work. This can mean that disabled people are increasingly able to use services and facilities that were previously hard to access or, in some cases inaccessible. However, participants to the research recognise the need for appropriate training to be developed for all staff including contract workers.

'There's little point in ploughing all your resources into having a building with disabled access if when you get through the door people look through you or over you

as if you don't exist. There's contract staff, cleaners, maintenance, caterers all of whom may not have had the training that the full-time workers have had, but they are often the only people you come into contact with' (Woman 30, wheelchair user from Rathfriland).

It is impossible to gauge the extent to which discrimination and exclusion impacts on the self esteem and subsequent community safety of people with physical impairments and disabilities. However, it is clear that there is a relationship between the two, and that in order to fit into a non-disabled world, some disabled people have tried to minimise their impairments. The effects of social exclusion through the awarding of short-term employment contracts, of having to negotiate an unfavourable physical environment and of unequal relationships impacts on the perceptions and reality of safety particularly for individuals whose vulnerability and levels of confidence at engaging with new situations and forming relationships that allow for trust to be built.

There are a variety of government-led initiatives specifically designed to encourage the employment of disabled people and many of the participants to the research were involved in the Pathways to Work, the DEL initiative which marks the primary route to employment and engages people living with disabilities with the Careers Service. DEL were also involved with the Disability Advisory Service, which advises individuals on vocational and pre-vocational programmes including the Job Introduction Scheme, New Deal for Disabled People, Access to Work (NI) and Workable (NI). Some had experiences of voluntary organisations such as Dr Bs Kitchen, ReThink Furniture and Mencap's Pathways to Employment Service, increase employability. Many of those interviewed for the research were satisfied with their working employment opportunities and felt they had secured employment in safe areas. Donal, a 42 year old Belfast man with cerebral palsy and epilepsy, had found a clerical position in the city centre which suited him well:

'and I'm happy because there's a lot of security in the areas, cctvs and security guards and these things are important if you are disabled.'

But despite the opportunities and experiences illustrated, Mencap (McKeown 2007 3.1) are keen to highlight the need for greater attention to be paid by departments and public bodies to the recruitment and selection processes used by public bodies, when deciding the location of offices and services, such as their proximity to public transport routes. Views on how health and safety protocols and on how the stigma attached to disability can impact on safety were also evident in the experiences of participants to the research who had physical impairments:

'Putting guidelines in place is absolutely essential, but it can also become a barrier for people being able to function at all in the workplace – sometimes the bloody box was what you leant on to get from A to B in the absence of other support'. (Female Company Director (50) with physical impairment and restricted mobility).

Disability Action (2003:4) reports that unemployment amongst people with disabilities is up to four times that of non-disabled people in Northern Ireland. Furthermore, it is not unusual for people with impairments to fall into the low wage versus the benefits trap. Consequently, some people with impairments are disabled by unfavourable employment circumstances and the discrimination in the workplace they face can be interpreted as part of the broader issues that impact on safety, touching as it does on issues of independence, poverty, social networking and inclusion.

Julie who lives in supported accommodation, has a degree in visual communication and a strong curriculum vitae based on extensive paid and voluntary experience. She laments the fact that she has had to *'move from job to job'* when describing a system that has only ever offered her short-term contract after short-term contract. This, she interprets as being a prejudicial practice: *'I was finding it difficult when I lived at home to get long-term contracts and I attribute that to people making assumptions about my disability.'*

Because of this discrimination, Joanne was unable to achieve any degree of independence or autonomy when living with her family and consequently opted to move into supported accommodation. But this in turn impacted on her employment

opportunities: *'I got place in this house because I wanted to live independently, but because of the way this place is funded I was advised to just work voluntarily. In effect the system is rendering you unemployed.'*

David (42) is a language teacher at a grammar school where he coaches his school's First Eleven Hockey three times a week and is responsible for all hockey in the school. A permanent wheelchair user, he became paraplegic after a sporting accident twenty years ago, which put a stop to his hill-walking. He continued playing tennis for a while afterwards but now prefers to play table tennis, representing Scotland in an able-bodied league. He is an active cyclist, regularly cycling a four-five hour journey with his eight year old son.

