



Minority Ethnic Carers in Northern Ireland: A Report

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Executive Summary

Key findings show:

1. The fact that service provision for BME carers can only improve if significant improvements are made in the current levels and quality of ethnic monitoring and consultation. The situation and circumstances of BME carers in Northern Ireland and in specific Trust areas should be monitored henceforth through ongoing further research.
2. A need for increased English language tuition for BME carers, in tandem with the need to provide language and cultural awareness training available for frontline staff and relevant healthcare personnel.
3. The need to build and develop enhanced networks of support for minority ethnic carers – and also for the BME Carers Strategy Group to look at ways of enhancing its own support networks and exchanging best-practice models through linkages with other agencies in the UK.
4. A need to address and prioritise specific supports for minority ethnic carers, with issues of access to services and integration important elements to be considered.

The report concludes by proposing that future initiatives and improved ways of working be explored and where possible implemented in five thematic (though not mutually exclusive) areas. These are:

- Monitoring and Research
- Communication
- Network Development
- Best Practice
- Support for Carers

Recommendations for specific activities addressing each of these areas are given as a conclusion to the report.



Commissioned by the Regional BME Carers Group, a sub-group of the regional minority health and social wellbeing steering group, *Minority Ethnic Carers in Northern Ireland: A Report* represents the first piece of research to examine the situation of BME carers in Northern Ireland.

Through an analysis of newly-acquired and existing data, the report provides information on numbers and needs and, through interviews for case studies, valuable insight into the lives of carers from non-indigenous backgrounds.

In Part One, 'Northern Ireland's Minority Ethnic Carers' provides an overview of the BME carers landscape and research to-date. 'Establishing numbers, establishing needs' presents a selection of the data collected in recent months by the five Trusts and the results of a survey to establish carers' own needs and preferred supports. These are considered alongside Census 2011 data and other research findings of relevance from the growing body of literature on BME communities in Northern Ireland and the UK.

Approaching Northern Ireland's minority ethnic carers as distinct groups with their own levels of need, Part Two of the report provides recent case studies from a range of ethnically and linguistically diverse interviewees. These are considered within three discrete groups:

**Established
Communities**

**Post-EU
Accession
Arrivals**

**Asylum
Seekers and
Refugees**

A fourth group, that of support workers comprising interpreters, healthcare workers (including GPs) and managers and staff of a range of BME advice and support organisations and carers organisations provided additional viewpoints and proposals for an improved strategic response to minority ethnic carers' needs. A small selection of these is also presented.

Introduction

The present report is based on the scoping exercise initiated by the Regional BME Carers Group, a partnership initiative of Northern Ireland's five Health & Social Care Trusts, the Public Health Agency, and the Carers Trust, designed to identify the size and make-up of BME Carers within the five Health and Social Care Trusts. With representation from all the HSC Trusts, the Public Health Agency and voluntary organisations working with BME Carers, the group has been developing small local initiatives over a number of years. However, very little is still known about the overall BME Carers landscape in Northern Ireland, and the Regional BME Carers Group is grateful to the DHSSPS Physical and Sensory Disability Strategy for its foresight in funding this research.

The group's first initiative was a leaflet produced in 2014 in the most widely spoken minority ethnic languages in the province, and its subsequent successful launch in each Trust area. The group then identified the need for preliminary research into the contemporary landscape of minority ethnic carers across the five Health Trusts with a view to providing an increased understanding of that landscape in 2016 that would help inform and underpin a strategy and resulting initiatives in the coming year and beyond. A key outcome of the present exercise is therefore the set of recommendations made on the basis of the findings within. It is hoped that this will enable Trusts, relevant agencies and stakeholders to monitor the emerging BME Carers map and help inform future interventions and initiatives for the benefit of carers from minority ethnic backgrounds.

Even in the comparatively short space of time of the last two decades or less, a substantial and growing body of publications and policy documentation relating to minority ethnic communities in Britain and Ireland has appeared, and continues to form a focus of research. However, research into the situation of ethnic minority *carers* in Northern Ireland is lacking. One of the challenges of the present exercise has been to absorb and analyse the discrete research findings published and information available on 1. Ethnic minority communities *and* 2. Carers, in an attempt to understand and identify this hitherto unresearched area and to make a start on establishing numbers and needs.

The very titles of research publications on the situation of BME communities and migrants in Northern Ireland in recent years immediately point to issues of difference and difficulty: 'We Asked For Workers But Human Beings Came' (McVeigh, 2008),

'Life as a Stranger' (McAreevey, 2010) and, most recently, 'Walking this thin line' which addresses Black and Minority Ethnic experiences of mental health and well-being in Northern Ireland (Radford et al, 2015). (The title of this last report is taken from the remarks of a Polish woman, one of the cited case studies, who is quoted as saying: 'There is an extremely thin line between life and death for me. I am walking a narrow road, and I never really know when I could be on the other side.')

The present report is not an offering in isolation. While it is unique in that it is the first research exercise to begin to examine the unexplored 'niche' where carers reside in the narratives of BME communities, it has been conducted while other research findings that have a bearing on the situation of minority ethnic communities continue to emerge. Thus, our knowledge has been enhanced in recent months by the publication by the Joseph Rowntree Foundation of the grimly illuminating *Poverty and ethnicity: Key messages for Northern Ireland* (Lucas, O. and Jarman, N., February 2016) and the HSC's important intervention in the area of data collection, *Guide to the Ethnic Monitoring of Service Users in Health and Social Care in Northern Ireland* (February 2016). These follow other valuable contributions to the growing landscape of research into BME citizens' circumstances within Northern Ireland in 2015–2016, such as the Institute for Conflict Research's report noted above, entitled '*Walking this thin line*': *Black and Minority Ethnic (BME) Experiences of Mental Health & Wellbeing in N. Ireland* (December 2015) and the recently formed Newry, Mourne and Down Diversity Forum's contribution (January 2016) of recent statistics through an online survey into perceptions of and interaction with BME people in local communities.

Research-in-progress of relevance to Northern Ireland's *largest* minority ethnic community includes Justyna Bell's examination of the mental health and well-being of Polish migrants in Northern Ireland, under the auspices of the UKCRC Centre of Excellence for Public Health (NI) at Queen's University, Belfast. Recently gathered interviews with carers from the Roma Community by the Belfast Trust have added their voices to the diverse range of minority ethnic carers interviewed for this report. The recent arrival in Northern Ireland meanwhile of displaced and traumatised Syrian families as part of the UK's Vulnerable Person's Relocation Scheme has added a new dimension to the challenge of responding to BME carers' needs in the future.

In order to provide as multi-dimensional a picture as possible of minority ethnic carers' lives in Northern Ireland, the present research has focused not only on carers themselves but also where relevant and possible on the views of support workers (interpreters, healthcare staff, and managers and staff of a range of BME advice and support organisations and carers organisations). As well as case studies of BME carers, then, a number of responses and interviews from such support workers are also included for the light they shed on BME carers' issues and concerns – and the solutions they propose.

Acknowledgements

Grateful thanks are due to the many people and organisations who responded to requests for information or interviews. Among the many individuals who responded with valuable information and support have been the following:

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Images by kind permission of Diversiton

Methodology

A significant component of the present report involved extensive desk research and a review of existing and emerging literature and policy documentation. A trawl of existing carer services to establish/investigate current use from BME communities in Northern Ireland included, with the help of the Carer Co-ordinators and their teams in each of the Trusts, the collation of unique up-to-date data on numbers and nationalities of BME Carers and those in their care

Group discussions and individual meetings and interviews with carers and members of BME communities were conducted, and information and opinions gathered through questionnaires and interviews with, on the one hand, carers from a range of minority ethnic backgrounds and, on the other, support workers and healthcare professionals (these have included interpreters registered with the Northern Ireland Health and Social Care Interpreting Service, care workers, GPs, and managers and frontline advice and support staff in ethnic minority support organisations and local councils). Questionnaires in electronic and hardcopy format were made available in English and translated into Polish and Mandarin for focus groups. Among those whose views were solicited were the personnel and selected members of some 40 organisations and all interpreters registered with Northern Ireland Health and Social Care Interpreting Service (a total of 295). These also formed the starting-point for case-study interviews. A second questionnaire was devised for support workers and healthcare professionals soliciting their views on present policies and practice pertaining to minority ethnic communities.

In addition to many interviews and conversations with carers from diverse backgrounds and support organisations' personnel throughout Northern Ireland, a total of five focus groups were held, conducted primarily in English, though also Polish (and, in two instances, partly in French) and, through interpreters, Mandarin and Cantonese. These were held in the Belfast and Southern Trust areas. Grateful acknowledgement is made to the following organisations for kindly facilitating these meetings: the Belfast Health and Social Care Trust, the Chinese Welfare Association, Newry Carers Centre, Newry, Mourne and Down Ethnic Minority Support Centre, and the Northern Ireland Community of Refugees and Asylum Seekers (NICRAS).

Part One: Northern Ireland's Minority Ethnic Carers

1. BACKGROUND

Carers from minority ethnic communities (often referred to as Black and Minority Ethnic (BME) communities), in common with carers more generally, work tirelessly in support of those they care for, often without pay or recognition and often to the detriment of their own health and well-being. While all carers, whether those of the local indigenous community or those of another ethnic origin, face similar difficulties in their caring role (notably: high levels of stress and difficulties securing paid employment), BME carers are known to experience unique challenges in accessing support services. Challenges may also arise due to a lack of self-identification among some BME individuals of their status as carers and hence an absence of policy recognition of their needs, compounded on occasion by stereotypical assumptions of what their needs are, and how they should be met.

People from BME communities do not constitute a homogenous group and have diverse support needs. This is particularly the case in mainland Britain, where there is a strong representation of Black and Asian communities with a presence stretching back over several generations. Northern Ireland offers a different profile of what is referred to both here and throughout the UK as 'BME' communities, with (since the expansion of the EU in 2004) the majority made up of foreign nationals of Central and Eastern European origin (and overwhelmingly white and from the Christian tradition).

One consequence of this trend, and a factor in addressing the needs of BME carers in Northern Ireland, is the fact that there is in general terms a closer cultural heritage in common with the local indigenous population (i.e. culturally sensitive issues regarding religious beliefs, dress, diet and other factors will not be factors in service provision for Poles and Lithuanians in the way that it might be for members of Northern Ireland's longer-established BME communities from India and Asia).

Research has highlighted the fact that migrant communities have different levels of success in adapting and functioning within their new environment:

The challenges facing them are exacerbated due to differences in language. Further, there are some ethnic groups who may not be integrating to the same extent as other groups, e.g. East Timorese. It is important therefore not to group all migrants together as their needs differ both within ethnic groups and between different groups. Some who move are proactive self-starters while others are less confident and require much more support and help... Furthermore, these needs change as the situation changes. For instance some who may not have been vulnerable a few years ago when the economy was buoyant are now in a very precarious situation as a result of less employment security. (McAreavey & McCormick, 2011)

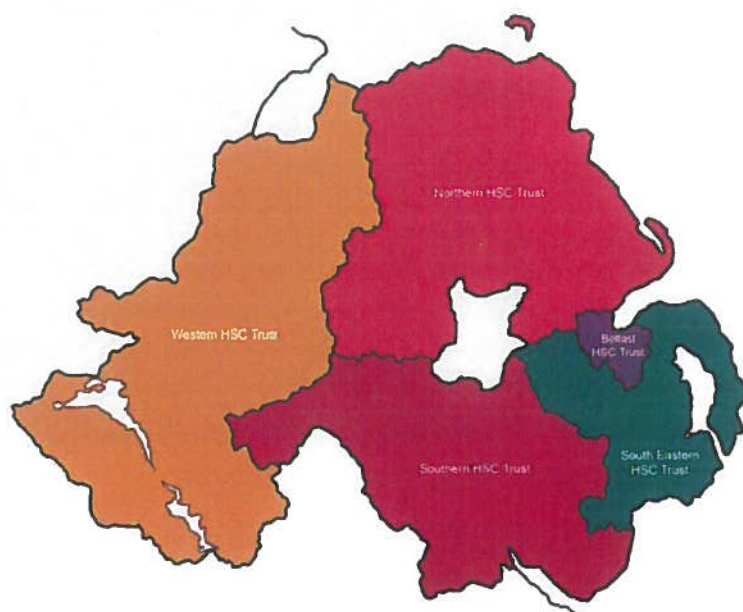
Even when BME carers are identified, however, research indicates that they face numerous barriers in accessing and using services. These barriers relate to and include: communication difficulties, a lack of culturally competent services, and a lack of understanding by BME carers themselves about how services can support them. The difficulties experienced by carers from a minority ethnic background are compounded by a number of significant barriers which indigenous carers do not as a rule have to face, notably: language barriers; a lack of understanding in relation to help available and where to access such help; a lack of wider family support as a result of their living in a distant foreign country; and loneliness and isolation due to various factors including onerous working hours of partner/spouse. (Some of these very themes are touched on by BME carers interviewed for the present report (see 'Case Studies' below.))

