Emerging Themes Document

Section 75 Equality Groups

Updated January 2014

CONTENTS

BACKGROUND

Section 75 of the Northern Ireland Act 1998 requires the all Health and Social Care (HSC) Trusts, when carrying out their work, to have due regard to the need to promote equality of opportunity between nine categories of persons, namely:

- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- between men and women generally;
- between persons with a disability and persons without; and
- between persons with dependants and persons without.

Trusts must also have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

Whilst much good work has been achieved over the last decade in promoting equality of opportunity and good relations, there still remain persistent inequalities within our society. The Equality Commission Northern Ireland (ECNI) revised 'Guide to the S75 Statutory Duties for Public Authorities' emphasised the need for public authorities to shift from 'process to outcomes'. Whilst the review found that whilst public authorities had worked hard to follow due process and develop transparent policy development processes, the review found that there was still a lot to be done to ensure that the statutory duties have a positive impact on people's lives.

The Equality Commission Northern Ireland (ECNI) revised 'Guide to the S75 Statutory Duties for Public Authorities' details a number of new recommendations from the Commission's Section 75 Effectiveness Review. Public Authorities had to develop a new/revised Equality Scheme and in addition to carry out an audit of inequalities and produce an associated action plan.

At a regional level all health and social care organisations have worked collaboratively to gather emerging themes in relation to key inequalities experienced by the nine equality categories. Collated data (qualitative and quantitative) was analysed and disaggregated by the Section 75 categories to develop indicators of levels of inequalities. The Emerging Themes document can be used as evidence for future screening and equality impact assessments and is a useful resource for both health and social care staff and representative organisations.

By regularly reviewing relevant literature the Emerging Themes document continues to be updated. This document was updated in January 2014.

Copies of this Emerging Themes document and the Trusts' Action Based plans can be found on the Trusts' websites as follows.

http://www.belfasttrust.hscni.net

http://www.northerntrust.hscni.net

http://www.setrust.hscni.net

http://www.southerntrust.hscni.net

http://www.westerntrust.hscni.net

http://www.niamb.co.uk

Alternatively you can request a copy of the action based plans from the relevant equality leads. Contact details are provided below.

Belfast Health and Social Care Trust
Orla Barron
Health and Social Inequalities Manager
First Floor, Graham House
Knockbracken Healthcare Park
Saintfield Road
Belfast
BT8 8BH
Tel: 028 9096 0069
Textphone: 028 9056 6755
Email: orla.barron@belfasttrust.hscni.net

Northern Health and Social Care Trust
Alison Irwin
Head of Equality
Route Complex
8e Coleraine Road
Ballymoney
Co Antrim
BT53 6BP

Tel: 028 2766 1377
Fax: 028 2766 1209
Textphone: 028 2766 1377
Mobile Text: 07825 667154
E-mail: equality.unit@northerntrust.hscni.net

South Eastern Health and Social Care Trust

Susan Thompson
Equality Manager
2nd Floor, Lough House
Ards Hospital
Newtownards
BT23 4AS
Telephone: 028 9151 2169
Fax: 028 9151 2171
Textphone: 028 9151 0137
Mobile: 07525 898850
susan.thompson@setrust.hscni.net

Suzanne McCartney
Equality Manager
Lagan Valley Hospital
Lisburn
BT28 1JP

Telephone: 028 9266 5141 Ext 2604
Fax: 028 9266 7936
Textphone: 028 9263 3522
Mobile: 07872 419376
suzanne.mccartney@setrust.hscni.net

Southern Health and Social Care Trust

Lynda Gordon
Head of Equality and Human Rights
First Floor, Hill Building
St. Luke's Hospital
Loughgall Road
Armagh
BT61 7NQ
Tel: 028 3741 2643
Fax: 028 3741 2620
Textphone: 028 3741 2446
E-mail: lynda.gordon@southerntrust.hscni.net

Western Health and Social Care Trust
Siobhan O'Donnell
Head of Service for Equality and Human Rights and Personal and Public Involvement (PPI)
Equality and Human Rights Unit
Tyrone and Fermanagh Hospital
Omagh
BT79 0NS
Tel: 028 8283 5278
Fax: 028 8283 5804
Textphone: 028 8283 5345
Email: equality.admin@westerntrust.hscni.net

Northern Ireland Ambulance Service Trust
Michelle Lemon
Equality and Patient Experience Manager
Ambulance Headquarters
Site 30, Knockbracken Healthcare Park
Saintfield Road
Belfast
BT8 8SG
Tel: 028 9040 0999
Fax: 028 9040 0903
Textphone: 028 9040 0871
Email: Michelle.Lemon@nias.hscni.net

Appendix 1 –Emerging Themes

EMERGING THEMES: GENDER

A. Emerging Themes for both Men and Women			
What are the Equality/ Inequality Issues?	**Potential Solutions - where these are offered in the literature Policy/Practice Issues?**	**Source of Evidence**	**Date**
1. Address Gender Blindness: Most health and social care strategies and policies are written in gender neutral language with general targets set for the whole population.	Need to recognise that men and women differ in their health and social care needs throughout their lifetime. Recognise groups that are particularly vulnerable e.g. older women, ethnic minority women, women living in rural areas, men who have experienced sexual abuse, and men who have experienced domestic violence, men in their role as fathers. Should be recognised in all Equality Impact Assessments of decisions and policies.	Statement on Key Inequalities in Northern Ireland - ECNI Men's Action Network, Derry	2007 2010
April 2008 – Sex Discrimination Order 1976 (Amendment) Regulations (Northern Ireland) Order 2006 came into force in Northern Ireland	• Change in definition of 'sex harassment' to prohibit unwanted conduct that is 'related to' a women's sex or that of another person. • Employers must take reasonable practicable steps to protect their employees from third party harassment – where harassment is known to have occurred on at least 2 other occasions • Removed the need for a comparator in complaints of discrimination on the grounds of maternity or pregnancy • Changes to entitlement of certain benefits of terms and conditions of employment whilst on compulsory and additional maternity leave	Equality Commission Northern Ireland - http://www.equalityni.org/archive/pdf/SexEqualityLegislationFactSheetSDOAmendentRegs08.pdf	2008