The role of sports, arts and leisure in the lives and rehabilitation of people with impairments is vast and diverse. Participants to the research had benefit from training and engaging in physical activities through a number of sports organisations who they considered value, recognised and promoted their services for disabled people and have their users' safety to the fore year round. Participants who had experience of the following organisations named them as providing safe and inclusive opportunities for people with impairments to participate and view sporting activities and events: Disability Sports NI; Knights Wheelchair Basketball Club; Special Olympics Ireland; Northern Ireland Blind Golf; Riding for the Disabled; while the facilities at the Share Centre, Lusty Beg, the Blue Lough Activity Centre, and Delamont were all considered to be safe and welcoming places. Participants with learning disabilities and physical disabilities generally tended to praise council-run facilities for their user-friendliness and accessibility with. Belfast City Council's Olympia Centre and Omagh receiving particular commendations for the staff.

However, many mental health service users found that their confidence at being in crowded places where there is much noise and people prone to erratic behaviour to be unnerving and none of those interviewed as part of the research reported being involved in an regular sporting activity for that reason. Barry is 48 and lives in a rural area outside Banbridge. He was a keen cinema-goer before being diagnosed with a

mental illness, which has resulted in two periods of prolonged hospitalisation. He explains:

'My world got smaller when I became unwell. Now I would get very anxious in public spaces and so that has stopped me going out. From that day I never even bought a newspaper and I would never watch the television and I'd never go to the leisure centre. I'd take a taxi from ReThink to Praxis and that would be about the height of it. But one day I'd like to find some way to play football again and I do go out when Praxis takes us to the concerts, I like that now.'

A number of people with physical impairments described how attending a gym alongside non-disabled people could give confidence at one level, but might also leave them feeling self-conscious and anxious and how such feelings of insecurity in turn can feed into feelings of being unsafe: *'If the gym is too busy I will not stay long. I would do things in the gym slightly differently to other people and when I'm in a room full of 'honey monsters' I feel like people are looking at me strangely. So I get flustered, and then I start to doubt my surroundings'*. One woman who was registered blind described an experience of being made to stand outside an aerobics class by the instructor after being told she was *'a danger to the class.'*

Some participants voiced feeling more comfortable attending activities such as table tennis, badminton, snooker and bingo in public places, or when making trips to the leisure centre if they had been organised by Disability Groups such as Gateway as they felt there was *'less risk of being abused and abuse than if accessing mainstream services.'*

Other non-sporting leisure venues that were familiar to participants and that they felt were *'friendly'* to people with impairments included the zoo, civic centres that hosted theatrical/musical events and W5. No mention was made of any museums, art galleries or libraries, though the education departments of those organisations and the arts and craft teachers working closely with disabled organisations are involved in the promotions and development of facilities specifically for people with impairments.

The researchers benefited from the help of Open Arts and the Arts and Disability Forum, both of whom facilitated the involvement and engagement of disabled people with a specific interest in arts and cultural activities. A number of other organisations were cited by participants as providing safe and confidence building programmes that focus on visual arts, music and digital media-based activities including: ArtsCare, the Northern Ireland Music Therapy Trust and the Creative Learning Centre.

Audience participation at open-air activities brought concerns for some people in relation to the size of crowds – but others welcomed the opportunity to be outdoors:

'I always felt cooped up in hospital – and I love to watch the rallying - I don't worry about the crowds – it's just good to be outdoors.' (Jason, 27 year old male with an acquired brain injury).

Built and Natural Environment

The limited opportunities for people with disabilities to spend time in some environments was noted. One participant who is a permanent wheelchair user commented on the National Trust's commitment to inclusion for wheelchair users in its properties and on its lands, but gave Divis Mountain as an example where access was problematic because a gravel path, and access was further blocked for wheelchair users by a gate spanning that path. While this might initially appear to be an issue of prohibition, the participant flagged up the safety implications of being separated from others in a group by these circumstances.

Other concerns that were raised in the context of the built environment included the:

- A shortage of panic buttons;
- A need for visual fire alarms and the hard-wiring of public buildings;
- A lack of guide rails;
- Steps at the bottom of wheelchair ramps;
- The use of cctv cameras (which was broadly welcomed as a deterrent for targeted and random crime;

- Limited number of motability scooters that are available; and
- The upkeep of roads and dropped kerbs.

