Hidden in our Midst:

Carers from minority ethnic backgrounds in Newry & Mourne

A report by The Ireland-Poland Cultural Foundation in association with Diversiton
Introduction: Terms of reference

This report into the situation of carers from minority ethnic backgrounds in the Newry and Mourne area has been commissioned by Newry and Mourne Carers with the support of The Community Foundation for Northern Ireland. Comparatively little research has been conducted on the situation of the BME community in Northern Ireland (and even less on the subject of carers within migrant families) and, until very recently, statistical data on numbers of BME residents in Northern Ireland were a matter of conjecture. With the on-going release of selected data from the 2011 Census, however, we now have, for the first time, a significantly clearer picture of the dimensions/scale of the situation. Research undertaken for this summary report indicates that there is a significant number of carers within Newry and Mourne’s (and by extension Northern Ireland’s) migrant communities who are, quite literally, ‘hidden in our midst’.

The situation of carers from minority ethnic backgrounds

Carers from minority ethnic communities (more properly known and generally referred to in policy documentation 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. These challenges arise in the main from a lack of self-identification among BME individuals of their status as carers and hence an absence of policy recognition of their needs, compounded by stereotypical assumptions of how their needs are, or 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 the majority (though by no means all) 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 constitute the challenge to a provider in Newry and Mourne that they would to services in, for example, Bradford).
The findings of a 2011 focus group study of migrants in Northern Ireland (with particular reference to the Southern Trust area) also 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; loneliness and isolation due to various factors including onerous working hours of partner/spouse.

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 take-up 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 part of the present research, a minority ethnic carers’ focus group was organised in Newry and Mourne Carers’ Centre on 31st January 2013. Among the valuable information that emerged from the group was not only an overwhelmingly positive response to suggested help and support mechanisms, but a helpful indication of preferred ways towards integration and support for carers and their families. Thus, carers themselves, in response to the question ‘What three things would best help you / improve your situation as a carer?’ cited the following preferential areas of support.
Regular meeting-place / Support centre 40%
Information service (in own language) 20%
Trips, outings 15%
Financial advice / support 5%
More active cultural life 5%
Easier & faster access to doctors 5%
Psychologist 5%
Therapeutic medicine 5%

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) that carers and their families crave.
1. L. (41, Lithuanian)

L (41) and her daughter (14) have lived in Northern Ireland since August 2011. L came to Northern Ireland in search of work in the agricultural sector. She found employment on a mushroom farm in Newtownhamilton where she worked for two months before moving to another mushroom farm to work where she was hired for a further two months. Since she suffered from diabetes she was unable to work as fast as other women: for instance, she needed at least 4 breaks in the course of her shift to administer insulin. Constantly shouted at for not being efficient, she was eventually dismissed. She moved to Newry 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 St Mary’s in Newry and has turned out to be an exceptionally good pupil. They both were offered a room by friends in Newry but the landlord refused to allow them to stay. They sought help in the Ethnic Minority Support Centre in Newry and were eventually referred to Women’s Aid where they were offered temporary accommodation. L’s daughter is virtually a carer for her mother 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. She receives no help from anyone.

2. 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).
3. P. (30, Polish)

P’s son (11 years old) has been diagnosed with bone cancer. He has just undergone chemotherapy. P is a classroom assistant in one of the primary schools in Newry (where she works 25 hours per week). As a classroom assistant she is paid only for the number of hours she works each week. She is presently on sick leave, with the result that she is without any income.

Her husband is unemployed and not in receipt of any benefits. Although P and her husband receive carer’s allowance, they too (again with the notable exception of Newry and Mourne Ethnic Minority Support Centre) have no access to any form, regular or otherwise, of support such as meeting points, outings, group interaction and native-language information services.

It is no accident that two of the above three sample case studies from Newry and Mourne document the situation of carers from the Polish community, given that, in common with the present overall demographical make-up of Northern Ireland, Poles now account for over 1% of the population of the province (with the true percentage likely to be well in excess of this figure from the 2011 Census (see Table 1 below)).

After English, Polish is now the most widely spoken language in Northern Ireland (and also the Republic of Ireland, where its prevalence has superseded the national language of the state). Seen in this light, it is a cause for concern that carers from such a significant part of society are not able to access any co-ordinated system of support.
Establishing numbers and the scale of need

Establishing the number of residents from an ethnic minority background in Northern Ireland

Although there are no precise figures for the number of ethnic minority residents in Northern Ireland and in any given region (including Newry & Mourne), recently released data from the 2011 Census provides information whereby an approximate minimum number may be reliably estimated. Based on the criterion of a resident's main language (an indicator of ethnic origin) (see Table 1 below) we can conclude that at least 2.9% (the percentage of combined non-English language and non-Irish language residents) of the province’s population in 2011 are from minority ethnic communities. Translated into the number of BME residents in Northern Ireland, where 1,735,711 accounts for the entire population, we arrive at a figure of 50,336 residents. It is important to note that not all minority ethnic residents (long- and short-term) will have completed Census forms; indeed, what precise percentage of Northern Ireland’s BME community will have done so is a unknown key factor in arriving at a true picture of the ethnic landscape of Northern Ireland (for example, if 50% of BME residents participated in the 2011 Census, then the true BME population would be in excess of 100,000). In short, we must assume that a true figure for the number of residents from an ethnic minority background in Northern Ireland is likely to be significantly in excess of 50,336.