B. Emerging Themes Specific to Women			
What are the Equality/ Inequality Issues?	**Potential Solutions - where these are offered in the literature Policy/Practice Issues?**	**Source of Evidence**	**Date**
1. Structural Inequalities: e.g. low pay, lack of childcare, lack of involvement in internal decision making, etc.	HSC organisations already play a key role in this area. How can we build on this good practice? Recognise that this is a huge area. What additional actions can HSC organisations take to tackle the structural inequality between women and men?	Other Borders Women's Health in Ireland Women in Disadvantaged Communities	2005 2006 2009
2. Lack of involvement in planning and decision making: of health care services particularly by more marginalised women e.g. lesbian women, women with disabilities, older women, women from black and minority ethnic groups including traveller women, women from disadvantaged communities, etc.	Improved participatory approaches to planning and delivery of HSC services. Monitor who we are talking to. Work in partnership with community groups to provide capacity building for women from the most marginalised groups.	Other Borders Women's Health in Ireland Women in Disadvantaged Communities	2005 2006 2009
3. Mental Health Issues: High rates of mental ill health, in particular for travelling women, women with disabilities, lesbian women, etc. - has huge consequences for women accessing training, employment, education or participating in public life.	Crucial that mental health services planning takes into account the needs of the most marginalised women. (See Item 2).	Other Borders Women's Health in Ireland Women in Disadvantaged Communities	2005 2006 2009
4. Maternity Services: Particular issues for women with disabilities, travelling women and BME women, younger women, etc.	Crucial that maternity health services planning takes into account the needs of the most marginalised women. (See Item 2).	DHSSPS Literature Review Ethnic and Social Inequalities in Women's Experience of Maternity	2006 2007

		Services - Care Quality Commission	
5. Domestic and Sexual Violence and Abuse: GP's, A and E and maternity staff are important points of contact. Their response is critical and can make an immense difference to the future choices of the woman.	Ongoing training for GPs, A and E and maternity staff. Evaluate and update training. Need to develop and regularly review DV policies and protocols for referral and asking the routine questions re DV.	NI Women's Aid Federation Domestic Violence and Health Professionals DHSSPS Literature Review Western Interagency Domestic Violence (WIADV) Partnership	2003 2006 2010
6. HSC Staff Domestic Violence Policies	Ensure all Trusts have in place a staff Domestic Violence Policy. All staff trained in regard to its implications.	Unison and WIADV Partnership	2010
7. Domestic Violence and particular issues for marginalised women: Women with disabilities or from ethnic communities or women, who are lesbian, have additional barriers to accessing support for Domestic Violence.	Targeted programmes for the most marginalised women. Need to review how current services are or are not meeting their needs.	NI Women's Aid Federation Domestic Violence and Health Professionals DHSSPS Literature Review Western Interagency Domestic Violence (WIADV) Partnership	2003 2006 2010
8. Attitudes of Staff: Many women, particularly those who are most marginalised frequently experience staff attitudes as unsupportive/judgemental.	Ongoing staff training in equality, diversity, etc. Prioritise attendance by senior managers/team leaders.	DHSSPS Literature Review Ethnic and Social Inequalities in Women's Experience of Maternity Services - Care Quality Commission	2006 2007
9. Inequalities for lone parents, women living in isolation, Travellers, women with disabilities, women living with domestic violence and older women living in the North West of Ireland: The North West is disadvantaged in terms of	Does not make recommendations. Describes how 38 partners will work cross sector, cross border for the benefit of those groups of women within the North West who are socially excluded and who are at the wrong end of the inequalities divide. The drive for this programme came from women living in the North West, both sides of the border.	Levelling Up: Securing Health Improvement by Promoting Social Inclusion - Derry Well Woman	2008

investment, infrastructure and location of public sector jobs. The North West is doubly disadvantaged as a consequence of its distance from the centres of power in Ireland (Belfast and Dublin) and also because it is a border region.	They secured cross border, cross party support. Need to expand this model across the whole border region of Ireland. 'Levelling Up' is an instrument of change. Core to the process of its development were women who knew WHAT change was needed linking with organisations and individuals who knew HOW to make it happen. The CAWT Social Inclusion programme is taking this forward.		
In equality between women and men persists in areas of social economic and political life – The Commission has identified five priority areas for this report, these are; education, employment, pensioner poverty, decision making and health.	• The priority areas were placed in the relevant articles in the Convention, including Article 12: Healthcare. • The Commission recommended that the committee urge the government to: • Ensure health strategies and policies are analysed by gender • Recognise the needs of carers, the majority of whom are women. • Call for the same access to reproductive healthcare services and rights in Northern Ireland as are available in Great Britain	***CEDAW REPORT*** United Nations Convention on the Elimination of all forms of Discrimination Against Women - http://www.equalityni.org/archive/pdf/CEDAW(F).pdf	2008
This brief submission will raise some issues of concern for black and minority ethnic women living in Northern Ireland in response to the UK's seventh periodic report.	• Violence against Women and the exploitation of women – policy and legislative framework • Gender based violence and no recourse to public funds. • Human trafficking • Participation in public life • Access to the labour market • Women's health • Traveller women as a vulnerable group • It is hoped that the issues raised in this submission will help to inform the	Submission to the UN Committee on the Elimination of All Forms of Discrimination Against Women pre-sessional working group to the fifty-fifth session - http://www.nicem.org.uk/uploads/publications/NICEM_submission_to_CEDAW_pre-session_(55th_session)_working_group_14-9-12.pdf	2012

	pre-sessional working group in drawing up the list of issues for the UK government in advance of the UK's examination in July 2013.		
C. Emerging Themes Specific to Men			
What are the Equality/ Inequality Issues?	**Potential Solutions - where these are offered in the literature Policy/Practice Issues?**	**Source of Evidence**	**Date**
1. Lack of research: Ignorance and lack of understanding of men's needs in this area.	More research: Key areas: Men as victims of domestic abuse, male health needs, role of fathers, homophobia and homophobic attacks, men as perpetrators and victims of violence, needs of rural men.	DHSSPS Literature Review Priority Issues which need to be addressed in the Men's Action Plans - Men's Action Network; Work with Young Men Unit; The Men's Project	2006 2009
2. Tackling health inequalities in relation to men ***:** For example, men tend to die younger and are more likely to commit suicide, etc.	Developing a Men's Health Strategy similar to the policy developed in the Republic of Ireland (2008). Health services need to see the benefit of making health services more accessible to men. A great deal is about prevention.	McEvoy and Richards: cited in DHSSPS Literature Review Priority issues which need to be addressed in the Men's Action Plans Men's Action Network	2006 2009 2010
3. Addressing risk taking behaviours by men.	Increased advice and health information in places accessible to men e.g. workplaces sporting venues, pubs, social clubs, etc.	McEvoy and Richards: cited in DHSSPS Literature Review Priority issues which need to be addressed in the Men's Action Plans	2006 2009
4. Social attitudes re: men's health: Cultural norms, false perceptions, ignorance and lack of confidence.	Provide staff training to challenge stereotypes.	Priority issues which need to be addressed in the Men's Action Plans	2009