In recent years, research and legislation have helped to place carers' circumstances near the top of the policy agenda, with carers' needs increasingly being assessed independently from those they care for and addressed through tailored support services. Alongside this welcome trend, however, is evidence that carers from BME communities are not being adequately supported and that greater efforts have to be made to reach out to these individuals and to design services in line with their distinct and diverse needs.

Low uptake of support by minority ethnic carers cannot be taken as evidence that they do not want or need help. On the contrary, research shows that BME carers have a real need and strong wish for support and advice – as the consideration of BME carers' numbers and needs that follows – and the numerous recent case studies presented within – show.

2. ESTABLISHING NUMBERS, ESTABLISHING NEEDS

In the ten years between the 2001 and 2011 Censuses, the proportion of the usually resident population belonging to BME groups more than doubled – from 0.8% in 2001 to 1.8% (32,400) in 2011 (NISRA and Rogers & Scullion, 2014). The map below shows Northern Ireland divided into the geographical areas that the five Trust areas each administer. Overleaf are statistics from the 2011 Census giving, in each area, numbers of ethnic groups by provision of unpaid care.



CENSUS 2011: ETHNIC GROUP BY PROVISION OF UNPAID CARE



Table population:

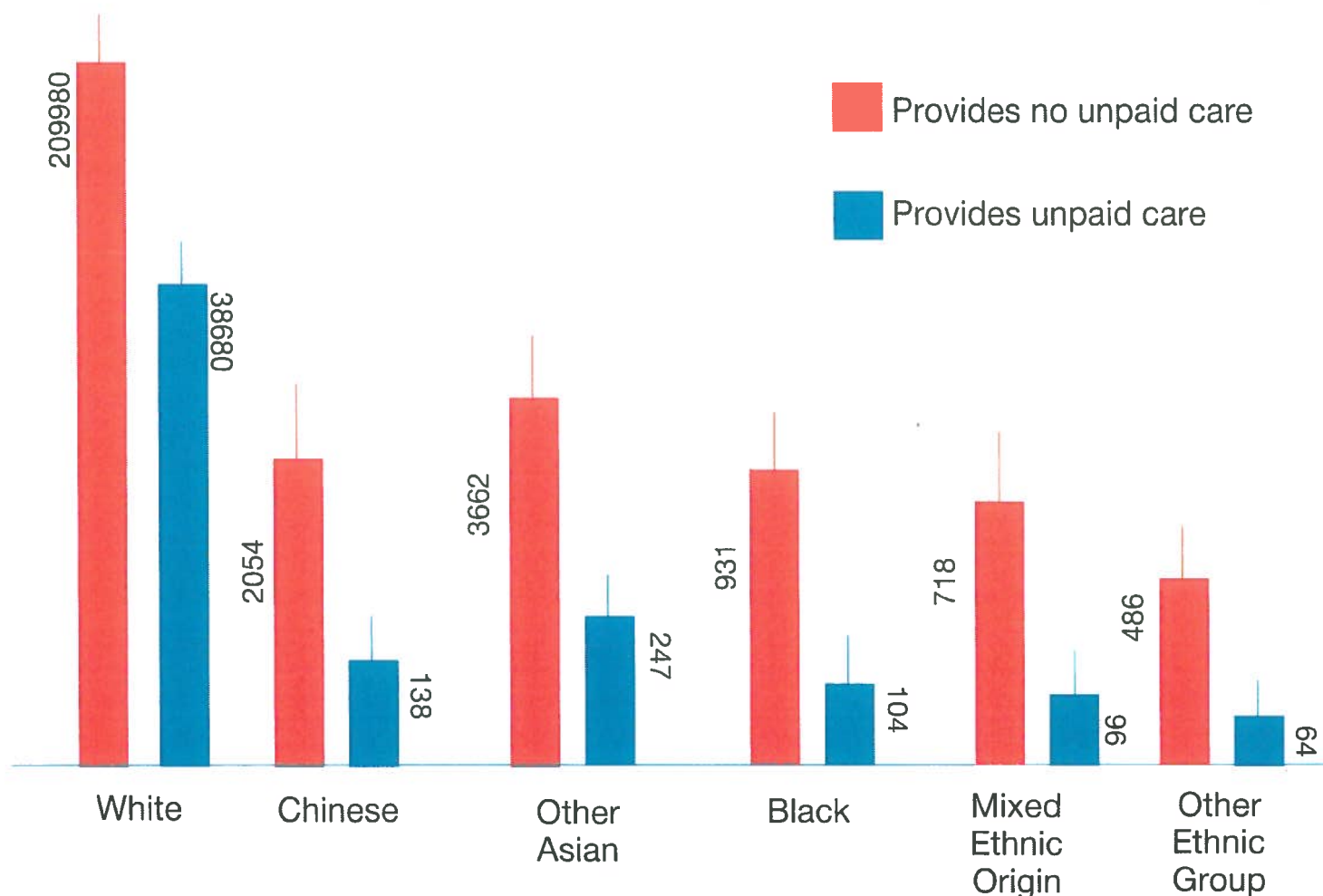
All usual residents aged 16 to 74



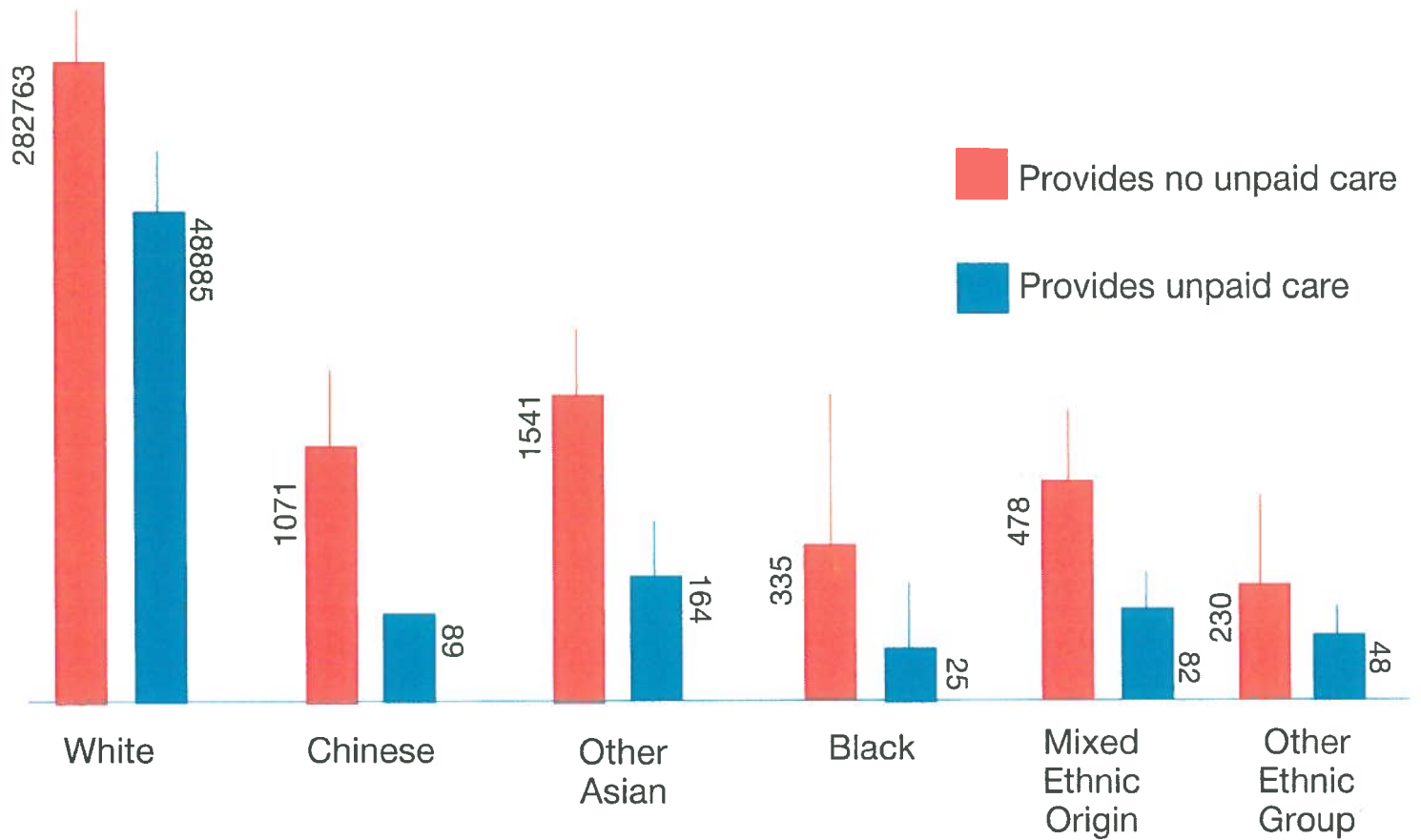
Geographic level:

Health and Social Care Trust

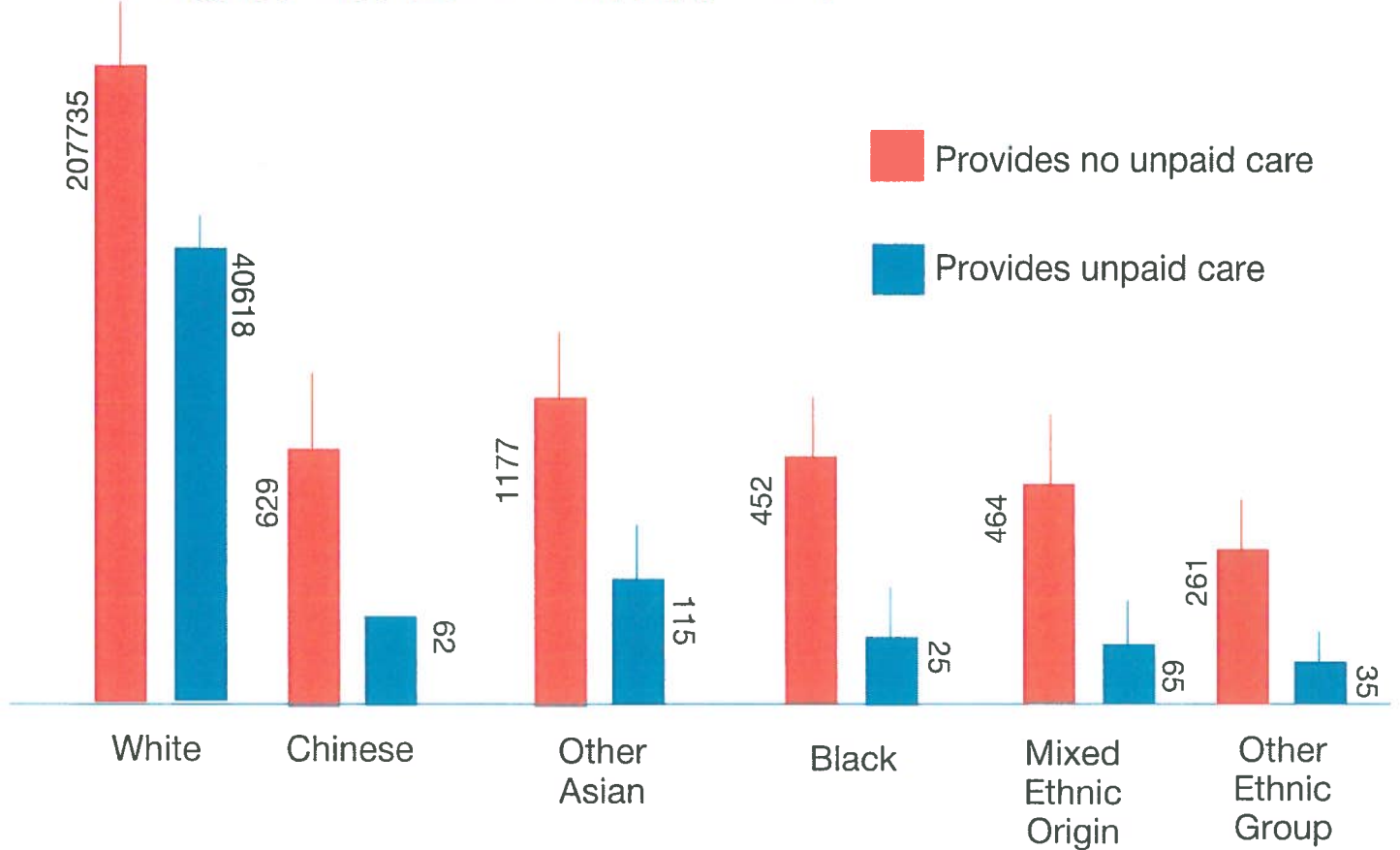
Belfast HSCT



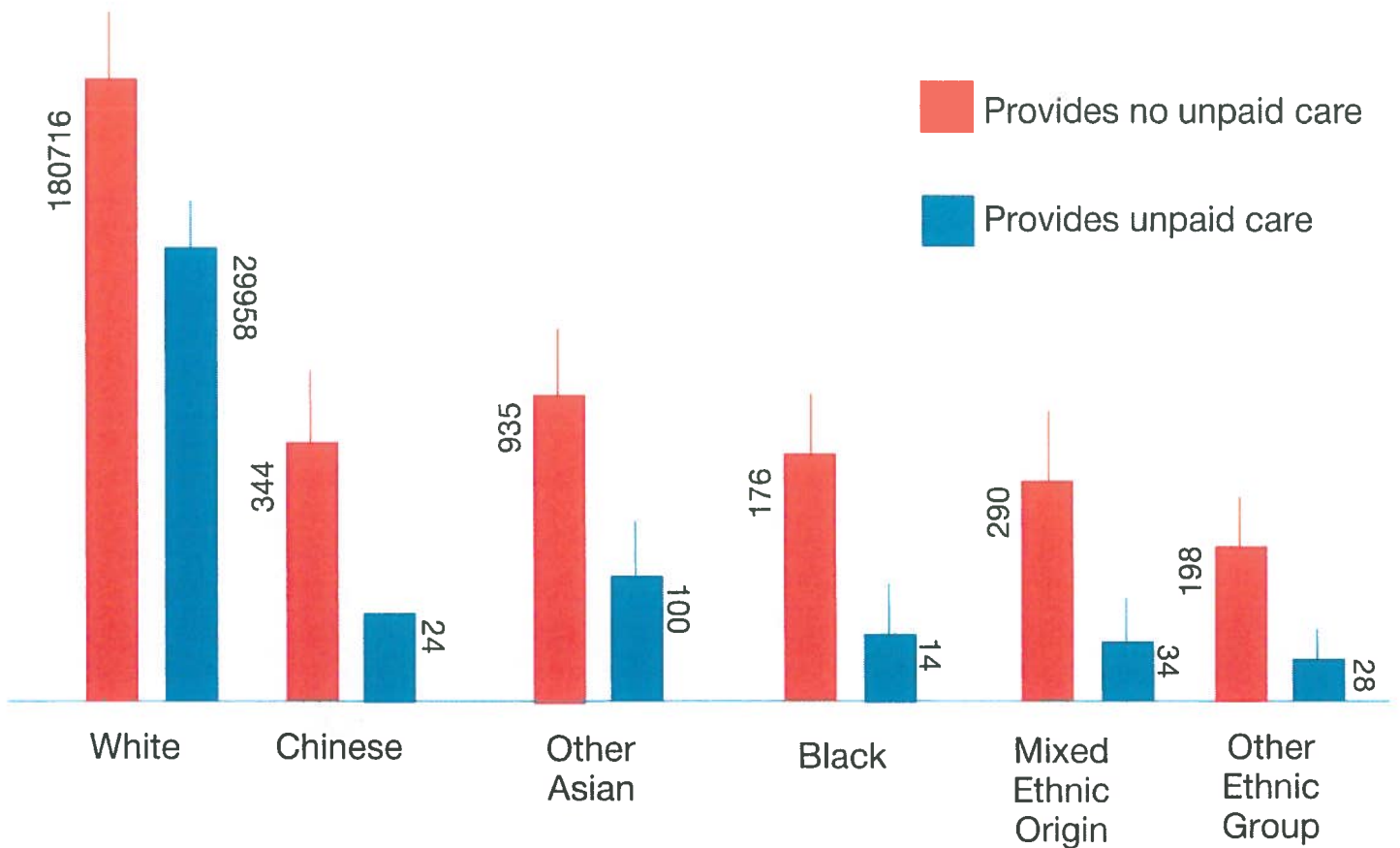
Northern HSCT



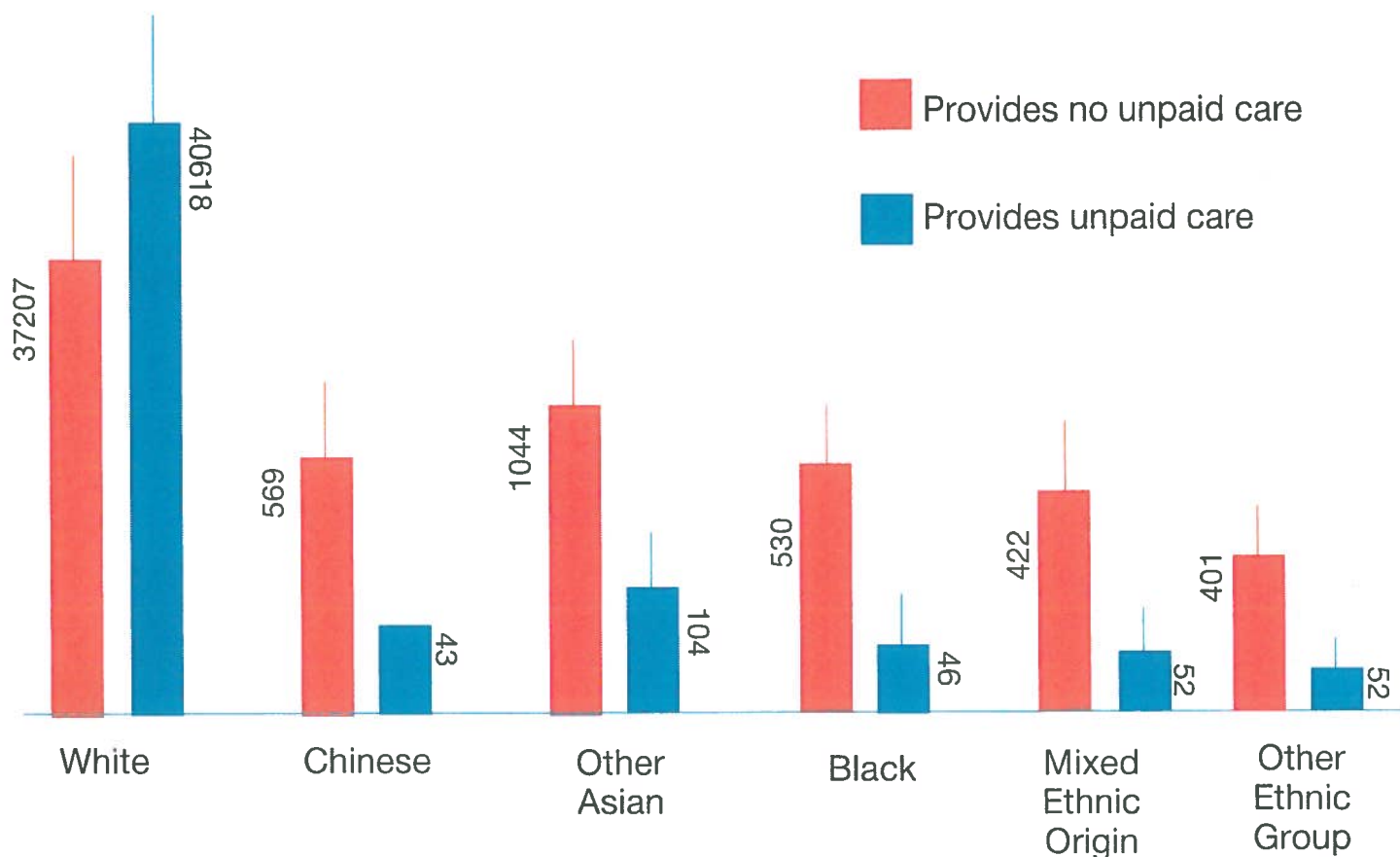
Southern Eastern HSCT



Western HSCT



Southern HSCT



While these data sets provide interesting information on the geographical spread of certain minority ethnic groups *on the basis of ethnic origin*, we are left in the dark when it comes to learning the number of Poles, Lithuanians, Portuguese, etc., who will have been classified as and subsumed under the ethnic description 'White'. It is precisely the absence of such data which accounts for the difficulty in providing accurate information on carers with regard to country of origin and first language. This is a significant gap in our understanding of BME carers' nationality and linguistic profiles, and one which the recently published *Guide to the Ethnic Monitoring of Service Users in Health and Social Care in Northern Ireland* seeks to address

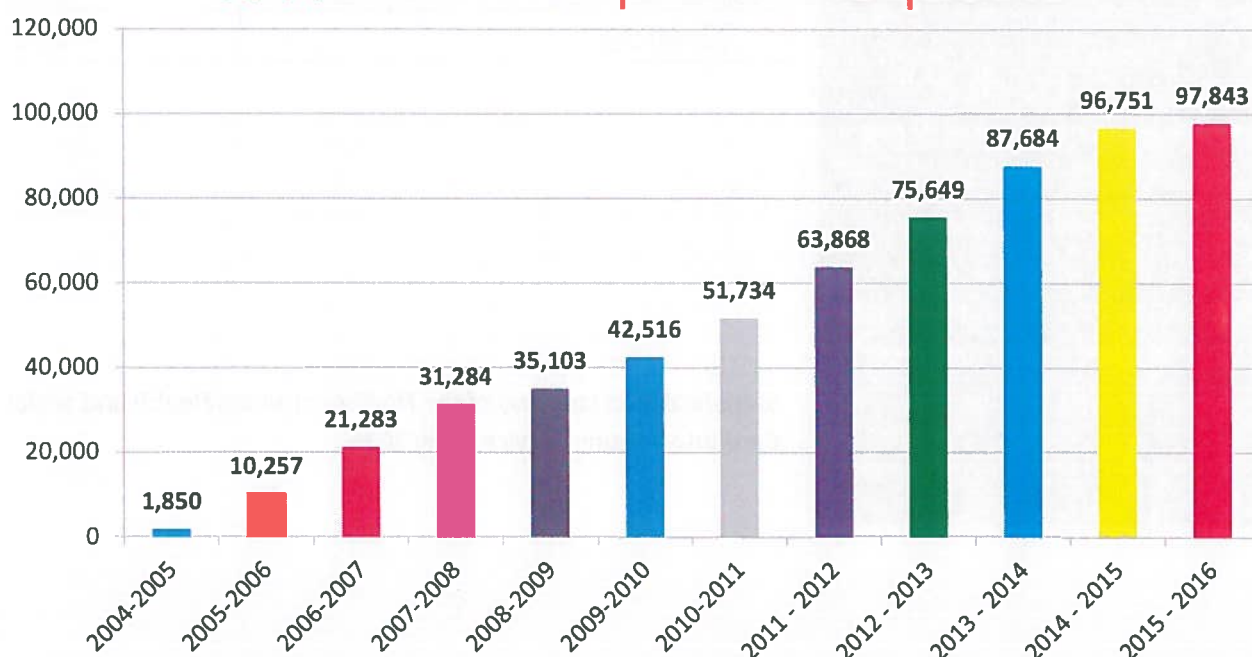
The 2011 Census provided important information on the population of Northern Ireland in respect of the increasingly multicultural make-up of its society. Minority ethnic community profiles compiled by the Northern Ireland Strategic Migration Partnership based on Census 2011 findings provide useful data of relevance to an examination of the present BME carer landscape in Northern Ireland:

1. Of the 1,810,863 people resident in Northern Ireland, 80,621 were born outside the UK or Ireland. This represents 4.5% of the population.
2. 50,376 residents aged 3+ speak a language other than English or Irish as their main language. Of those whose main language is not English or Irish, 26.5% cannot speak English, or cannot speak it well. (Polish is by far the most widely spoken language, with 17,731 speakers; second place goes to Lithuanian, a long way behind on 6,250.)
3. 10% of babies born in Northern Ireland in 2012 were born to mothers who themselves were born outside the United Kingdom or Ireland. In 2001 this figure was 3%.



The most dramatic statistic, however, and one of particular interest and relevance to the present research, concerns the phenomenal numbers of requests for interpreters through the Northern Ireland Health and Social Care Interpreting Service. Established in 2004, the year in which the EU accepted eight new member states, the Service attracted nearly 2,000 requests (1,850) in its first year of operating. It quickly established the statistical trend (with the exception of the years 2007/8–2009/10) of an annual increase on the previous year of approximately 10,000–12,000 requests for interpreters.