'A big part of my social and daily life would be spent outdoors. I meet friends outside love to be in the park and so I spend a good part of the day on a fine day going down the road to Botanic Park. I'd cross the road outside Methody – it's very safe there, doubly so at some times because of the crossing men. But the kerb drop at the Botanic Post office is really, really bad. You can get in and out of the post office because they put a ramp outside it when it opens up each morning, but - the road itself goes into holes where the pavement has a drop kerb - so your front wheels stick and that can be the same if you're on sticks. It's been like that for a long, long time.'

One of the benefits of having flattened kerbs at regular intervals on roads was that it permits wheelchair users to cross at will and enable them to avoid routes or confrontations with people or situations in which they perceive themselves to be unsafe:

'But if one side of the road is inaccessible, you simply can't avoid unsafe situations by crossing over'.

The design, as well as the misuse, of parking bays was a frequently raised issue:

'Parking bays may have a wheelchair or indicate they are specifically for disabled use only, but if they are not wide enough to enable you to open a door fully to get a wheelchair out without banging into the next door car, then they are not user-friendly. The lower level of parking at the RVH is a case in point. All these failings in environmental issues can impact on perceptions of safety.'

Some issues relating to the use of public buildings have already been highlighted in relation to accessing education and socialising in pubs, clubs and restaurants. However, it is worth rehearsing here the comments by participants that even since the

introduction of the DDA, premises do not always meet appropriate standards. The following issues in particular were cited as continuing to create difficulties:

- The lack of sliding doors and the prevalence of rotating doors;
- The lack of lifts and prevalence of escalators; and the quantity of public premises that are built without evacuation lifts;
- The lack of enforcement of the DDA in terms of general usage: including such matters as the narrow design of aisles in many shopping environments;
- The non-dedicated use of disabled washroom and toilet facilities;
- Inappropriate seating for wheelchair users; and
- A lack of grab rails and generally poor quality of signage.

We briefly highlight a few of the points made in relation to some of these issues by participants in the research.

‘Places of refuge are the easy way out for builders, but that isn’t the case for the wheelchair user who is seeking to escape a burning building. It’s strange to think that I’ve got to the stage in life now where if I make a choice to go into a place that I know it will be hard to get out of, I have to instruct my friends to leave me behind if something goes wrong.’

Andrew is a musician who plays regularly in buildings that are owned privately as well as those administered by the state. As a paraplegic wheelchair user, who works as a disability arts activist, he is familiar with amendments made to the Disability Discrimination Act (DDA). He feels that the spirit of the DDA is frequently flaunted describing as ‘violations of intended use’ the attitude of some of those who manage the use of public buildings. Places of refuge are the preferred option for builders and architects rather than the provision of escape routes which do not leave people with physical impairments dependant on being ‘rescued’, but rather able to exercise their autonomy.

The provision of disabled toilets in a number of pubs and clubs was perceived to pay lip service only to the DDA: *‘disabled toilets are always the dumping ground for*

mops and buckets', and a number of premises were named as having lost repeat business specifically because of their attitude to disabled toilets and the concomitant safety issues for clients: *'Having a toilet that is not really accessible might allow businesses to meet DDA and H&S regulations in theory, but in practice demonstrates the little regard they really have for the clients. It's not only disrespectful, it is downright dangerous.'* It was also noted that the trendier the venue, the poorer the signage could be to indicate the location of toilets or which gender they catered for.

Dedicated seating for disabled people in public venues, such as theatres and cinemas is often difficult to find. It was felt by a number of research participants that staff who might wish to exit areas quickly, often prefer people to sit in their own wheelchairs all night rather than spend time with finding identifying more comfortable seating with wheelchair storage places. Furthermore, the design and placing of seats are not always wheelchair-user friendly:

'Most paraplegics like myself, would prefer to sit in the comfort of a cinema or a theatre seat, but they are not designed to be friendly to us. They are invariably pop up seats which means that your levering hand has to fulfil two functions – it has to hold the thing down at the same time that you are bringing yourself across and that means you, the wheelchair and the pop up chair are more likely to flip over.'

Planners and architects came in for a considerable amount of criticism, in particular for their use of cobbled streets and other resurfacing materials in attempts to 'authenticate' rural areas and market towns. While district and city councils argue that the gaps between stones might be compliant with building regulations, they are still considered to create unnecessary hazards for people using sticks, wheelchairs or other aids to walking. In Omagh, it was suggested that: *The cobblestones near Supervalue are very hard work, and it's a real disappointment because yet again the planning department consulted but did not listen to our suggestions. The traffic lights are much better but some of them have now been replaced by zebra crossings'*. The local Access Forum had raised the fact that steps and dips on pedestrian routes and at

crossing points created significant difficulties for a number of people, but were informed that the appropriate design standards had been met.