5. Men as Fathers: Men often feel excluded from decisions re: child birth and care of their child.	Improved awareness of midwives to encourage new and prospective fathers to be actively involved in decision regarding their baby.	Fathers Direct: cited in DHSSPS Literature Review Priority issues which need to be addressed in the Men's Action Plans	2006 2009
6. Decision making: While many key decision makers are male very few are working class men or young men.	Improved participatory approaches to planning and delivery of services. Monitor who we are talking to. Work with community groups to build capacity of the most marginalised people.	Priority issues which need to be addressed in the Men's Action Plans	2009
7. Men and Domestic Violence: HSC staff reluctant to acknowledge male victims.	Raise staff awareness of the issue. Develop appropriate support services for men.	Priority issues which need to be addressed in the Men's Action Plans	2009
8. Men and Mental Health: Lack of support structures – particularly men in rural areas, plus reluctance to discuss issue with GPs.	Need more awareness of men's issues when developing mental health services.	Health Inequalities CAWT Report	2005
Over the past ten years, the rate of deaths from suicide has been five times higher in males than in females.	• The two key factors that are known to be effective in reducing suicide rates are physician education in depression recognition and treatment, and restricting access to lethal means of suicide.	Young Men and Suicide Project – A Report on the All-Ireland Young Men and Suicide Project http://www.mhfi.org/ymspfullreport.pdf	2013

D. Emerging Themes Specific to Transgender People			
What are the Equality/ Inequality Issues?	**Potential Solutions - where these are offered in the literature Policy/Practice Issues?**	**Source of Evidence**	**Date**
1. Lack of awareness and understanding resulting in behaviour by health staff that can be profoundly	**Equality and diversity training for staff:** should include awareness of transgender issues and should challenge attitudes that	Fair for All - NHS Scotland.	2008

humiliating: Most people do not knowingly interact with transgender people and subsequently do not have any life experience to help inform their interactions in the workplace. Some health staff refuse to use the appropriate gender pronoun. Many make inappropriate assumptions about the person's sexual orientation.	undermine people's gender identify. Increase staff capacity to interrupt prejudicial behaviour and attitudes. Trans awareness should be included in all medical training.	The Luck of the Draw - a Report on the Experiences of Trans Individuals reporting Hate Incidents in NI - Institute for Conflict Research Health Care Issues for Transgender People Living in Northern Ireland - Institute of Conflict Research Trans Community Statement of Need (England)	2010 2011 April 2011
2. Choosing appropriate health services/ward: Many services are set up specifically for men or women e.g. sexual health services. These may exclude transgender people as they may need to access clinical services due to their birth gender not their true gender.	It is important to consider the options with the person and to recognise the person's wishes and true gender and not to send them to a service or place them on a ward determined by the proposed clinical treatment. Further research into health care needs of trans individuals.	Fair for All - NHS Scotland Health Care Issues for Transgender People Living in Northern Ireland - Institute of Conflict Research	2008 2011
3. Lack of access to Transgender Health Care: Positive attitude to Gender Identity Clinic (GIC), but concerns about the limited number of staff and accessibility for those who live outside of the Greater Belfast Area.	Increase funding to the GIC in line with increased referrals. Allow a wider number of organisations to provide services.	Health Care Issues for Transgender People Living in Northern Ireland - Institute of Conflict Research Trans Community Statement of Need (England)	2011 April 2011
4. Vulnerability of Children and Young People: Young people's treatment in United Kingdom, including Northern Ireland, is below international standards.	DHSSPS should develop a comprehensive framework to ensure support for gender variant children and young people. Adopt best practice from across UK and internationally.	Health Care Issues for Transgender People Living in Northern Ireland - Institute of Conflict Research Trans Community Statement of Need (England)	2011 April 2011

5. Legal Anomalies	Eliminate all discrimination. Make all treatment equality and human rights compliant.	Trans Community Statement of Need (England)	April 2011
6. Inappropriate Psychiatric Model	Eliminate all automatic psychiatric referrals.	Trans Community Statement of Need (England)	April 2011
This is the first piece of research from Northern Ireland to specifically investigate the experiences of young people who experience gender distress and/or identify as transgender (aged 25 and under). The data presented was collected through a series of 12 interviews and 5 focus groups.	• This report found that the general lack of societal awareness, understanding and knowledge of trans issues in Northern Ireland impacts every dimension of the lives of young trans people. • A standardised gender identity question should be developed that can be used by public bodies for administrative purposes and equality monitoring. • CAMHS teams should specifically record referrals made to its service relating to gender distress and/or gender identity issues. • Referrals made to the GIC should be collated in order to identify referral trends. Referral trends should be regularly analysed in order to ensure that the GIC receives adequate funding to meet the needs of service users.	Grasping the Nettle: The Experiences of Gender Variant Children and Transgender Youth Living in Northern Ireland	2013