Establishing the number of carers from an ethnic minority background in Northern Ireland

Recently released data from the 2011 Census provides invaluable information on the ethnic make-up of the caring community within Northern Ireland. Table 2 below presents the percentage of all usual residents (indigenous and migrant) of Northern Ireland providing unpaid care, with the typical number of hours of care provided per week. Table 4 provides further data on the numbers of residents providing unpaid care in the three administrative areas of relevance to the present overview: Northern Ireland as a whole, The Southern Trust area, and Newry and Mourne.

As Table 2 shows, the percentage of all usual residents of Northern Ireland providing unpaid care (from 1 hour up to 50 or more hours per week) is 11.82%. This accounts for some 214,044 residents irrespective of their ethnic origin. Translated into the minimum number of BME residents (a minimum of 2.9% of the population) providing unpaid care in Northern Ireland, we arrive at a figure of 6,207 residents.
As a result, we must assume that a true figure for the number of unpaid carers from an ethnic minority background in Northern Ireland is likely to be significantly in excess of 6,207.

Establishing the number of carers from an ethnic minority background in the following relevant areas:

1. The Southern Trust

As Table 2 shows, the percentage of all usual residents of the SHSCT area Northern Ireland providing unpaid care (from 1 hour up to 50 or more hours per week) is 11.82%. This accounts for some 41,220 residents irrespective of their ethnic origin. Translated into the minimum number of BME residents (a minimum of 2.9% of the population) providing unpaid care in Northern Ireland, we arrive at a figure of 1,195 residents.

As a result, we must assume that a true figure for the number of unpaid carers from an ethnic minority background in the SHSCT area is likely to be significantly in excess of 1,195.

2. Newry & Mourne

As Table 2 shows, the percentage of all usual residents of Northern Ireland providing unpaid care (from 1 hour up to 50 or more hours per week) is 11.82%. This accounts for some 11,142 residents irrespective of their ethnic origin. Translated into the minimum number of BME residents (a minimum of 2.9% of the population) providing unpaid care in Northern Ireland, we arrive at a figure of 323 residents.

As a result, we must assume that a true figure for the number of unpaid carers from an ethnic minority background in Newry and Mourne is likely to be significantly in excess of 323.

It is vital to note that these figures are 1) not inclusive of those carers in receipt of carer’s allowance (statistical data unavailable); and 2) that the true figure in each of the above areas is likely to be significantly in excess of these documented minimum numbers.
### Table 1 [Census Table KS207NI: Ethnicity, Identity, Language and Religion / Main Language]

<table>
<thead>
<tr>
<th>All usual residents aged 3 and over</th>
<th>English</th>
<th>Polish</th>
<th>Lithuanian</th>
<th>Irish (Gaelic)</th>
<th>Portuguese</th>
<th>Slovak</th>
<th>Chinese</th>
<th>Tagalog / Filipino</th>
<th>Latvian</th>
<th>Russian</th>
<th>Malayalam</th>
<th>Hungarian</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,735,711</td>
<td>96.86</td>
<td>1.02</td>
<td>0.36</td>
<td>0.24</td>
<td>0.13</td>
<td>0.13</td>
<td>0.13</td>
<td>0.11</td>
<td>0.07</td>
<td>0.07</td>
<td>0.07</td>
<td>0.06</td>
<td>0.75</td>
</tr>
</tbody>
</table>

### Table 2 [Census Table KS301NI: Health / Health and Provision of Unpaid Care]

<table>
<thead>
<tr>
<th>All usual residents</th>
<th>Provision of unpaid care ¹</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage of all usual residents who provide unpaid care:</td>
</tr>
<tr>
<td></td>
<td>No unpaid care</td>
</tr>
<tr>
<td>1,810,863</td>
<td>88.18</td>
</tr>
</tbody>
</table>

¹ 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.
### Table 3 Census 2011: Ethnicity, Identity, Language and Religion: Country of Birth

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Ireland</td>
<td>1,810,863</td>
<td>47,207</td>
<td>45,290</td>
<td>3,908</td>
<td>2,297</td>
<td>7,341</td>
<td>19,658</td>
<td>1,996</td>
<td>2,681</td>
<td>6,315</td>
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<tr>
<td>SHSCT</td>
<td>358,034</td>
<td>16,376</td>
<td>15,968</td>
<td>501</td>
<td>1,133</td>
<td>4,840</td>
<td>6,389</td>
<td>1,300</td>
<td>132</td>
<td>463</td>
</tr>
<tr>
<td>Newry &amp; Mourne</td>
<td>99,480</td>
<td>3,869</td>
<td>3,761</td>
<td>102</td>
<td>287</td>
<td>918</td>
<td>1,902</td>
<td>68</td>
<td>33</td>
<td>106</td>
</tr>
</tbody>
</table>