NIHSCIS Interpreter Requests



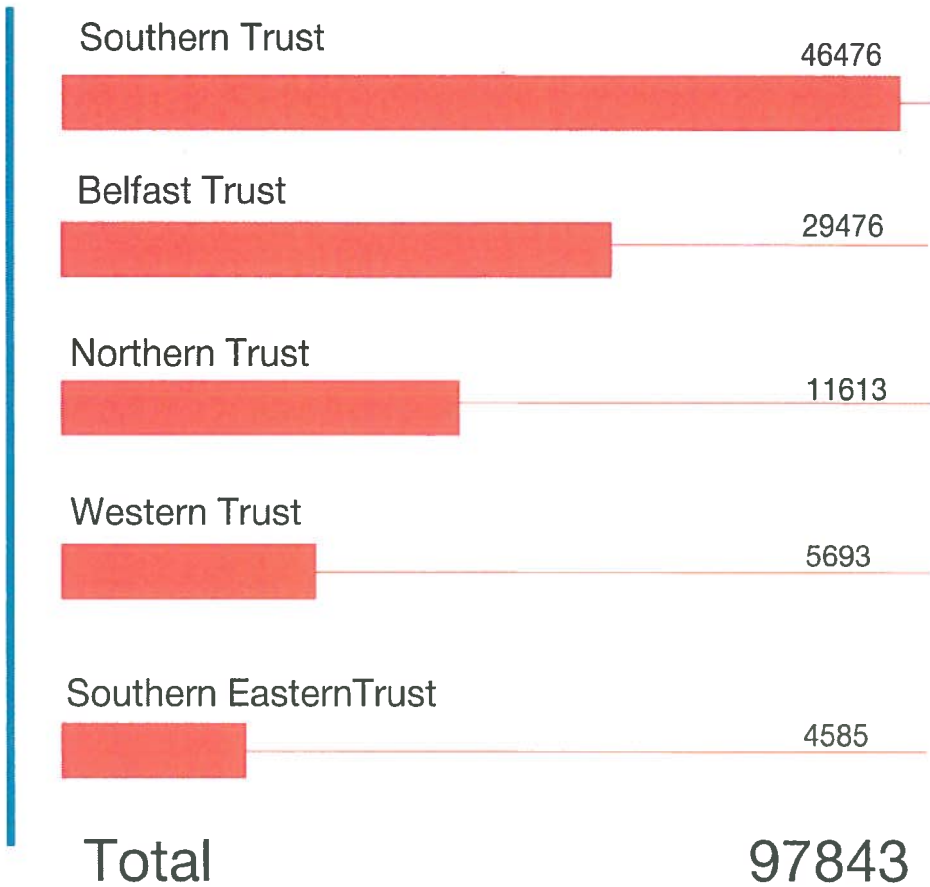
The table below gives the most up-to-date statistics we have on the twenty leading languages in Northern Ireland with regard to numbers of interpreter requests in the period 1 April 2015 – 31 March 2016.

1. Polish	30466
2. Lithuanian	15780
3. Portuguese	8472
4. Romanian	7278
5. Chinese - Mandarin	5431
6. Tetum	4808
7. Slovak	4765
8. Hungarian	3329
9. Chinese - Cantonese	3174
10. Russian	2665
11. Arabic	2339
12. Bulgarian	2176
13. Latvian	2120
14. Somali	1095
15. Czech	748
16. Chinese - Hakka	508
17. Spanish	432
18. Bengali	376
19. Farsi	261
20. Urdu	221

As can be seen, Polish now accounts for almost one third of all requests for interpreting services across all Trust areas, with 30,466 appointments out of a total of 97,843 received in the course of the past (financial) year.

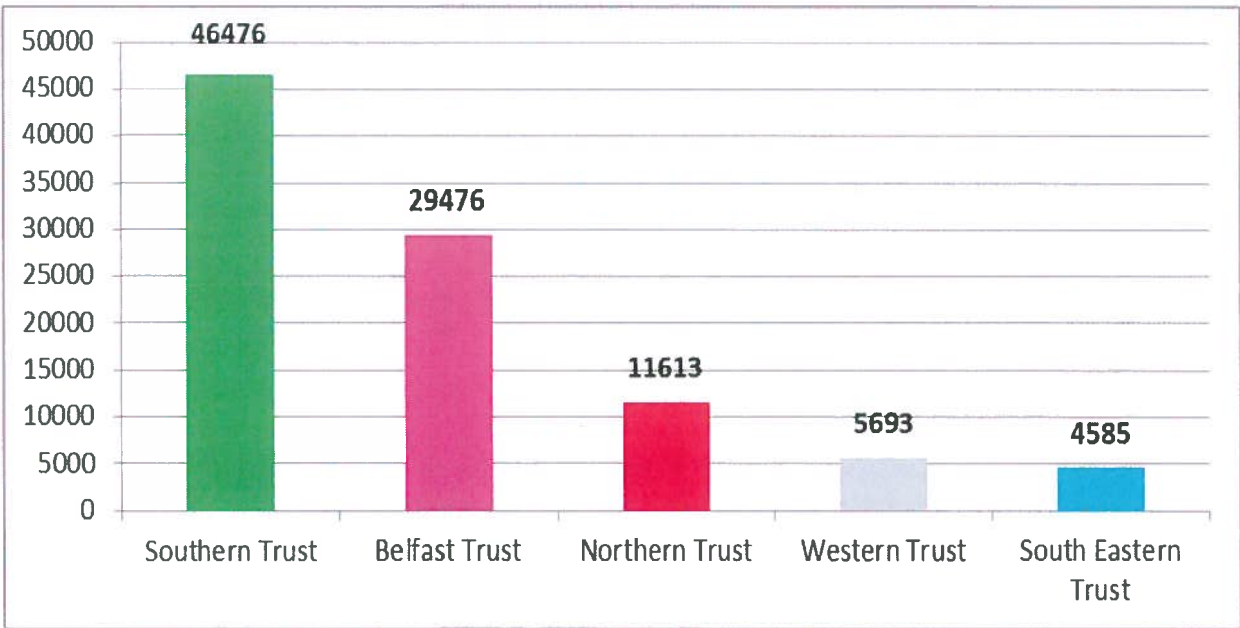
Statistical data courtesy of the Northern Ireland Health and Social Care Interpreting Service, May 2016

When we examine the locations of requests for interpreters, we see that close on half of all such requests originate in the Southern Trust area, as shown by the following table giving the precise breakdown of the number of appointments in each of the five Trusts in the same twelve-month period:



Statistical data courtesy of the Northern Ireland Health and Social Care Interpreting Service, May 2016

Presented as a bar chart, we gain a clear and instructive picture of the differences in usage of / demand for the Health and Social Care Interpreting Service among minority ethnic patients in each of the Trusts:



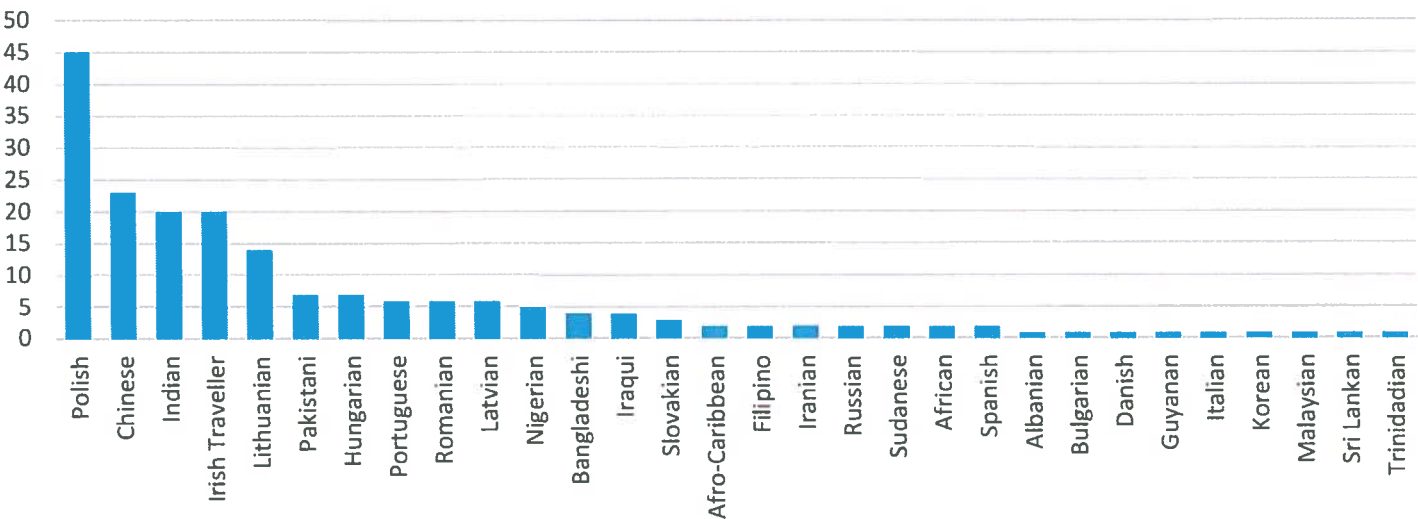
The most striking observation at first glance is the very high number of requests for interpreters in the Southern Trust relative to other areas. This can be accounted for primarily by the high concentration of Polish, Lithuanian and Portuguese migrants employed in the area. In fact, their decision to locate to the Southern Trust area on arrival in Northern Ireland was in many cases the result of recruitment drives through advertisements in Poland and Lithuania by a number of the major employers in Newry and environs. These include the veterinary pharmaceutical company, Norbrook, the ABP abattoir, and Regen, a recycling operation. Moy Park in Dungannon, meanwhile, has attracted a Portuguese-speaking workforce through advertising in Portugal.

Another pertinent observation relates to the status and success of the Newry, Mourne and Down Minority Ethnic Support Centre. Regarded by many as a model of best practice in the provision of advice and active support for the local BME community, including some 30 carers and their families of predominantly Polish but also Lithuanian and Latvian origin, the Centre is now a vital part of the structure and services of Newry, Mourne and Down District Council.

Complimentary to these illuminating Interpreting Service statistics have been the five Health Trusts' own figures gathered specifically for this research exercise in each trust area by Carer Co-ordinators and Trust services and teams.

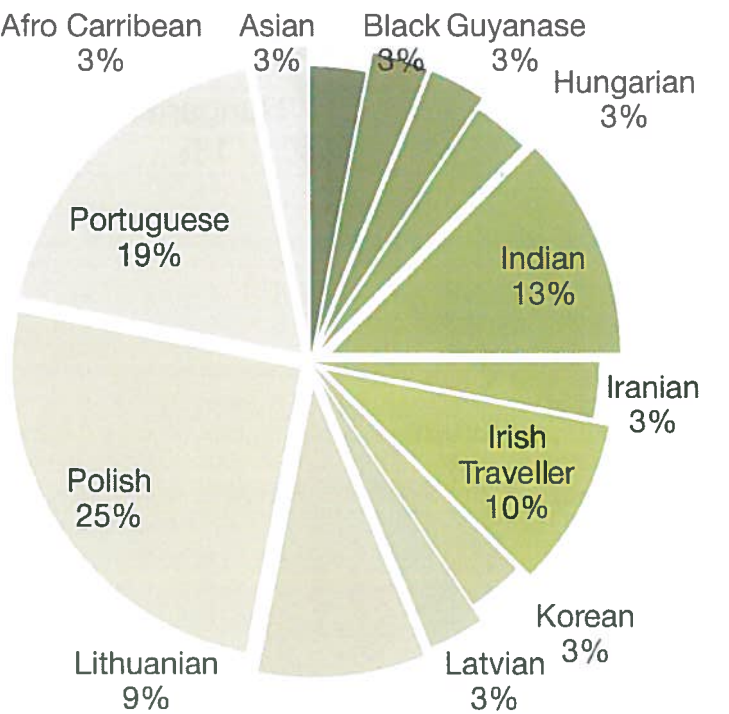
The following bar chart combines data from each Trust to give an accurate snapshot of actual carers from a very diverse range of ethnic and linguistic backgrounds with whom the Health Service is engaged. The parallels with Census and Interpreting Service data with regard to linguistic background are noteworthy.

BME Carers by Nationality/Ethnicity

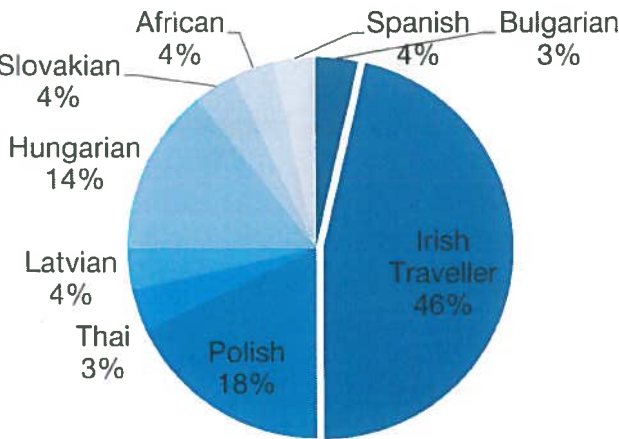


[Note: Data is presented as 'Nationality/Ethnicity', in keeping with the at times inconsistent categorisation recorded (thus a small number of data received gives 'African' and 'Afro-Caribbean' (ethnic origin) without specifying country (nationality)). These are of course two separate categories, and the report's Recommendations will highlight the importance of the collation of consistent data for future monitoring purposes.]