EMERGING THEMES: AGE: YOUNG PERSONS

What are the Equality/ Inequality Issues?	Potential Solutions - where these are offered in the literature Policy/Practice Issues?	Source of Evidence	Date
Newly qualified social workers dealing with complex child protection cases without the necessary training, raises serious issue of child protection and protection of the rights of vulnerable children in custody and secure care. Example given of untrained staff dealing with mental health issues responding inappropriately to young person following a self-harm incident Difficulties for minority ethnic groups in registering with GPs and dentists, leading to additional pressures on emergency clinics. Responses of health professionals influenced by stereotyping.		Submission to the United Nations Committee on the Rights of the Child for consideration during the Committee's scrutiny of the UK Government Report (July 2007)	
DHSSPS dual set of complaints systems potentially confusing: The Children Order procedure for complaints re: children's' services and the Wilson Procedures, applicable to services provided by health and social care services, potentially confusing for children and young people attempting to make complaints on own behalf.	The Trusts should engage in proactive complaints publicity and awareness raising among vulnerable groups of children and young people about their rights and complaints procedures.	Cousins *et al.* The Care Careers ofYounger Looked After Children: Findings from the Multiple Placement Project - Institute of Child Care Research, Queen's University Belfast Children's Rights in Northern Ireland – NICCY in association with Queens University Belfast	2003

		http://www.niccy.org/article.aspx?menuid=381	
Negative impact of poverty for children from ethnic minorities, with disabilities and LGBT young people: Negative impact of poverty on young peoples' health and wellbeing including higher prevalence of mental health, rates of suicide, self harm and teenage pregnancy.	Statutory agencies must be encouraged to respond to the evidence based link between poverty and poor health in children and young people. Multi-agency approaches must be developed and urgent provision made of fully resourced mental health and regional based sexual health services put in place to guarantee the physical and mental health needs of children and young people are met. Inequalities and discrimination in health care policies and practices for children in minority groups should be challenged.	Children's Rights in Northern Ireland - NICCY in association with Queens University Belfast http://www.niccy.org/article.aspx?menuid=381 Northern Ireland Commissioner for Children and Young People's (NICCY's) 2008 Review of Children's Rights in Northern Ireland Children in Poverty - Anti-Poverty Network http://www.niccy.org/uploaded_docs/CRR/71784_NIC71784%20Childrens%20Rights%20Text%20intro.pdf	2004 2008 2008
Medical and social work professional awareness of cultural issues and complex child protection cases: Issues for nurses training re obtaining consent of children re (minor) medical procedures and in communicating effectively with children re: surgical procedures.	Training needed - medical professions need specialised training on particular cultural issues that arise for ethnic minorities and training required on consent issues.	Children's Rights in Northern Ireland – NICCY in association with Queens University Belfast http://www.niccy.org/article.aspx?menuid=381 Northern Ireland NGO Alternative Report	2004 March 2008
Children in Care: Expressed frustration at not being involved in decisions made regarding their care plans and the lack of information or feeling of genuine	Information should be discussed in a way that they can understand and, whenever the young person is talking, the foster carer should be out of the room to facilitate them	Children's Rights in Northern Ireland – NICCY in association with Queens University Belfast	2004

involvement in reviews. Evidence of experience of disadvantage due to lack of placement stability, special educational needs, higher rates of teenage pregnancy than peers, mental health and well-being affected by instability, lack of contact with their birth family; placement moves; change of schools and friendship networks	speaking freely.	http://www.niccy.org/article.aspx?menuid=381 Save the Children and the Children's Law Centre http://www.savethechildren.org.uk/en/docs/NI_NGO_ALTERNATIVE_REPORT.pdf	2007/ 2008
Northern Ireland has youngest population in UK, 25% are aged under 18, more than one third of children in Northern Ireland live in poverty (c.122,000), of these 44,000 experience severe poverty. People living in the most deprived electoral wards have poorer life expectancy, higher death rates, higher rates of hospital admission, more infant deaths and more suicides than in the NI population as a whole. Also, high rates of suicide amongst young people in NI - suicide rate for young males living in deprived areas nearly twice that for those living in wealthier communities. Of the 2,500 Travellers in NI, about half are aged under 16. Many Traveller families experience poor sanitation and access to electricity and water, have poor access to healthcare and education. Increased risk of early childhood mortality than in settled children due to the increased likelihood of accidents and preventable diseases.		Save the Children – What We Do in Northern Ireland http://www.savethechildren.org.uk/en/docs/Northern_Ireland_CB_07.pdf Northern Ireland NGO Alternative Report Submission to the United Nations Committee on the Rights of the Child for consideration during the Committee's scrutiny of the UK Government Report (July 2007) http://www.savethechildren.org.uk/en/docs/NI_NGO_ALTERNATIVE_REPORT.pdf	2007 2008 March 2008

12 year old children have almost 3 times level of tooth decay for age group (against UK average). Children living in the 20% most deprived wards are almost twice as likely to have experienced dental decay as children from the 20% most affluent wards. Between March 2005 and March 2007, the number of under-18s in treatment for drug and/or alcohol abuse more than trebled from 271 to 847, representing 15% of the total number of 5,583 individuals in treatment. Young people from poorer families are more likely to engage in smoking, drinking alcohol, solvent and drug abuse than young children from wealthier backgrounds.			
Disabled children and their families frequently raise issues about poor, or late, assessment of needs. Services required to meet these needs are not always locally available.	Full implementation of the rights of children with disabilities requires effective assessment of their needs and adequate resourcing of appropriate services.	Save the Children and the Children's Law Centre http://www.savethechildren.org.uk/en/docs/NI_NGO_ALTERNATIVE_REPORT.pdf	2007
Mental Health Issues: Over 20% of children under 18 suffer significant mental health problems. Mental Health (NI) Order 1986 fails to require age-appropriate in-patient facilities for children, consequently often placed in adult facilities. Some young people sent to England for treatment (e.g. those with complex mental health problems or eating disorders). Disruption		Northern Ireland NGO Alternative Report Submission to the United Nations Committee on the Rights of the Child for consideration during the Committee's scrutiny of the UK Government Report (July 2007)	2008

to family life, education and work opportunities, social and leisure activities with friends. Incidence of mental health problems is disproportionately high among children and young people with disabilities, living in poverty, in conflict with the law, in or leaving care, who identify as LGBT. Less than 5% of the mental health budget is spent on child and adolescent mental health services, despite under-18s representing approximately 25% of Northern Ireland's population.			
It has become clear from the Young Life and Times Survey that there were substantial barriers among young people to accessing mental health services. Many of these barriers exist due to the stigmatisation of mental ill-health which, despite growing numbers of young people facing, and being diagnosed with, mental and emotional health problems, is often seen as a taboo subject.	• The report is divided into sections discussing mental health issues individually with regard to background variables that allow for an identification of health inequalities between different groups of 16-year olds • At the end of each section key findings are summarised in a box.	The Mental and Emotional Health of 16 year olds in Northern Ireland – http://www.patientclientcouncil.hscni.net/uploads/research/The_mental_and_emotional_health_of_16_year_olds_in_NI.pdf	2010
Educational/Behavioural Outcomes and Health: Girls are advantaged in cognitive, educational, behavioural outcomes and in general health, but are more likely to be overweight at age 5. Parents' longstanding illness and mental distress linked to poorer cognitive, educational and behavioural assessments and general health in children.		OFMDFM - Consequences of Childhood Disadvantage in Northern Ireland at Age 5 http://www.ofmdfmni.gov.uk/the_consequences_of_childhood_disadvantage_in_northern_ireland.pdf	June 2010