Information dissemination and signage in public spaces was frequently reported as being poor, leaving people with impairments and learning disabilities unsafe. Makaton and Boardmaker symbols are not incorporated routinely as critical information in public places and *'if someone doesn't understand verbal directions or written instructions there is no way you're getting signage right'* (Disability Action).

Transport

Being able to access appropriately equipped and staffed public transport was seen by many to be *'the luck of the draw, at the minute.'* One young woman who travelled by bus from Armagh to Newry was unable to get a bus that could secure her chair and didn't feel confident in using the system. Arrangements to access an appropriate bus in some instances had to be made up to two weeks in advance and that was seen to undermine any sense of spontaneity in travel. As both the narrow steps and the grab rails at the top of steps that are designed to be used for getting on and off buses are not appropriate for people in wheelchairs and other physical impairments, Translink were commended for their 'kneeling buses':

'I hate Ulsterbus - getting on and off them buses is difficult – I can only go one when I'm with someone because at 16 stone I'm having to jump across onto the bottom step – and lift myself on which is just not possible' (Male wheelchair user in 50s).

Several people with visual impairments also commented on how frequently drivers assume that it is appropriate to *'shout the stop down the bus'* which means that visually impaired passengers wanting to preserve independence and privacy are left feeling exposed. Furthermore, the driver invariably has to *'compete with screaming babies and rowdy schoolchildren'* so there is always the potential of being misheard.

Train operators were frequently criticised for the automated recordings and incorrect human announcements – *‘I’ve never yet been on the train to Lisburn or Dublin when there isn’t a wrong announcement or when it’s audible’*. (Aaron, passenger with visual impairment). Both train and bus drivers from a variety of companies were criticised for the shortage of visual display systems on vehicles.

One or two negative experiences can significantly impact on people’s confidence levels and willingness to continue to use public transport. Gina is 18 and has a learning disability but doesn’t feel safe travelling by public transport:

‘At the bus depot my hairband got knocked off – I was in tears, I didn’t fight the lass back, and I had to tell my friends, but they just said to ignore it and when I spoke to the Inspector and he said stay away from any people who might hurt me – and because they leave any bruises he didn’t seem that bothered so I don’t go by bus anymore.’

Similarly Bridie who lives alone and has degenerative blindness prefers to travel by taxi:

‘Whenever I lost my license, I took the bus a few times, but there was always pushing and shoving – so I go by taxi but even then you’re panicking they don’t take you to the same place and who might be following you into your own home.’

Despite the aims and vision of the Department of Regional Developments’ Accessible Transport Strategy, participants reported very low levels of confidence in public transport schemes. While rural areas were particularly poorly serviced by public transport, so too were certain urban areas, particularly where black taxis are the norm, and there is a limited bus service:

‘The Springfield Road is not good for public transport therefore it’s hard to judge whether the residents would feel safe on buses.’ (Employee, Leonard Cheshire Supported Housing).

Having to rely on taxis in rural or urban areas where there are poorly serviced bus routes was a challenge to many disabled people, some of whom found their finances already stretched due to discrimination in employment practices. One student who is blind has to get taxis to and from her child's nursery and schools in the area of west Belfast in which she lives and spends up to £10 on transport a day. Particular taxi firms such as Value Cabs and Fon-a-cab were praised for their drivers' attitudes to disabled people whereas others were deemed to have

'Poor communication and poorly trained drivers who shouldn't be working with people with disabilities'.

The 'Door to Door' system enables local access to services within town boundaries for those who could not normally access public transport. Using this system (for those deemed eligible) and costs approximately £1.50 per trip, which has been described as: *'Brilliant if someone's doing project work, or a job, or has appointments and happens to live in the right area'*. Conversely those who have been means tested and are eligible to use the DARD and DSD Rural Link Run initiative pay £2.50 per driver per journey and an extra 40p per mile, and while the service is cheaper than a taxi fare it remains expensive: *'if you're coming in from Fintona for examples which is maybe 12 miles from the town - it can be expensive'*.