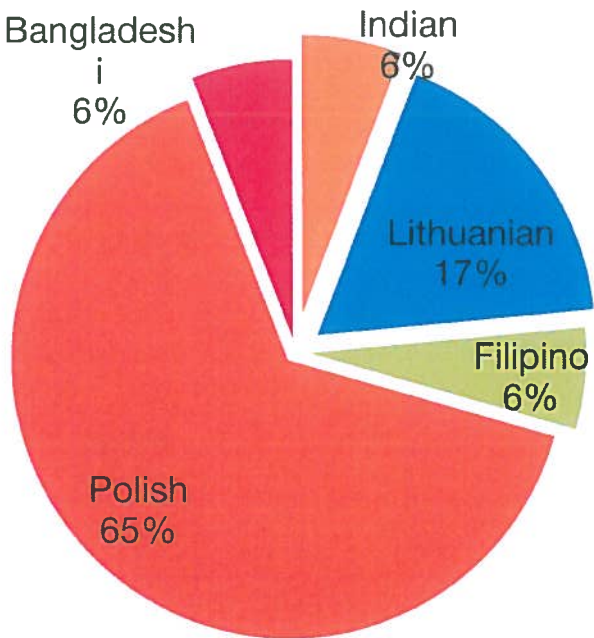
An analysis of the above data by individual Trust area shows the greatest diversity of ethnic background in the Belfast Trust. We can also see, when presented by individual Trust areas, confirmation of data above regarding concentration of certain groups in particular areas. The following pie charts show a percentage snapshot of those BME carer communities Trusts are presently aware of. (While the ethnic as opposed to linguistic group Irish Travellers is not a focus of the present research exercise, it is noteworthy that of ethnic groups identified by Trust teams carers from an Irish Traveller background were most prevalent in the Western Trust area.)



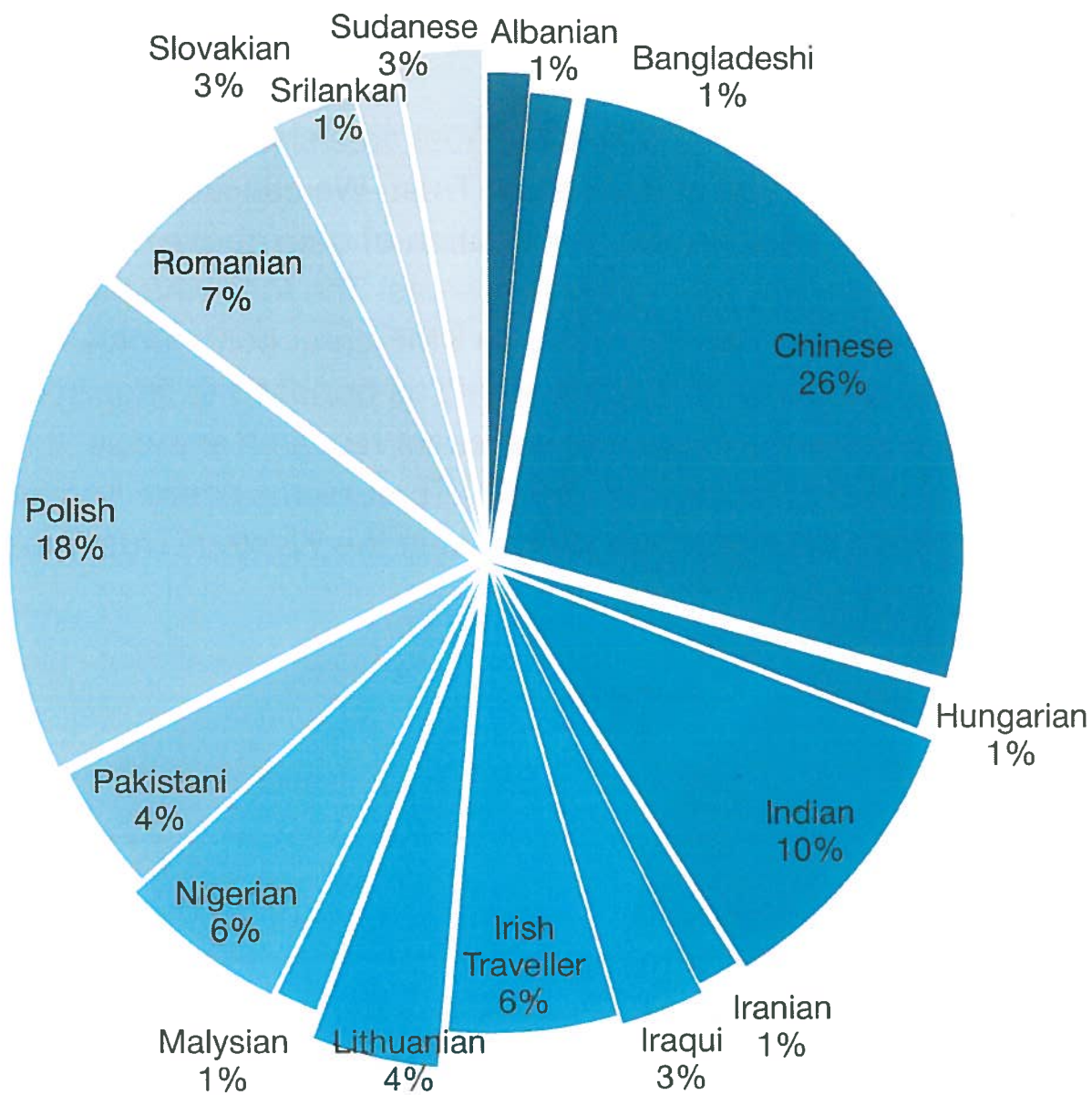
BME Carers by Nationality/Ethnicity: Southern HSCT



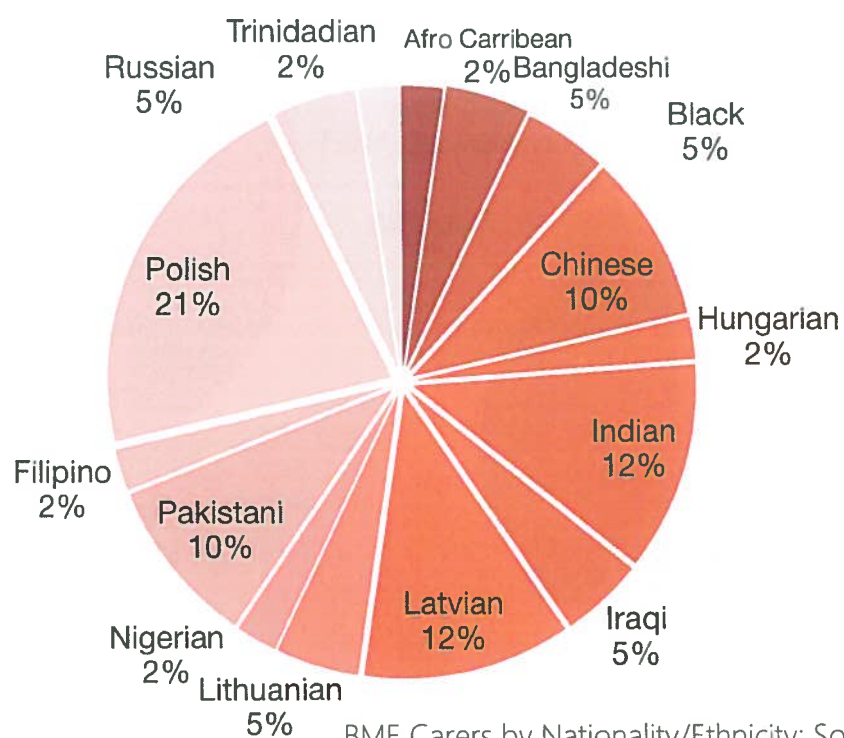
BME Carers by Nationality/Ethnicity: Western HSCT



BME Carers by Nationality/Ethnicity Northern HSCT



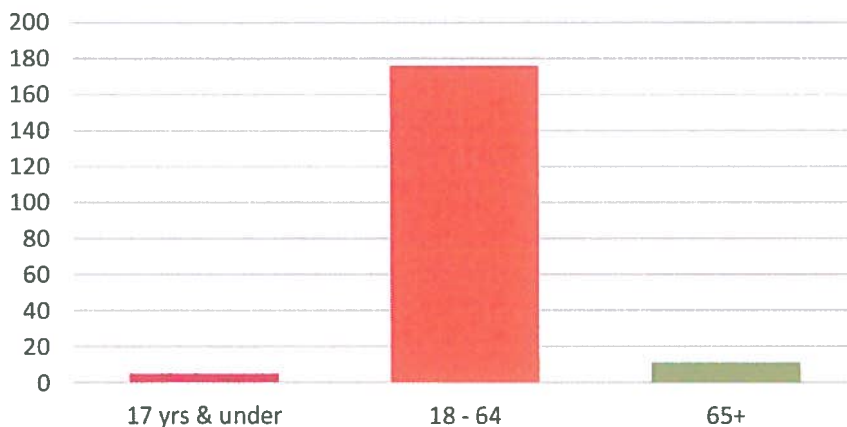
BME Carers by Nationality/Ethnicity: Belfast HSCT



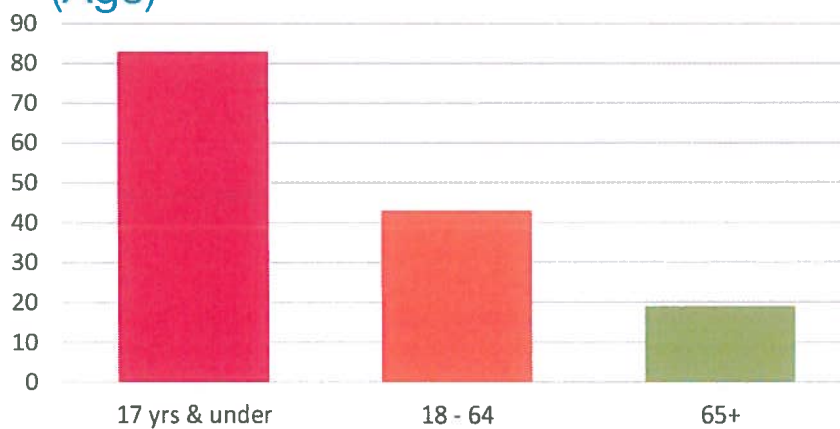
BME Carers by Nationality/Ethnicity: South Eastern HSCT

A second valuable set of data focused on the age profiles and ratios of carer and cared-for-person within the above data set, with findings confirming the great majority of carers adults of working age, most of whom (though by no means all) care for children:

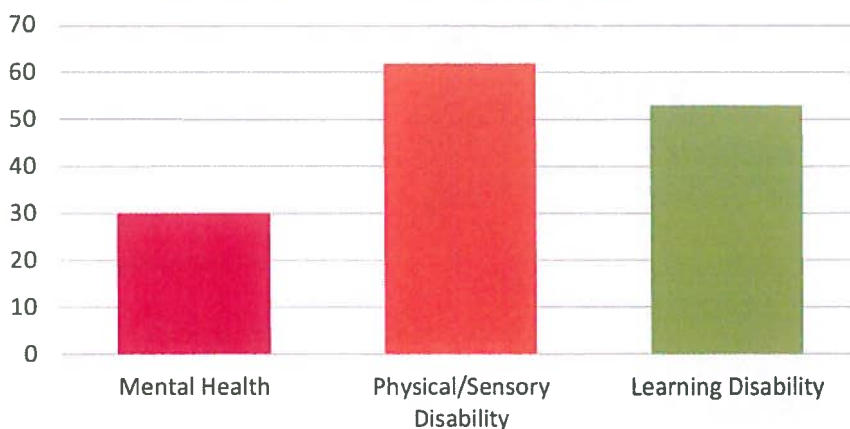
BME Carer Data (Age)



BME Cared for Person Data (Age)



BME Cared for Person Data (1)



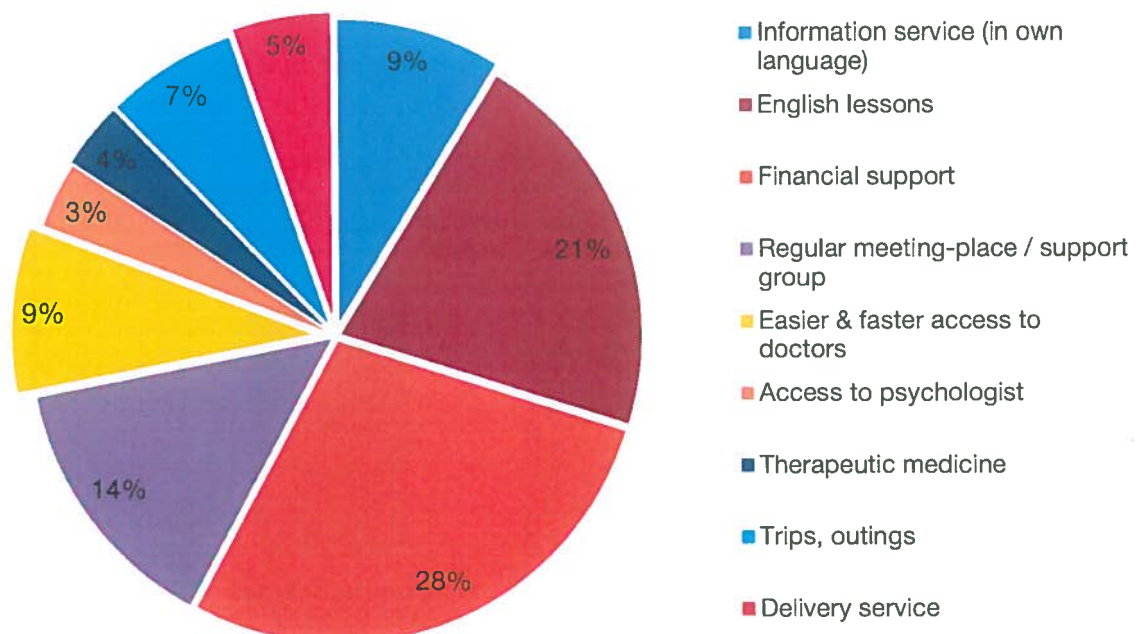
A further consideration – that of the category of illness to which identified cared-for persons belonged (Mental Health, Physical/Sensory Disability or Learning Disability) – was also captured by Trust services and teams, confirming that combined numbers across Trusts indicate a majority of (predominantly young) people suffering from a Physical/Sensory Disability, followed by those with a Learning Disability. There are about 50% fewer known cases of mental health issues than those with a physical or sensory disability, knowledge which may have implications for the deployment of resources in any future BME carers engagement initiatives.