Considerable variations exist in both health service outcomes for children, and it follows, their whole-of-life-course outcomes.	• The approach should be not only to protect children from hazards, known to have a negative impact on health and well-being, but also promote exposure to positive experiences which enhance assets and resilience. • Health services should be aware of these adverse determinants of lifestyles, and tailor the delivery of services to both mitigate against their adverse effects • As well as building on positive aspects to improve outcomes. An example would be positive support for involving extended family and/or community members to support the family.	Children and Young People's Health Outcomes Forum - INEQUALITIES IN HEALTH OUTCOMES AND HOW THEY MIGHT BE ADDRESSED https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156067/CYP-Inequalities-in-Health.pdf.pdf	2013

EMERGING THEMES: AGE: OLDER PEOPLE

What are the Equality/ Inequality Issues?	Potential Solutions - where these are offered in the literature Policy/Practice Issues?	Source of Evidence	Date
For Service Users			
Older women are the majority in Northern Ireland: Health and social care organisations must take account of their needs.	Tackle inequalities in coronary heart disease. Recognise increase in breast cancer. Redress the imbalance given to osteoporosis and arthritis, blindness and deafness for older women.	Northern Ireland Women's European Platform – 12 Critical Areas	
Older people in health care were especially vulnerable to ill treatment.	The Human Rights of Older People in Health Care highlighted that older people	The Human Rights of Older People in Health Care, 18th	2006/07, Joint

	in health care were especially vulnerable to ill treatment because of their dependency on others for their basic needs. There is also evidence that the organisational division between mental health services for adults of working age and older people had resulted in the development of an unfair system, as the range of services available differed for each of these groups	Report of Session	Commit-tee on Human Rights, 2007
Those receiving practical help have an increase in health related quality of life.	Recent evaluations by the Personal Social Services Research Unit (PPRSU) of the Partnerships for Older People Projects (POPPS) show how not only was there an increase in health related quality of life – 12% for those individuals receiving practical help, the projects also found a significant reduction in the use of hospital emergency beds. Overnight hospital stays were reduced by 47% and the use of Accident and Emergency departments by 29%.	The National Evaluation of Partnerships for Older People Projects - PPRSU, Department of Health, London	
Less care packages are provided.	Statistics reveal that in 2008, Trusts provided 176 less care packages (23,553), during this period. In terms of the Meals Service, for the period 2008/09 to 2009/10 there has been a 10% reduction in this service	DHSSPSNI (2010) Adult Community Statistics - DHSSPSNI	2009-2010
Specific needs of older people from ethnic minority backgrounds.	The differences between and within ethnic minority groups in access services need to be taken into account by policy makers and planners.	Social Inequalities in Later Life: the socio-economic position of older people from ethnic minority groups in Britain - Kings College London	Autumn 2000
The current definition of abuse focuses heavily on the vulnerability of older people (physical and safety needs), rather than	The Second World Assembly on Ageing recommended the elimination of all forms of neglect, abuse and violence of older	United Nations	2002

empowerment to counter elder abuse.	persons and the creation of support services to address elder abuse. The World Health Organisation (WHO) recognised the need to develop a global strategy for the prevention of elder abuse. Other international initiatives include the International Network for the Prevention of Elder Abuse.	WHO Global Response to Elder Abuse and Neglect	2008
Older people are more likely to have a sedentary lifestyle than younger people: Of those aged 75 and over, 63% were sedentary.	None – statistical report only.	Equalities and Inequalities in Health and Social Care in Northern Ireland – A Statistical Overview - DHSSPS	2004
The vast majority of delayed discharges were among older people.	None – statistical report only.	Equalities and Inequalities in Health and Social Care in Northern Ireland – A Statistical Overview - DHSSPS	2004
Older people have lower expectations of healthcare provision: Anecdotal information from health care providers suggests that professional pragmatism in the rationing of delivery of services impacts on the care delivered to older people.	Further research is required to establish the perceptions and socially held beliefs about how older people are valued and as a result, treated when health services are delivered to them. The way in which caseloads are prioritised particularly within acute or secondary care and specialisms of cardiology should be investigated.	Older People's Experience of Health Services in Northern Ireland - Help the Aged, OFMDFM and Northern Ireland Human Rights Commission (NIHRC)	July 2004
Social exclusion exacerbated in later life: Women's income in retirement is on average only 57% that of men's. Ethnic minority pensioners are more likely to be in low income households than white pensioners. Ethnic minority groups are also more likely to experience multiple deprivations. There are two million people	Need a more responsive model for services for older people that addresses their needs. Encourage take up of benefits and entitlements. Review of pensions.	A Sure Start to Later Life - Ending Inequalities for Older People - Social Exclusion Unit Final Report	January 2006

with sight problems, 90% of whom are over age 60.			
Report reviews the introduction of the funding and operation of long term care policy in Scotland focusing particularly on the policy of free personal and nursing care in Scotland. Looks at wider lesions for the UK as a whole.	**Key Lessons:** • The affordability of free personal and nursing care, in relation to wider public spending. • Changes the balance of care towards care at home. Free personal care does not reduce the level of informal caring. It supports carers and helps them to provide other forms of care. • Overall a very positive impact for clients in particularly for those with modest means or dementia. Created a fairer system. • Free personal care supports clients' wishes and can improve clients' quality of life. • Older people who use care services and their families' feel that the arrangements introduced in 2001 are more equitable and an improvement on the past. • Social care managers in Scottish local authorities and care home providers also feel very positively about the provision.	David Bell and Alison Bowes Financial Care Models in Scotland and the UK - Joseph Rowntree Foundation	2006
Social isolation is caused by a number of factors: Including differential access to and availability of health and social care services.	None – statistical report only.	Statement on Key Inequalities in Northern Ireland - ECNI	October 2007
Research highlighted the failure of the NHS in addressing the mental health needs of older people.	None.	Statement on Key Inequalities in Northern Ireland - ECNI	October 2007