The standards, and consequently the feelings of safety that disabled people might expect when undertaking air travel proves to be erratic. The limited amount of wheelchairs that airlines or the airports make available were found to be inadequate: *'The last time we were flying back to Aldergrove me and my mum needed wheelchairs – they only had one so we had to wait on the plane for another one to come from the terminal to the plane to pick us up.'*

The lack of general courtesy on the part of airport security was also mentioned:

'I took a fit onetime and we're just crossing the bags – we were going to Spain and I cracked my tooth and the air staff said, is that fella OK is he? Did he take any kind of drugs.'

Some of the larger airlines were considered more helpful to disabled people than the budget lines on short haul flights. Two of the low cost airlines were the subject of much criticism, an example being the experience of two people, one with cerebral palsy and another with Huntington's who were travelling with their carers, they arrived five minutes late for a flight and were refused permission to board which meant that had to find accommodation and rebook flight next day. This was particularly stressful and felt to be discriminatory, because when they returned the following day, a non-disabled family of four who arrived late were allowed to board. EasyJet were commended for their support for disabled people, but condoned for not disseminating information very clearly:

'I didn't know until third time that I could have a chaperone on EasyJet. You tell them you have a disability and you can get easily lost, it's like when they take children, they can do it for people with disabilities.'

Medium and long haul travel on a number of airlines was not thought to be a pleasurable experience, nor was changing terminals or attempting to make connecting flights. While there are a number of private companies who advertise a service to help people with disabilities through airports, they were criticised for invariably not being able to help at the carousel with luggage and that their preferred method of supporting people with a disability is to provide a wheelchair which is considered highly inappropriate by some of those people with learning disabilities or with visual impairments who have used their services.

Media Representation

Many participants saw the small amount of positive media representation of people with impairments and disabilities as regrettable. That perspective has also been

expressed by Bamford (2007: 3.3) who suggests that the media has distorted views and interpretations of what someone with a mental health problem or a learning disability is like.

Those television programmes which were particularly memorable for their portrayal of people with disabilities and which were considered to de-stigmatise attitudes to disability, and thus play a proactive role in community safety issues included Britain's Missing Top Model, Ballamory, Coronation Street, East Enders, and Stephen Fry's *The Secret Life of the Manic Depressive* 'that was the most wonderful thing ever'. A number of high profile media campaigns were considered by some participants to have impacted positively on their willingness to engage in health advocacy work but some campaigns were more familiar to people in urban areas: *'The campaign was brilliant, but it was mainly on the sides of busses or at the airport and so it didn't reach the rural areas. We are always out of the way in the country.'*

8. Conclusions: Safety and Capacity Building

The premise of this report is that community safety is a key quality of life issue for all people with disabilities. The definition of community safety used in this report is drawn from the NIO Community Safety Unit which sees its function as “preventing, reducing or containing the social, environmental and intimidatory factors which affect people’s right to live without fear of crime and of crime and which impact upon their quality of life. It includes preventative measures that contribute to crime reduction and tackle anti-social behaviour.”

Safety issues and concerns may be perceived differently by different people and the ways that such issues are perceived and impacts on individuals is often as dependent on their personality as much as it is on their impairment. Furthermore, people living with a disability in Northern Ireland are a very diverse group of people, and need to be considered as a number of communities, rather than a single constituency, thus issues related to safety will be perceived and impact differently depending on the nature of a disability, but also on factors such as age, gender, ethnicity and place of residence. Consequently, participants’ different responses to experiences, perceptions, fears and concerns indicate that there is no single way to approach any community-led training intervention programme. Any project or programme that aim to address issues of community safety thus need to acknowledge and work with this diversity, rather than view it as an inconvenience.

The research confirms that the line between community safety and social inclusion issues is not always an easy one to define. Furthermore, that it is only through long-term attitudinal change and the development of a culture of inclusivity that the community safety of disabled people can be secured and sustained.

The research indicates that in keeping with good practice in local and international rights-based work, people living with disabilities and impairments want to be core to the development and dissemination of any further practice or research work to be undertaken as part of this programme. As such there is an identified need for disability

advocacy and campaigning to be a precursor to assessing what types of training and delivery mechanisms are most helpful to address the sectors needs in terms of community safety.