\(^2\) Other Europe refers to other than UK and ROI.
### Table 4 Census 2011: Health and Provision of Unpaid Care

<table>
<thead>
<tr>
<th></th>
<th>All usual residents</th>
<th>Provision of unpaid care: Provides no unpaid care</th>
<th>Provision of unpaid care: Provides 1-19 hours unpaid care per week</th>
<th>Provision of unpaid care: Provides 20-49 hours unpaid care per week</th>
<th>Provision of unpaid care: Provides 50+ hours unpaid care per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Ireland</td>
<td>1,810,863</td>
<td>1,596,883</td>
<td>122,301</td>
<td>35,369</td>
<td>56,310</td>
</tr>
<tr>
<td>SHSCT</td>
<td>358,034</td>
<td>317,427</td>
<td>22,852</td>
<td>7,076</td>
<td>10,679</td>
</tr>
<tr>
<td>Newry &amp; Mourne</td>
<td>99,480</td>
<td>88,169 (8.63%)</td>
<td>6,070 (6.10%)</td>
<td>2,026 (2.04%)</td>
<td>3,215 (3.23%)</td>
</tr>
</tbody>
</table>
Key points

- Minority ethnic carers face particular difficulties in accessing and using support services, over and above those experienced by native/indigenous/non-BME carers
- Low uptake of services by BME carers cannot be attributed to their lack of interest in receiving support
- Many BME carers are unaware of the services that exist to support them
- A lack of language-matched information is perceived by BME carers to be among the greatest barriers to accessing services
- There is a need for culturally competent services, based on culturally appropriate and language-matched assessment processes
- Planners and providers of health and social care services have a legal duty to offer services that are accessible and appropriate to all sectors of the community, irrespective of ethnic origin
- It is a cause for concern (and no little alarm) that carers from such a significant part (BME) of Northern Irish society are for the most part excluded from any co-ordinated system of support.
Recommendations

Research indicates that service provision for carers from minority ethnic communities in Newry and Mourne (and throughout Northern Ireland) is very poor in comparison with that available in other parts of the United Kingdom. MECOPP, for example, the Edinburgh-based Minority Ethnic Carers of People Project, provides 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. There is no comparable service for BME carers in Newry and Mourne and in other parts of Northern Ireland. The present summary report highlights the important finding that there is little or no provision for or account taken of carers within any of the several new communities in N&M. Indeed, this is likely to be indicative of the situation throughout Northern Ireland.

A provider or providers emulating such a sorely needed range of services for BME carers in Newry and Mourne and further afield in Northern Ireland is therefore at the heart of the recommendations of the present report. The first and a fundamental recommendation of the present report is therefore that an established support organisation for carers in the area be identified and empowered – through adequate and long-term funding and support – to lead on the implementation of the remaining recommendations.

These recommendations are as follows:

- Identification of key service provider through provision of funding and opportunities to engage meaningfully over the longer term with the situation of BME carers in Newry and Mourne.

- Development of programmes/initiatives aimed at addressing ‘key points’ concerns, namely: issues of availability of and access to support services; low uptake of services; awareness of services; provision of language-matched information and advice. (Raising awareness of services and support within migrant communities is a key element to improving the uptake of support.)

- Explore opportunities for engaging and empowering BME carers, such as using the arts (workshops, creative projects, events, etc) to enable them to express their views and experiences in an enjoyable and confidence-enhancing way.

- BME carers should be included in the strategic planning of personal social services, including community care, and the impact of their participation monitored to ensure that their views are considered

- Ethnic minority families with caring responsibilities should be offered all Carers’ services currently available to carers in the Newry & Mourne area. In addition, to meet their specific needs, it is recommended that the folllowing be introduced:
  - A quarterly BME Carers’ Forum.
- Online presence of Newry and Mourne Carers (website and social media) to reflect inclusion of BME carers’ support services within NMC remit.

- Multi-lingual online and print materials (brochures, newsletters, information leaflets, etc) to be made available in all non-English/Irish languages of Census 2011 (e.g. language translation of brochures and expansion of current NMC Carers’ Newsletter to include information geared towards BME Carers).

- Regular (eg twice-monthly) BME Carers’ Coffee Mornings where they can meet existing carer members as part of a strategy of inclusion.

- Develop a programme with Young Carers Project to start a BME ‘buddy’ adoption programme at its weekly Youth Club and activities.

- Other avenues of support and empowerment for BME carers should be explored and, where practicable, implemented. These may include, though are not restricted to, the following suggestions made by BME carers themselves during focus group meetings: English language lessons (to facilitate access to local (indigenous) support groups and further well-being and integration); specialised support groups (e.g. mothers with autistic children (of which there are at least 6 in N&M); outings (e.g. ecological farm trips); Physiotherapy / Massage / Swimming pool (e.g. hire pool for 1-2 hrs per week); Equine therapy; Translators / Interpreters / Personal Point-of-contact (e.g. identify & employ special translator for e.g. (a) autistic (b) other illnesses; but ‘more than a translator’ – a point of contact / advice / support).

- Finally, research suggests that service provision for BME carers can only improve if significant improvements are made in the current levels 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.
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