Differential access to transport may be producing a profound effect in access to healthcare for older people, particularly those with a disability and/or in rural areas.	None.	Statement on Key Inequalities in Northern Ireland - ECNI	October 2007
Social exclusion and pensioner poverty are a particular issue for older women.	None.	Statement on Key Inequalities in Northern Ireland - ECNI	October 2007
Older people treated differently in terms of attitudes, waiting lists, treatment of illnesses	The Northern Ireland Life and Times Survey, Attitudes to Older People in 2008 found that: • 57% agreed that health and social workers treat older people differently with regard to their attitudes to them; • 51% agreed that older people are treated differently with regards to waiting lists and operations; • 53% agreed that older people are treated differently with regard to the treatment of their illness.	Northern Ireland Life and Times Attitudes to Older People - ARK, Belfast	2008
Older people are more likely to be discriminated against in relation to healthcare.	None offered.	ARK NI Research Update Number 61 – Attitudes to Age and Ageing in Northern Ireland	June 2009
There is no legal basis in Northern Ireland on which to challenge age discrimination in the provision of goods and services, including health and social care services.	Recommends that the law in Northern Ireland be amended to outlaw discrimination on age grounds when people are accessing goods, facilities or services.	Making Older People Equal: Reforming The Law On Access to Services In Northern Ireland - Report for the Changing Ageing Partnership (CAP) by the Institute of Governance, School of Law, Queen's University Belfast	February 2009
Age discrimination when accessing goods, facilities or services.	Recommends that the remedies available for age discrimination in relation to access to goods, facilities and services should be just as effective as the remedies available	Making Older People Equal: Reforming the Law on Access to Services in Northern Ireland	February 2009

	in other discrimination contexts. (Recognises existence of Section 75 legislation). Highlights the low expectations that older people have in relation to health care.		
Increase in elderly population.	For example, people over 60 in Northern Ireland make up 19% of the population and the number of older people is increasing rapidly. Figures from the Department of Finance and Personnel show that the number of pensioners aged 85 or over in Northern Ireland has increased by almost a quarter in seven years with 28,700 people aged 85 or over in Northern Ireland today. People in Northern Ireland also experience the lowest disability-free life expectancy of any nation in the UK. Pensioner poverty in Northern Ireland is increasing and as poverty and inequality go hand in hand.	NISRA 2009 Mid-Year Population Estimates Age NI Response	2009 March 2011
Older people may be denied treatment offered to younger patients. **In some hospitals the standard of hygiene and nutrition given to older people fall below minimum standards.**	The Kings Fund review on discrimination concluded that while there are many examples of excellent care for older people, there is also much unfair age discrimination.	Emilie Roberts *et al*. Old Habits Die Hard – Tackling Age Discrimination in Health and Social Care - The King's Fund, London http://www.kingsfund.org.uk/publications/old_habits_die.html	2009
Early intervention projects produce earlier outcomes and greater efficiency for health and social care	There is clear evidence that projects which promote early intervention and independence such as re-ablement programmes, show how this approach, through a strategic shift to prevention and early intervention can produce early outcomes and greater efficiency for health and social care. Examples include the	Evaluation of Ageing Well Reach Project - Community Evaluation Northern Ireland, Belfast Blake Associates Evaluation of First Connect Service - Age Concern Help the Aged NI	2009 2009

	Ageing Well Reach in Northern Ireland, First Connect Service and the Partnerships for Older People Projects in Great Britain. A recent evaluation of the First Connect Service run by Age NI, suggested that the service has proved to be a valuable service for older people and that the HandyVan, SeniorLink and SeniorLine services under First Connect are value for money.	The National Evaluation of Partnerships for Older People Projects - Personal Social Services Research Unit (PPRSU), Department of Health, London	2010
Pensioner poverty in Northern Ireland remains high: Older, single, female pensioners experience some of the highest levels of poverty.	Extend clause in Welfare Reform Act 2009 related to state pension credit schemes to Northern Ireland. An innovative approach to benefit uptake is needed.	Age NI Briefing Paper – Evidence to DSD Committee on the Welfare Reform Bill	May 2010
Older Women Coping with Lifelong Domestic Violence: Effects on Health and Wellbeing.	Recommends: public awareness; professional awareness; support victims. Local Domestic Violence Partnerships should ensure that representatives from the organisations representing and working with older people are members of the partnership. Service providers need to consider developing supports, services and interventions specifically for older women with experience of domestic violence that specifically cater for older women's needs.	Older Women's Lifelong Experience of Domestic Violence in Northern Ireland	January 2010
By the year 2024, one in five people will be of pensionable age – a 32% increase. By 2033 many individuals within the pensioner population will be living for much longer.		The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee	November 2010
Too often older people are grouped into one or two cohorts – thus disregarding the diversity of issues within every stage of later life.	Whilst there is an urgent need for social care, there must be a broader conversation about the wider life experiences of older people.	The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by	November 2010

		Sara McKee	
There remains an alarming number of older people who are eligible for basic statutory financial support but who do not receive it.		The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee	November 2010
Older members of society have been some of the hardest hit by the recent recession.		The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee	November 2010
Advice and financial guidance for poorer people approaching older age is patchy.		The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee	November 2010
Social dynamics and the physical nature of communities is important to the overall quality of life and well being		The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee	November 2010
There is a group of older people who experience persistent loneliness, isolation and severe social exclusion- often triggered by the death of a spouse.	In policy terms – reforms to tackle loneliness, isolation and social exclusion have been lukewarm. The role of neighbouring and neighbourliness, often neglected in social policy, is another way of tackling these problems.	The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee	November 2010
Since ageing often increases mobility – reliable, safe and accessible transport networks should be available.	Free transport passes has had highly positive impact.	The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life.	November 2010