As already noted, low uptake of support by minority ethnic carers cannot be taken as evidence that they do not want or need help. On the contrary, research shows that BME carers have a real need and strong wish for support and advice.

The results of a survey conducted as part of a research exercise into BME carers in the Southern Trust in 2013 revealed carers' own preferred supports as: an information service (in own language); English lessons; financial support; a regular meeting-place or support group/centre; easier and faster access to doctors; access to a psychologist; provision of therapeutic medicine; trips and outings; and a more active cultural life (McCabe, 2013). As part of the present research exercise, a small-scale informal follow-up survey was devised to elicit the views of BME carers and support workers on their preferred needs and supports. Carers were asked (in face-to-face or telephone interviews, during focus groups and through a questionnaire) the following question: 'Which 3 of the following would most help to improve your situation as a carer? Please number 1, 2 and 3 in order of preference.' A scoring system (whereby 1st preference = 3 points, 2nd preference = 2 points, and 3rd preference = 1 point) produced the following breakdown of preferred supports from a range of nationalities / ethnic backgrounds:

BME Carers on needs & supports



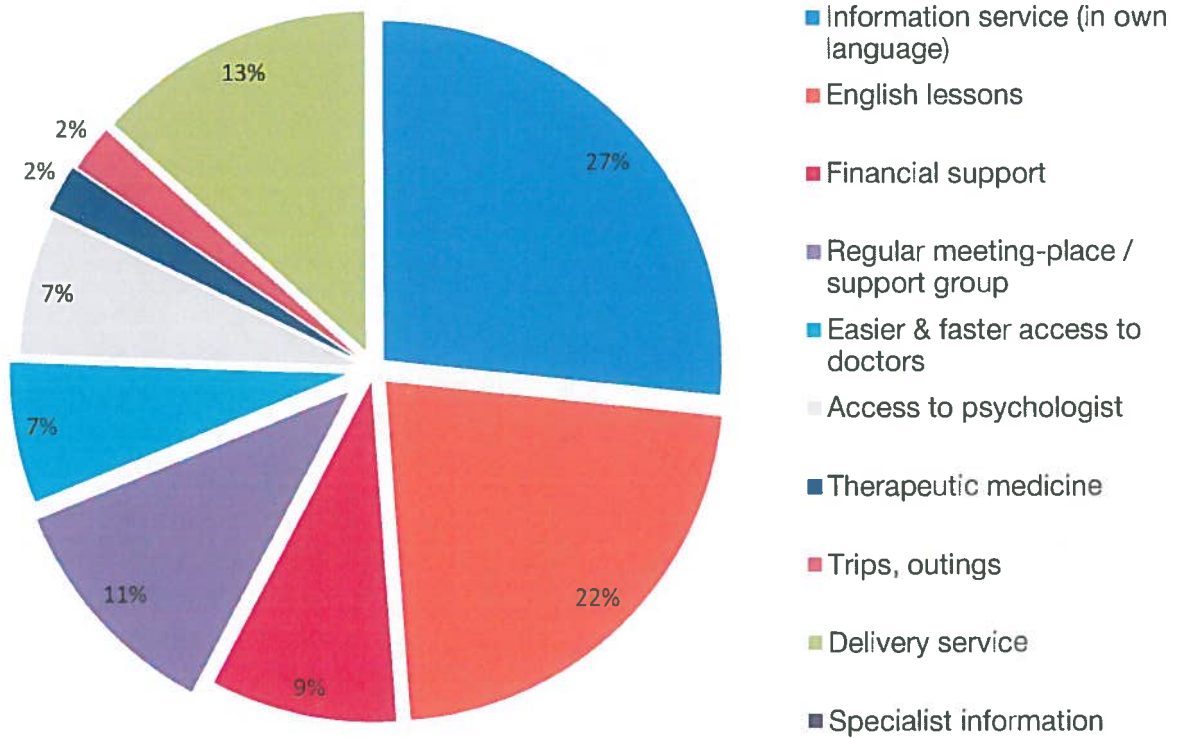
The same exercise was duplicated (in face-to-face, phone or email interviews, availing of a similar questionnaire: 'In your view which 3 of the following would most help improve the situation of carers from minority ethnic backgrounds?') with a range of support workers comprising healthcare practitioners, advice or support workers, and interpreters engaged by the Interpreting Service. The same scoring system produced the following analysis by percentage of responses (the majority of which were from NIHSCIS interpreters, a group with an intimate and long-standing knowledge of their communities' health and care requirements):

During discussions within focus groups and in face-to-face interviews (with particular emphasis from elderly carers from the Chinese community) the additional category 'Delivery service' was added. It is also important to note that the strong interest voiced for 'Financial support' was often qualified by carer respondents explaining that they had chosen this option because they 'wanted to buy a hospital bed' or 'can't afford a taxi to go to the shops or pay delivery charges'. Carers are clear on what they require financial support for – and the consistent and convincing reason given is that of easing and improving the situation of their cared-for husband, wife, daughter, son, mother, father or, in numerous cases, a combination of these.

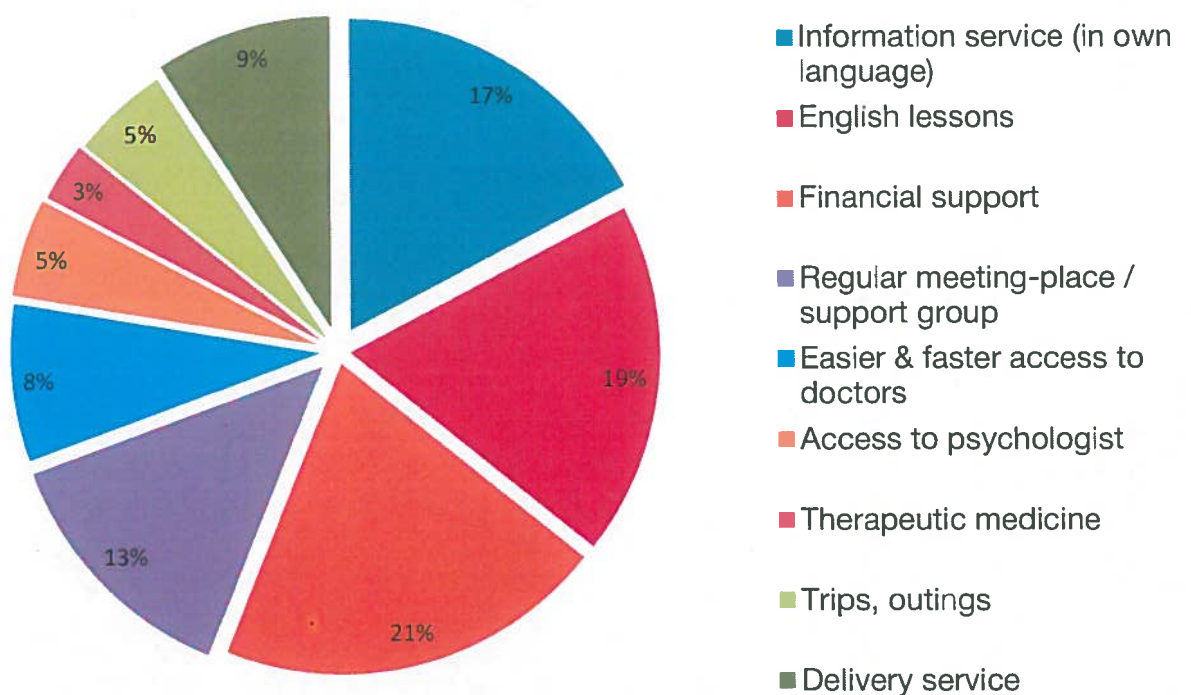
The above combined views of BME carers and support workers with a knowledge of their circumstances could perhaps form a useful starting-point for reflecting on future interventions and initiatives by the BME Carers Strategy Group and others.

These responses confirm other research findings and anecdotal evidence pointing to the fact that it is, above all, an invitation and access to organised communal interaction and support (rather than simply financial or medical interventions alone, welcome and vital as these are) that carers and their families crave.

Support workers on needs & supports



Needs & Supports: Combined views



Part Two: Case Studies

It may be helpful to consider carers and patients generally from minority ethnic backgrounds and their respective needs and priorities in three discrete categories:

- 1 Established BME communities
- 2 Post-2004 EU Accession states (the 'new wave'); and
- 3 BME individuals and families classified as refugees or asylum seekers

1 Established BME communities

Lowest needs levels

As research has shown, and as will be seen from the recent case studies below, carers from Northern Ireland's longest-established minority ethnic communities (Chinese, Indian, Pakistani, others) exhibit what we might call the lowest needs levels of the three categories under consideration. Accordingly, they demonstrate the greatest awareness of and understanding of how to access services for carers. As a result, they also exhibit the greatest satisfaction levels.

2 Post-2004 EU Accession states (new wave)

Significant or high needs levels

It was only a relatively short time ago that researchers were providing up-to-date information on Northern Ireland's ethnic minority communities that is now, just over a decade later, obsolete and altogether inaccurate in 2016. One mapping exercise noted that the Chinese community in Northern Ireland 'is by far the largest minority ethnic community with around 8,000 people estimated to be of Chinese origin' (Holder, 2003). In 2016 Northern Ireland, as we have seen, the linguistic balance of power among migrants has shifted exponentially in favour of Polish, followed by Lithuanian.

3 BME individuals and families classified as refugees / asylum seekers

High or even critically high needs levels

According to the 1951 Refugee Convention, a refugee is someone who: '...owing to wellfounded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.' ¹

This remains the current definition used by the UN High Commission for Refugees (UNHCR).² The UNHCR defines an asylum seeker in the following terms: 'An asylum-seeker is someone who says he or she is a refugee, but whose claim has not yet been definitively evaluated.'³

¹Article 1A(2) of the UN Convention and Protocol Relating to the Status of Refugees: <http://www.unhcr.org/3b66c2aa10.html>

²'Refugees', UNHCR website: <http://www.unhcr.org/pages/49c3646c125.html>

³'Asylum Seekers', UNHCR website: <http://www.unhcr.org/pages/49c3646c137.html>.

Asylum data is collected nationally by the Home Office; however, the Home Office does not publish Northern Ireland data. Organisations such as the Law Centre have long argued that regional data should be published, citing the need for access to data as essential for planning and monitoring. It is also, they argue, important to counter scaremongering claims. In the absence of any official data, the Law Centre has provided its own estimates based on information compiled from different sources. (These include the Northern Ireland Strategic Migration Partnership, Home Office Official Immigration Statistics (UK-wide), the Home Office NI Asylum Stakeholders Forum and the Refugee & Asylum Forum.)

There were almost 200 applications for asylum in Northern Ireland in the year ending August 2015 (less than 1% of the UK's asylum applications).

Asylum seekers come from countries from around the globe that are experiencing war, conflict and human rights abuses. In Northern Ireland, asylum applicants are most commonly from China, Somalia, Sudan, Nigeria and Zimbabwe. There were approximately 600 asylum seekers living in asylum support accommodation in August 2015. However, because some asylum seekers are not entitled to any support and therefore are not reflected in these figures, the total number is higher. The majority of asylum seekers live in Belfast.