The research study had the objective of addressing **four principle aims** that aspired to increase the perceptions and the realities of community safety among people with a disability. These four aims are to:

1. Increase capacity for self-protection and reduced levels of fear of crime among participants;
2. Build community capacity and community ownership of better and safer environments by providing opportunities to promote active citizenship;
3. Develop strong community and voluntary and statutory relationships; and
4. Increase opportunities for volunteering and engagement within and between communities – volunteer trainers will harmonise province-wide training and support.

The research highlighted a number of key safety issues across a broad sample of people with a wide range of disabilities, these included issues of physical assault and verbal abuse; bullying and harassment; damage to property and possessions; issues related to trust and respect and also to awareness and confidence; and a variety of issues related to more diffuse elements of personal safety and security.

The research also clearly identified a variety of safety issues that were related to or dependent upon different physical environments, with the main distinctions being between:

- The home environment, be that own, family or communal;
- Public open spaces near the home such as the street or municipal parks and gardens; and
- Other public environments including shopping centres, public transport and leisure facilities.

Furthermore safety issues could also be dependent on the time of the day and the seasons of the year; and whether people were on their own or in the company of others.

The broad thematic exploration of issues raised by the participants to this research indicate that a number of safety issues are embedded in structural challenges facing people living with impairments and who are disabled by the systems with which they are engaging. While many of these are beyond the remit of this research it is important to acknowledge these and to begin to explore what changes need to be made to wide policy and practice to address these concerns.

The following section briefly indicates how some of the key safety concerns that have been highlighted in this research can be contextualised and responded to within the framework of the core issues that have been outlined above, and the four principal aims of the programme.

Aim 1: To create an increased capacity for self-protection and reduced levels of fear of crime among participants.

A diverse range of issues of personal safety have been identified in the research and developing an effective response to increase capacity for self protection could involve the following:

- General crime prevention training, which should be structured in a modular manner to focus separately and specifically on, for example: general personal safety, ensuring safety and protection around the home, safety of person and property in public spaces, safety while moving around, and general road safety.
- Developing crime prevention skills, which could involve assessing the quality and effectiveness of available personal and home safety aids and devices.
- Peer work with disability groups to develop and design simple and appropriate signs and symbols that increase safety and security.

- Addressing issues related to safety with money and finance, including accessing banks and ATMs, use of on-line financial services.
- General safety issues related to the use of computers, which include accessing financial services, but also issues associated with personal identity safety.
- Work could be done to develop safety skills and awareness in relation to accessing leisure facilities and participating in sports activities. This would also demand reciprocal training for sports and physical activity trainers and providers.
- Interactive work with the PSNI to increase individuals' awareness of safety issues and awareness among police officers of the specific needs and concerns of people with disabilities.

The research also raised some more challenging safety issues in relation to a variety of leisure and social environments, among the issues that have been identified are:

- The need to increase awareness and acceptance of the rights of people with disabilities to access social and leisure environments;
- The need to improve standards of services and resources provided to people with disabilities in social and leisure environments.
- Addressing safety issues in relation to socialising will require specifically tailored elements of advice and training.
- Such training should also include issues related to sexual safety.

While it is important to work to increase people's sense of safety, many people also indicated that wanted more independence even if this involved creating greater risk.

Work could thus be done to:

- Increase individuals' capacity for a greater level of independent activity through preparatory training on risk avoidance and management.
- Encouraging the creation of 'disability champions' in key public environments who would be responsible for increasing awareness of disability safety issues.

- The development of accessible information and advice about how to seek help and assistance in response to concerns for safety, and how to register problems that have been experienced.

People indicated that in general they have a culture of neither complaining nor of seeking help. In some instances evidenced in the research, this may mean that they find themselves more vulnerable to abuse and discrimination which impacts on their levels and perceptions of community safety. This could be addressed through:

- Training to build people's confidence to make complaints to, or demands on, safety service providers, such as the PSNI, community wardens, traffic wardens etc.
- Developing relationships with key agencies to ensure that they respond effectively and promptly to reports and complaints from people with disability and thus encourage ongoing reporting of problems.