		An Interim Report by the Older Age Working Group, Chaired by Sara McKee	
There is an undeniably strong link between social breakdown and poor health. The circumstances, in which people are born, grow up and age determines their quality of health. While average life expectancy rises, the National Audit Office has found that the gap in life expectancy between the richest and the poorest is widening.		The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee	November 2010
There remains a significant problem of malnutrition across society, including in places where there is a duty of care on professional staff.		The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee	November 2010
Older people have some of the highest rates of alcohol-related hospital admissions each year and people aged 65 and over are the most likely age group to drink every day.		The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee	November 2010
There are clear links between inactivity and deprivation among older people.	Support initiatives to encourage older people's physical activity and explore possible community based models that are cost effective and productive.	The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee	November 2010
Volunteering is one of the major opportunities offered by older age that ought to be promoted – older people are crucial to the success of volunteering.		The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee	November 2010

Digital exclusion precludes the possibility of older people benefiting from such things as information access, free financial advice etc.		The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee	November 2010
The importance of housing reaches far beyond the basic physical shelter that a roof provides – housing design, conditions and standards have a significant bearing on overall wellbeing.	Buildings and environments should reflect older people's diverse needs.	The Forgotten Age – Understanding Poverty and Social Exclusion in later life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee	November 2010
Whilst many older people want to remain in their own homes for as long as possible – due to declining personal mobility and inflexible household design this can be extremely difficult as people age.	The provision of assistive equipment can have a hugely beneficial impact on maintaining or improving an older person's quality of life. The present system for adaptations is too bureaucratic.	The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee	November 2010
Supported housing offers securing and peace of mind. Therefore the likely reduction in Supporting People programme will impact on the quality and availability of such facilities for people of low and mid range incomes.		The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee	November 2010
Political debates about older age have resulted in older people being portrayed solely as a problem society has to pay for but social care is a very real concern for older people.	How to provide social care in a ageing society is a subject that must be reasoned with sensibly and sensitively	The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee	November 2010
There are approximately 6 million carers in the UK – with particularly high instances of caring in some black, minority and ethnic communities.		The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by	November 2010

		Sara McKee	
In 2008/09 1.2 million people aged 65 and over received services from their local authority. Residential care may be the right choice for those older people with the highest intensity needs – local authorities' service models still remain weighed towards residential care.	• Preventative social care is crucial as we adjust to our ageing society. • Personalisation – whether through Direct Payments or personal budgets should be welcomed. • More integration between health care and social care teams.	The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee	November 2010
There are currently 419,000 residents of UK care homes – with 95% older people. In both nursing and residential care the typical resident is far frailer and older than even 10 years ago.		The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee	November 2010
The lack of medical presence in care homes was the biggest theme which emerged from evidence gathering on care. The major consequence of poor primary health coverage has been services defaulting to hospital admission when an emergency arises.		The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee	November 2010
Older people who are isolated are at greater risk of abuse than those who regularly meet other people – older people with poor levels of community support were five times more likely to report mistreatment, compared to those with strong or moderate levels of community support.	Services that support and empower older people to carry out their everyday tasks and stay connected to their communities and friends, as they help to prevent the potential for elder abuse in the first place. Such services include personalised transport schemes, social clubs, educational opportunities or home support service in Northern Ireland.	Naughton *et al.* Abuse and Neglect of Older People in Ireland: report of the national study of elder abuse and neglect - Health Service Executive (HSE) and University College Dublin (UCD) Centre for Ageing Research and Development in Ireland (CARDI) – Insights into Elder Abuse	2010 June 2011

Elder Abuse by Carers The participants felt that care can lead to stress and strain on caring relations – Home Care staff are responsible for elder abuse in just 2% of cases, while family members are responsible in 50% of cases.	A mentoring service, whereby family carers could ring someone for information and support on how best to approach the challenges of caring for an older person. Advice and support on choosing nursing homes and other options. An ageing policy can help to support family and unpaid carers through providing adequate respite care, particularly at night time.	Naughton *et al.* Centre for Ageing Research and Development in Ireland (CARDI) – Insights into Elder Abuse	2010 June 2011
Expectation that an older person or their family may have of dignified, pain-free end of live care, in clean surroundings in hospital, is not being fulfilled. Report presents a picture of NHS provision that is failing to meet even the most basic standards of care with a theme of poor communication and thoughtless actions extending to discharge arrangements which were shambolic and ill-prepared. Most basic of human needs were often neglected e.g. clean and comfortable surroundings, assistance with eating, available drinking water, ability to call some who will respond.	In each of the ten investigations, a series of recommendations were made e.g.: Procedural changes i.e. asking A and E patients if they are accompanied; review of nursing documentation; introduction of holistic assessment tool for the palliative care team to make sure a person's care needs are met and their discharge is properly planned; changing the way patients meals are delivered; centralised complaint handling; regular teaching sessions for A and E doctors about prescribing and monitoring medication; reminder to staff how to access interpreting services for deaf patients; acknowledged need to promote effective communication; monthly record keeping audits; benchmarking against Essence of Care standards for privacy and dignity involving people who use their serviced and their carers.	Care and Compassion? Report of the Health Service Ombudsman on Ten Investigations into NHS Care of Older People	February 2011
Age discrimination and human rights violations against older people can	Such as: • Upper limits for intervention;	Age NI Response	March 2011

manifest themselves in many different formats.	• Prejudicial attitudes among health and social care providers; • Implicit age limits for certain services; • Restricting movement in some settings; • Lack of referrals to specialist services, screening and preventative options.		
2% of people aged 65+ in Northern Ireland had experienced abuse in the past 12 months.		Centre for Ageing Research and Development in Ireland (CARDI) – Insights into Elder Abuse	June 2011
In Northern Ireland there is a lack of legislation addressing elder abuse, and the response of services is perceived as not taking into account the needs of older people.	The government responded by establishing a Working Group on Elder Abuse. This was a seminal policy document setting out a framework of action under a number of recommendations. One of the key recommendations was placing responses to elder abuse within the wider context of health and social care for older people. Documents were created to promote the guiding principles of respect, dignity and independence while affirming the individual rights of older people in terms of access to information; support in making complaints; urgent investigation of abuse; and receiving treatment after abuse. Procedural guidance documents outline procedures for staff to take if they suspect abuse or if a case of abuse has been disclosed to them. The Health and Social Care Trusts in NI typically have in place Safeguarding Vulnerable Adults Forums that comprise senior managers from appropriate Directorates and programmes	Centre for Ageing Research and Development in Ireland (CARDI) – Insights into Elder Abuse Protecting Our Future: Report of the Working Group on Elder Abuse Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guide	June 2011 2002 2006