With regard to *refugees*, the Law Centre estimates that there are 200–300 new refugees in Northern Ireland each year, inclusive of family members. Some refugees choose to live in Northern Ireland permanently. Many move to mainland Britain to be closer to extended family members or existing communities and support networks which do not exist for them in Northern Ireland. It should also be noted that some refugees return to their home country when they feel it is safe to do so. As far as the interviewee here (from North Africa) is concerned, this is however not an option for her and her family.

CASE STUDIES 1–4

Established BME communities

1 R. (58), Pakistani

Most members of the Pakistani community live in the Greater Belfast or greater Craigavon areas (although there are smaller numbers in other parts of the province). R. has lived in Northern Ireland for over 35 years, and recounts with pride and satisfaction that she 'thinks of Belfast as home'.

Holder (2003) notes what he calls 'the significant statistic that the vast majority (92%) of Pakistani households have at least one person proficient in English. This offers an explanation as to why very few in the community had requested interpreters as much interpreting work is done informally by family members.' R.'s comments confirmed that this was still the case in 2016, and that she herself acted as an interpreter for her disabled mother. (The issue of the potentially inappropriate practice of family members acting as interpreters was not broached in this interview.) Further confirmation of this tendency is provided by the Interpreting Service's 'Top 20 Regional Languages' for the period April 2015 – March 2016 which show Urdu in twentieth place, with a mere 221 requests for an interpreter made out of the year's province-wide total of 97,843.

My situation as a carer in Northern Ireland is certainly better than it would be in Pakistan. I'm very happy with the support I receive here. Care workers call five times a day. They are very helpful and reliable. I also receive financial assistance and advice.

What I particularly like about the system here is that everyone is treated as equal. In Lahore it would be very different. Bureaucracy and corruption. A very different experience. I couldn't dream of social workers calling so regularly to enquire about our needs and bring us information and equipment – whatever.

What would most help to improve my situation as a carer? Well, I can't really complain and am in quite a good situation, because I don't need help with English or financial support (since I already receive allowances) or a regular meeting-place (since I am part of a very good support group for carers, which provides advice and support and other activities of interest) or any of the other things you say other carers would like. I'm very happy with the support I have. I wouldn't want to live anywhere else. I think of Belfast as home.

L. (66), Indian

The Indian community is one of the longest-established communities in Northern Ireland, with roots that can be traced as far back as the 19th Century, although the first major migrations began in the 1920s and 30s.

I have lived in Northern Ireland for about thirty-five years. I'm happy with my situation as a carer because in my country there are no facilities for people with a disability. There are no wheelchairs at airports in India. No wheelchairs or disabled parking. Health and safety is a foreign concept.

It wasn't always like it is today in Northern Ireland. There have been changes for the better in services for carers since I first arrived back in the seventies. Now we have DLA. That is very important. Then we got a disabled badge for my husband as the cared-for person. That transformed our lives! There were always terrible problems with parking when going to hospital appointments. And with payment for parking, which can be very expensive. Yes, parking access changed my life – for the better. That would be unthinkable in India.

Northern Ireland's Indian community has its origins in two distinct regions: northern central India and southern India. The former would tend to be Punjabi or Hindi speakers. There would be many second- and third-generation members of this community, alongside an elderly first generation. The latter, with whom L. would identify, speak a range of other languages that could include Kannada, Kanta, Malayala, Marati, Oriya, Tamil and Telugu

A speaker of Kannada *and* Hindi, L. belongs to the migrations of the 1970s and 80s (rather than to those later arrivals, migrant workers coming to Northern Ireland to take up employment in the areas of nursing and IT). As with the majority of the Indian community, English is one of L.'s mother tongues..



The growing number of Mandarin speakers includes Q., whose situation is more representative of a younger migrant population, many of whom would have arrived in Northern Ireland in the past decade.

S. (76), Chinese (Cantonese)

S. is typical of those older Chinese people who left China or Hong Kong in the sixties and have spent the greater part of their lives as part of a close-knit and practically self-sufficient community, where the norm is semi-literacy (or illiteracy) in their native language (Cantonese) and little or no knowledge of English.

(Cantonese's status as by far the most common spoken dialect of China in the province in 2003 (Holder (2003) recorded 80%-90% of the Chinese community largely originating from Hong Kong, Macao, Malaysia, southern China and Vietnam's ethnic Chinese population) has now been superseded by the growing number of Mandarin speakers (mainly from the Republic of China). The migration narrative to which she belongs is one of unschooled young adults from farming backgrounds in Hong Kong emigrating as a result of government controls imposed within the former British colony which made it impossible to make a living from farming.

S.'s children are grown up and she cares around-the-clock alone for her elderly husband who suffered a stroke three years ago, as a result of which he has difficulty walking and related health problems.

I moved here – let me think, it's too long ago to remember exactly! [Laughs] – fifty years ago, when I was in my twenties. My family were farmers in Hong Kong. We used water from rivers to grow rice and vegetables, but the government took away the water supply and we were unable to continue farming.

When I first arrived in the UK I lived in Southampton. My younger brother was then in Northern Ireland. He had a motorbike accident, and I came over to look after him. My husband was working here too. There were better employment opportunities outside London, in Northern Ireland and elsewhere. I found a job as a waitress in a Chinese restaurant outside London. I worked like a robot, not like a human being. I was pregnant and was working in a take-away the day I went into labour! I cleaned the whole place, finished work at midnight, then went to hospital at 2 a.m., and the baby was born at 5 a.m. And now I have to look after my husband! My life is hard.

Do I like living in Northern Ireland? Yes, that's why I stayed. Even during the Troubles, many Chinese people went back, but I didn't leave because I was worried that I might not be able to come back here later.

Do I miss Hong Kong? Well, I was born there; I grew up there; it's my country. There were lots of places to go, lots of things to do... I miss the food! [Laughs] Those fresh vegetables you can't get here, pachoi, yam and Chinese beans... We used to go back once a year, usually in winter, when it's cold here. But I haven't been back to Hong Kong since my husband's stroke.

Although S. receives Carer's Allowance, money is a worry.

If I had more money, life would be easier. I could take a taxi to the shop, or pay for the delivery of groceries. It would make a big difference. If I had money I could get people to do things for me. Have shopping delivered. If I want to order something, I need to pay a delivery charge. Even pizza. Sometimes I'm tired and don't want to cook. But everything is expensive.

My children are all grown up now. Two of them live in Northern Ireland. If my husband has to go to hospital for an appointment, they sometimes help by driving him. But they cannot always take time off work to drive us to hospital appointments and also interpret for us.

I want to get a wheelchair for my husband, but I don't know how. The doctor only gave him a frame, but he needs a wheelchair to be able to go out. We are housebound now. We could go to the park if he had a wheelchair. In the past he could drive and do the shopping. Now I have to walk with a bag to and from the shop. But I am strong [Smiles] because I worked on a farm when young.

Q. (25), Chinese (Mandarin)

Q. arrived in Northern Ireland ten years ago. She cares for her young son who has a learning difficulty.

I like living here, and there are many positive things about life in Northern Ireland. For example, the system is fairer to everyone in Northern Ireland than in China, where there is a lot of corruption and you have to know someone in an office or hospital to be able to arrange many things.

Yes, there are many positive things about life in Northern Ireland compared to China. But there are also negative ones. For example, sometimes we are discriminated against here. I had a lot of trouble with the flat I was living in when people began throwing stones at my window. It was frightening for me and my son. It went on for two years. There was nothing I could do. Finally, my request to be moved from my ground-floor flat to a higher floor was granted, and the problem ceased. I was very pleased with the support I was given then by the police and the Housing Executive.

The most important things for me as a carer for my son are his safety and well-being. And also my own sanity: it's really good to be able to leave him to children's activity classes for an hour or two after school; then I can have a little precious time for myself. But my son is the most important. I would like to have information and training to prepare him for life when he grows up.



Another case study from the Chinese community alerts us to the need to be wary of assumptions and preconceptions when it comes to categorising patients on the basis of stereotypical ethnic origin and linguistic group.

H. (611), Chinese (Hakka)

Hakka (also called Kejia) is spoken by a small percentage of mainly elderly members of the (Hong Kong) Chinese community in Northern Ireland. (It is also spoken or understood by a proportion of Cantonese speakers.) It is the mother tongue of H.'s elderly mother, for whom she now cares, though, as she explains below, not her own language of choice.

I was born in Mauritius of Chinese parents. We spoke Hakka at home, but outside of the house the language or patois of the street was Creole, and the newspapers and so forth were in French. However, because the school system on the island was British, lessons were in English. So my Chinese is not so good, and most Chinese people I am in touch with in Northern Ireland are originally from Hong Kong and speak Cantonese.

I care for my two children, both adults now. For a long time it was difficult to assess them. My elderly mother has recently come over from England to live with me. She, too, requires constant care. Although I receive Carers' Allowance to help me care for my children, I do not receive any financial support to help me care for my mother; but I believe and hope that this will be forthcoming, as she has only recently arrived and been registered in Northern Ireland.

H.'s view that carers from minority ethnic backgrounds are 'well supported' in Northern Ireland reflects her own experience and that of the longer established Chinese community to which she belongs. She even compares her elderly mother's situation here as preferable to the level of service she received in England.

I would describe my situation as a carer in Northern Ireland as 'well supported'. Certainly with regard to elderly people being cared for. Lots of things are in place on their arrival here. It has been much better here for my elderly mother than in England. She received an excellent assessment when she came to Northern Ireland. A social worker put us in touch with the Chinese Welfare Association, which has been of great help with meeting and socialising with other elderly people from the Chinese community. All the positive things that have happened to my mother here arose from her first visit to hospital. From that moment onwards, services were set in motion.

What would most help to improve my situation as a carer? A regular meeting place and support centre, which I have been lucky to find. Perhaps also the provision of therapeutic medicine. One thing I do not have but would like to have in my house is a hospital bed for my mother. That is why I would also mention the need for financial support for such expensive purchases.

CASE STUDIES 6–8

Post-2004 EU Accession states (new wave)

6

S. and K. (52, 50, Married, Polish)

Both S. (52) and K. (50) have serious health issues and act as each other's carer.

Diagnosed with cancer, S. underwent an operation in Craigavon. He has no other benefits, with the exception of a Disability Living Allowance. Despite attempts to find work, he has consistently been refused Employment and Support Allowance on the grounds that: a) he has never registered himself with the Workers' Registration Scheme; and b) his last employer did not pay any National Insurance contributions on his behalf. He is also deprived of any Statutory Sick Pay, and is now living solely off DLA (around £100 per month) and relying on help from the St. Vincent de Paul Society.

K. herself suffers from severe arthritis. She has been granted DLA but because she has not been working in Northern Ireland she cannot claim any other benefits. S. and K. are in the minority of BME community carers in that they are not only recognised as such but receive carer's allowances. In common with all BME community carers, however, they have no access to any form, regular or otherwise, of support such as meeting points, outings, group interaction and native-language information services (with the notable exception of Newry and Mourne Ethnic Minority Support Centre).

7

L. (43), Lithuanian

L. (43) and her daughter (16) have lived in the Southern Trust area since August 2011. L. came to Northern Ireland in search of work in the agricultural sector. She found employment on a mushroom farm where she worked for two months before moving to another mushroom farm to work where she was hired for a further two months

She moved to a larger town in the area hoping to find alternative employment. By the end of December she had no way of supporting herself and her daughter and was practically destitute. Her daughter goes to a local school and has turned out to be an exceptionally good pupil. They both were offered a room by friends in the town but the landlord refused to allow them to stay. They received help from the Ethnic Minority Support Centre in Newry and Women's Aid was able to offer mother and daughter temporary accommodation.

Yes, I came here with my daughter to make a better life. There is no work now where I live in Lithuania. I learnt from other Lithuanians about work on farms and in factories in Northern Ireland. And I saw advertisements in my country for workers to come to Northern Ireland from Lithuania.

The mushroom farms are very hard. Very tiring work. Since I suffer from diabetes, I was unable to work as fast as other women. [She explains that she needed at least four breaks in the course of her shift to administer insulin.] They were always shouting at me for not being efficient, always shouting 'Hurry up! Stop slacking!' Then I was told to leave. They gave me no money after.

L.'s daughter is de facto her mother's carer, as L. often feels sick, has spells of dizziness and needs help with preparing meals and getting dressed. L.'s daughter spends every afternoon and evening with her mother but, says L., she never complains. I'm so lucky to have such a wonderful daughter

A. (61), Polish

A. is the mother of four grown-up children, only one of whom, her 36-year-old son B., lives with her. He has, she says, 'the brain of a four- or five-year old'. Her husband is deceased.

We realised there was a problem with B.'s development when he was seven years old. He began to have problems with his speech, and I enrolled him in a special school. He could neither read nor write.