It is important to address the wider context in which safety problems develop and thrive, both with disabled people and those with whom they come into contact. Consequently a precursor to developing self-protection mechanisms, needs to take place perhaps in the form of a series of demonstrations, workshops, seminars, training programmes and other forms of information dissemination that would aim address the concerns raised within the research. This could involve:

- Training and advise for 'front of house' staff within public bodies and public space to raise awareness about disability safety issues.
- Any general awareness training should acknowledge the multiplicity of facets to an individuals identity, which include age, gender, ethnicity, sexual orientation and community background, as well as presence or absence of a disability.

Aim 2: To build community capacity and community ownership of better and safer environments by providing opportunities to promote active citizenship.

A number of the issues already identified, such as encouraging reporting of safety concerns and building links with safety providers, would have a positive effect on community capacity in relation to safety issues.

In general people tend to gauge themselves off one another and as many disabled people do not have the opportunity to measure themselves against others they can find that they might make poor social choices that leave them vulnerable, isolated and lacking in opportunities to engage with wider society. Thus it is important to highlight the benefits of peer volunteers, mentors, and advocacy workers as role models in any capacity building and community development designed to create a safer environment for people with disabilities. This could involve:

- General community safety training should actively involve people with a disability as peer trainers and project leaders and thus to emphasise the ‘can do’ capacity of individuals.
- Work within the disability sector could be carried out to identify existing models of good practice that have increased community safety, which could be built upon and adapted to both similar and different circumstances.
- Training should explore the specificity of safety needs that are related to the distinctive nature of different forms of disability, rather than assume that there is a one size fits all standard for community safety training.
- Support and assistance could be provided to help develop advocacy skills, training and activities to further encourage lobbying on safety issues.
- Training could be provided that outlines the role and responsibilities of the various elements of the criminal justice system to encourage awareness of need to report concerns over community safety issues and the methods of actually reporting.
- Opportunities for third party and online reporting of problems and concerns could be established similar to those set up for forms of hate crimes.

It was also indicated through the research that a variety of forms of general confidence building training could have a positive impact on self-perception and thus on capacity and desire to be more active and assertive in public environments.

Aim 3: To develop strong community and voluntary and statutory relationships.

The research highlighted a variety of key agencies and bodies that have a professional interest in responding to safety concerns. Participants to the research process also evidenced examples where good practice in partnership working is beginning to emerge for people wishing to develop community safety work, this provides a basis for developing sustainable community safety work, which could involve:

- Undertaking an audit of existing examples of positive and effective partnerships.
- Work could be developed to establish or extend networks involving the disability sector and key public safety providers: including the police, traffic, and neighbourhood community wardens.
- Disability safety issues should be established as a regular item on the agenda of all 26 Community Safety Partnerships.
- In all partnership working emphasis should be given to ‘normalising’ disability safety issues as a general rather than a marginal issue, and thus create an opportunity to further increase awareness of the specific safety concerns by mainstreaming disability awareness as an element of all community safety thinking.

Aim 4: To increase opportunity for volunteering and engagement within and between communities – volunteer trainers will harmonise province-wide training and support.

There is a general perceived need for the creation and opening up of opportunities for disabled people to work and volunteer within the community explicitly to make their environment a safer one.

- This might be undertaken through the creation of specific voluntary posts/befrienders/internships/traineeships or shadow positions within community-led organisations or educational establishments for individuals wishing to promote active citizenship for and with disabled people.
- It could involve the development of a training of trainers programme in community safety skills, specifically for people with disabilities, who would form a pool of peer trainers and advocates.

Finally, the research clearly outlines the need for some form of ‘champions’ or advocates who will raise awareness of and encourage creative responses to problems community safety among people with disabilities, to enable them to feel more comfortable and welcomed in a variety of public spaces and environments.

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APPENDIX

Organisations who agreed to participate in the research process.

Action MS
Arc
Ballymoney Community Safety Partnership
Barnardos
BLESMA
British Legion
Carers NI
Cause
Ceder Foundation
Centre for Human Rights of Disabled People
Community Development and Health Network
Community Safety Unit (NIO)
Cunamh
Deaf Association of Northern Ireland
Disability Action
Disability Arts Forum
Disability Matters North Down
Epilepsy Action
Headway
Kislev Training Consultants
Leonard Cheshire Disability
Mencap
Northern Ireland Council for Refugee and Asylum Seekers
Northern Ireland Housing Executive
Open Arts
Parkinson's Society
PSNI
Rethink
RNIB
Stepping Stones
Tell It Like It Is
Wave