Like other carers I know, I have my own health problems, too. My nerves are bad because of my son. It's exhausting at times trying to reason with a very young child in the body of a grown man. It was great when we had a local Polish carers support group to go to. It's a real shame it was discontinued. They organised hand and foot massages – that was wonderful as stress relief. I felt so light-footed afterwards!

Life is hard, but I am grateful for the help I receive here. I couldn't manage in Poland, couldn't afford the very expensive medicines, or to pay for a doctor, that's for sure. B. attended therapy sessions when we lived in Poland and in that respect support was better in Poland. But only in this one respect. Other supports are better here. It is good that B. now attends a special needs farm (instead of school). And that he sees a psychiatrist now, too.

Like many Polish women here, I work as a cleaner. Part-time only, of course, while B. is at the farm. I love going to work. It's an escape from the house, and I can socialise with the other Polish cleaners. I really look forward to it.

CASE STUDIES 9–10

BME individuals and families classified as refugees / asylum seekers

N. (33, North Africa)

My life is much worse now than before. I cannot give my children what they want. No sweets, no toys, nothing. My daughter says to me: 'At home you never say "No"; now you just say "No, no, no. Wait."'

It was better in Algeria. I had a job in a university, my husband was a policeman. We travelled once a year to Europe. We did have a choice about our lives, not anymore. Now we have no money. Thirty-five pounds a week for food. Today I went to Tesco. I bought only things to clean: tissues, cleaners, no food. I spent fifteen pounds. Do they think only food is necessary to live?

I would like to work, but I cannot. My husband cannot work. House they gave me is terrible. Cold and with mould on walls.

But if I have money, what can I do? I have no right to open a bank account. I cannot buy clothes that are only for sale online [Muslim dress]. I have to wear these cheap clothes. My family sent me money with Western Union; but I am not allowed to collect it! It cost 100 euro to send back – money wasted. This is three weeks' money for me.

I dream of the right to work.

The mother of three young children, N. cares for a child with learning difficulties. N.'s husband is a former policeman in their home country. As a result of his former occupation and the unpopularity of former members of the security forces, he cannot return for fear of violence against him and his family by, on the one hand, the present government, and, on the other, terrorist factions who have targeted former state security personnel.

N. is a university graduate with a command of five languages, including English. She has lived in Northern Ireland for close on three years. Comparing her present life and circumstances in Northern Ireland with her life in her home country, she says:

J. (25, Somali)

J. is a single mother caring for her young daughter. Her story highlights the isolation experienced by many minority ethnic carers and, once again, those without the right to work, who are living in poverty:

It is clear that there is an experiential abyss between the lifestyles and high satisfaction levels of some members of the longer-established communities (as recounted above) and the near-destitute existence that (predominantly African) carers without the right to work, even part-time, are ekeing out in our midst

I don't know my neighbours. In my country people come round and knock on my door. Not here. Maybe here I need to stay quiet, not go out...

My situation in Northern Ireland is worse than in my country, because I had a nanny and support in my country. I can't take time for myself. I am blocked by my daughter.

My room is terrible. Damp, leaks, dust. My daughter is allergic to dust. She has trouble eating solid food. I buy her yogurt and other soft foods which are very expensive for me. And I must pay for cleaning materials. I try to stay with [keep] four or five pounds for the weekend, because I don't know what might happen.

The most best thing of the week is on Sunday when I go to church.

I found a TV lying in the street and pushed it into the house. My daughter likes to watch it. But it doesn't always work.

CASE STUDIES 11–14

Healthcare Practitioners and Support Workers

One of the present research exercise's most useful areas of investigation has turned out to be the views gathered of support workers. These compliment and give additional voice and weight to the concerns of carers themselves.



M. (GP, Belfast Trust area)

I see a lot of ethnic minority patients in my East Belfast practice. Mainly Polish, but also Lithuanian, Portuguese, Slovak, Chinese, Indian and African, from Somalia mostly. A lot of rough stuff. Some are unaware that their situation is actually that of a full-time carer. Looking at question 5 on the questionnaire ['How would you describe the situation of BME carers in your area?'], I'd have to say they receive 'little or no support'.

What would help improve their situation? An information service in their own language, yes. And English lessons, for sure. These would have to be free, of course.

In terms of policy changes and how we operate on a day-to-day basis, there is definitely room for improvement. Greater information and an introduction for migrants on how the healthcare system works. That's one. Then they need to be made more aware of how to access doctors and allied healthcare teams. And increased information for healthcare providers on what services are locally available for ethnic minority patients.

C. (Carer Support worker, voluntary sector)

You meet so many unhelpful attitudes and barriers in the statutory sector. Minority ethnic carers are faced with barrier after barrier. Schools refuse their children because they have no uniform (which they cannot afford). There is difficulty getting child tax credits and child benefit and linking to Social Security and with processing benefits. A process for fast-tracking needs to be put in place. There are so many battles accessing general services: housing, benefits, healthcare.

I have seen the difficulties they encounter when trying to register with a doctor. The reception police at the GP's practice often say 'Oh, this surgery is full.' They don't want to be bothered. Or it's racism, plain and simple.

I know of a Somali grandmother who was shouted at on arrival at hospital for not fasting. The hospital had sent her information in English, which she couldn't read. 'We sent you a letter,' they said.

DELL introduced free English classes for BME people this year, but people can't get to college because there is no childcare provision.

Some African families I deal with have no English whatsoever, and have never been to school. I am trying to get a number of Somali children from the same family into school at present. It's a nightmare. They are passed from pillar to post.

If you are asking what changes would allow us to provide a better service for minority ethnic carers, then I would say:

- Training for front-line staff (e.g. reception staff at GP surgeries)
- Training for Trust staff booking appointments
- Training for SSA staff to provide more info
- Some sort of information service, perhaps through NINES [Northern Ireland New Entrant Service]
- More support for school entry – more information
- More information on how to access all welfare services.

Various voices (excerpts from interviews with BME advice and support centre Managers, interpreters and Carers organisation senior staff)

Thinking of the need for some form of respite for carers from their onerous and relentless routines, one BME organisation manager interviewed suggested 'a friendship club sort of situation'. 'Some of these people have never been out of Belfast; an outing or excursion, to the Antrim coast maybe, would mean a lot to carers and carees'. This and similar initiatives allowing for family excursions and a way of socialising and maintaining positive mental health would be a welcome recommendation for many carers.

*

'We need a greater awareness of the prevalence and onset of mental illness among minority ethnic carers, and ways to deal with it to prevent it getting any worse.'

*

'If only there was a place for all the carers to meet now and again and share information, or just to have a chat. Meetings with practical advice and psychological support I think would be really helpful.'

*

'Why not consider the adoption of a Triage service for BME carers to handhold them through the health system, through integration with generic carers on a regular basis as an essential means of reducing isolation and helping BME carers settle in the community? This could establish befriending services between BME carers and generic Carers – dedicated volunteers with language skills could man the Good Day Good Carer telephone service (NI-wide) to offer a listening ear to BME carers on a regular basis. They would make regular calls to BME carers and see how they are getting on and settling in.'

P. (Pediatrician, Belfast Trust area)

Yes, I see Polish patients. No need for an interpreter! [Laughs] I also have a little German, but there's not much need for that... How would I describe the situation of BME carers in my area? 'Not well supported'.

I think what's needed is more information. More information about resources available. And information provided in different languages. No, I haven't seen these leaflets before. They are a good idea. More information like that would be good.

From your list of things to help minority ethnic patients and carers, I think I would pick these three things: 1. Information service in own language; 2. Financial support. These people are struggling to make ends meet; 3. Regular meeting place or support centre, yes. They are often on their own, without any family support. It might be good for them to meet others and keep connected to the community. And a fourth: English lessons. Without English they can't understand anything: medicines, dosage, appointments, social security forms, anything really that they need to live normal lives. So yes, add English lessons. They can't all come to me for help in Polish! [Laughs] Or you, from what I hear!

P. is unusual in being a migrant herself. Originally from Poland, she studied medicine at Queen's University Belfast, and remained in Northern Ireland after graduating. A GP with an excellent command of English, her native Polish tongue allows her to provide a near-unique service, minus any interpreter, for those Polish patients she sees.

Recommendations

Recommendations are made in the following five thematic areas: Monitoring and Research, Communication, Network Development, Best Practice and Support for Carers.

Monitoring and Research

With regard to the need for improved systems of data collection, it is recommended that henceforth training be given to all staff involved in recording and monitoring data in respect of minority ethnic carers. The *Guide to the Ethnic Monitoring of Service Users in Health and Social Care in Northern Ireland* (HSC, 2016) should be adopted as a user's manual.

With regard to the need for ongoing research into the situation of minority ethnic carers in Northern Ireland, it is recommended that further research be carried out on an ongoing basis, with the BME Carers Group taking a lead role in identifying areas of research and disseminating findings.

Communication

It is recommended that initiatives be developed and training put in place in two areas in respect of improved communication skills for BME carers and support staff, as follows:

(i) Communication skills for minority ethnic carers

In line with the Regional BME Group's strategic priorities, a programme of (free) English classes (at beginner, intermediate and advanced levels) should be provided for minority ethnic carers of all ages (and their families) from across all Trust areas.

(ii) Communication skills for frontline staff and support workers

Similarly, language and cultural awareness training should be made available for frontline staff and other personnel engaged with minority ethnic services users. Priority should be given in the first instance to the largest linguistic communities.

Development of Networks

(i) BME carers: Networks

Establish and develop a network of minority ethnic carers' support groups in different towns across the five Trust areas. It is also recommended that consideration be given to establishing a quarterly or bi-annual NI-wide BME Carers Forum as part of a strategy of inclusion.

(ii) BME carers strategy group: Networks

Similarly, it is recommended that networking and co-operative venture opportunities be explored with minority ethnic carers support organisations elsewhere in the UK and internationally. These could take the form of information exchange, fact-finding missions, networking events and invitations to speak at meetings and events. Enhanced networks would then facilitate our fourth recommendation: learning from the exchange and use of best-practice models elsewhere in the UK.

Best Practice

It is recommended that opportunities be investigated for the exchange of best practice models with other organisations in the UK. These could take the form of study visits (to learn how minority ethnic carers' needs are being met in jurisdictions with a longer history and greater experience of a multi-racial society) and networking events. These could include, for example, the Edinburgh-based MECOPP (Minority Ethnic Carers of Older People Project) as a model of best practice with its provision of a portfolio of services that include: multi-lingual advice and information; advocacy and casework support; individual and group support; education, training and learning opportunities; healthy living programmes; and practical support in the home through a domiciliary care-at-home service.

Support for Carers

Finally, the report's findings and recommendations should inform the development of a three-year strategy (2017-2019) for the BME Carers Sub-Group to allow the group (working where possible in partnership with other agencies) to propose and implement programmes and initiatives to better support Northern Ireland's minority ethnic carers and their families.

Drawing on the results of the report's findings and the views of BME carers, support workers and others, it is recommended that programmes and initiatives be developed that would provide ways of meeting identified needs, notably:

- Funded programmes (such as delivery services, small grants scheme for essential equipment, etc.)
- A dedicated multi-lingual information service (with online and printed materials and resources) and online BME carers communities
- Improved access to doctors and psychologists
- Access to initiatives addressing issues of isolation and respite (trips, outings, etc.) and, as highlighted above, English lessons and regular support meetings

These recommendations are made with the aim of raising awareness and increasing uptake of services and support available to BME carers.

It is clear that a key element in satisfaction levels among BME community members (both with services provided and with one's own sense of well-being) is that of *integration*. Accordingly, it is recommended that programmes and initiatives, such as those set out in the recommendations above, be developed to facilitate this all-important goal.

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APPENDICES

Appendix 1

A8 Countries (in EU from 2004)

Czech Republic
Estonia
Hungary
Latvia
Lithuania
Poland
Slovakia
Slovenia

A2 Countries (in EU from 2007)

Bulgaria
Romania

Appendix 2: Census Table KS207NI: Ethnicity, Identity, Language and Religion / Main Language]

	Percentage of all usual residents aged 3 and over whose main language is:												
All usual residents aged 3 and over	English	Polish	Lithuanian	Irish (Gaelic)	Portuguese	Slovak	Chinese	Tagalog / Filipino	Latvian	Russian	Malayalam	Hungarian	Other
1,735,711	96.86	1.02	0.36	0.24	0.13	0.13	0.13	0.11	0.07	0.07	0.07	0.06	0.75

Appendix 3: Census Table KS301NI: Health / Health and Provision of Unpaid Care]

All usual residents	Provision of unpaid care			
	Percentage of all usual residents who provide unpaid care:			
	No unpaid care	1-19 hours per week	20-49 hours per week	50 or more hours per week
1,810,863	88.18	6.75	1.95	3.11

Provision of unpaid care' denotes looking after, giving help or support to family members, friends, neighbours or others because of long-term physical or mental ill-health/disability, or problems related to old age.

Author note

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