	of care. Forums monitor the implementation of the procedures and policies of the Safeguarding Vulnerable Groups (NI) Order. Cases of allege or suspected abuse are investigated in accordance with strict procedures by a social worker working in an appropriate team, such as elder care, mental health or disability. Thirty-two elder abuse case workers operate through local health offices, while a further structure of the elder abuse service comprises four dedicated elder abuse officers supported by regional steering committees. Procedures and policies are overseen by a National Steering Committee responsible to the Office for Older People situated in the Department of Health.		
Older people with significant physical or cognitive impairment who are dependent on others for care were identified as being particularly vulnerable to elder abuse.	Identifying elder abuse should be seen as having wider relevance to other professionals – for example, GPs, bank officials and solicitors, rather than simple those working within the health field. To enhance social awareness of the issue. While services that respond to elder abuse are crucial, empowering older people themselves can help to prevent elder abuse and facilitate the independence of older people in society.	Centre for Ageing Research and Development in Ireland (CARDI) – Insights into Elder Abuse	June 2011
Older people in this research believe there is a link between elder abuse and their	Education and information provision throughout a person's life were considered	Centre for Ageing Research and Development in Ireland (CARDI)	June 2011

own status and value to society.	vital towards creating awareness of elder abuse. Supply easy access to clear information on whom to contact and what steps to take if elder abuse is reported, and an assurance that investigations of alleged abuse will be speedily and sensitively dealt with. Peer support and community based sources of information and support – moving away from the more traditional ways of informing people.	– Insights into Elder Abuse	
Older People and Sexual Discrimination Issues of sexual orientation and gender identify have often been invisible in the planning and commissioning of services for older people.	Older LGB and T people are also protected by 'The Equality Act (Sexual Orientation) Regulations (Northern Ireland) 2006' which states that no person can be refused access to goods, facilities and services on the basis of sexual orientation. This would include access to residential or nursing care. Section 75 of the Northern Ireland Act states 'A Public Authority shall, in carrying out its functions relating to Northern Ireland, have due regard to the need to promote equality of opportunity between people of different sexual orientations'. Although Section 75 of the Northern Ireland Act does not apply to private care facilities it does apply to Health and Social Care Trusts and any subsidiary thereof. Promote awareness that although clients may indicate their sexual orientation and/or gender identity, or this may be apparent	Making This Home My Home: Making Nursing and Residential More Inclusive for Older Lesbian, Gay, Bisexual and/or Transgender People - Age NI	September 2011

	due to the gender of someone's partner or the way they dress, this does not necessarily mean that they do not remain invisible. More recently, legislation has been passed at Westminster to ensure that the provisions of the Human Rights Act apply to people who receive services through private and/or voluntary sector provision.		
As a result of prevailing negative social attitudes and experiences of homophobia, individuals often do not self disclose to service providers, resulting in later presentations to medical professionals when illnesses are at a more advanced stage and potentially more difficult to treat.	The Public Health Agency, together with the Health and Social Care Board and providers should take forward a focused plan of action to implement improved monitoring systems in the areas of sexual orientation and gender identity.	Diversity: Sexual Orientation in Home and Community Care, Canadian Research Network for Care in the Community (CRNCC) - Age NI Health and Social Care Act	September 2011 2008
Many service providers felt that homophobia was more common amongst the ageing population due to the lack of visibility of LGB&T people for a large part of their life. Therefore resulting in the social isolation of LGB&T clients within the care environment.	Understanding through training of what it means to be LGB and/or T, the experiences of LGB&T people when accessing services is an important aspect of care provision. Provide opportunities for LGB&T clients to access support through local LGB&T agencies and attend community events. Linking with communities to support LGB&T clients. These include organising trips or transport to events or to community centres. Bringing the community to the clients by organising events such as talks, workshops, and musical sessions as regular occurrences within the care	Age NI	September 2011

	environment. Carers should educate other clients and help create a more inclusive environment in the care home.		
There is evidence that older people face particular risks to human rights associated with the provision of care and support services, especially at home.	There are major opportunities for local authorities to promote and protect older people's human rights in: • The way they commission home care • The way they procure and monitor home care contacts • Assessing older people's needs • Reviewing older peoples on going needs and the care they are receiving • Providing information to people in need of home care	Close to Home – An inquiry into older people and human rights in home care – http://www.equalityhumanrights.com/uploaded_files/homecareFI/home_care_report.pdf	2011
A good understanding of the challenges of an ageing population is vital for policy makers. It is therefore important that the right strategic policy decisions are underpinned by a strong evidence base. It is hoped that these evidence reviews will contribute to the development of that evidence base and play a role in improving social care provision in Northern Ireland.	1. Social Care Evidence Review: Dignity 2. Social Care Evidence Review: Outcomes 3. Social Care Evidence Review: Rights 4. Social Care Evidence Review: Personalisation 5. Social Care Evidence Review: Prevention	1. http://www.ageuk.org.uk/documents/en-gb-ni/policy/evidence-reviews/age_ni_social_care_evidence_review_dignity_sept_2012.pdf?dtrk=true 2. http://www.ageuk.org.uk/Documents/EN-GB-NI/policy/evidence-reviews/Age_NI_Social_Care_Evidence_Review_Outcomes_Sept_2012.pdf?dtrk=true 3. http://www.ageuk.org.uk/Documents/EN-GB-NI/policy/evidence-	2012

		reviews/Age_NI_Social_Care_Evidence_Review_Rights_Sept_2012.pdf?dtrk=true 4. http://www.ageuk.org.uk/Documents/EN-GB-NI/policy/evidence-reviews/Age_NI_Social_Care_Evidence_Review_Personalisation_Sept_2012.pdf?dtrk=true 5. http://www.ageuk.org.uk/Documents/EN-GB-NI/policy/evidence-reviews/Age_NI_Social_Care_Evidence_Review_Prevention_Sept_2012.pdf?dtrk=true	
It is important that a strategy for providing long-term care for an ageing population is put in place, and understanding what the demand for care will be is a major part of this.	By 2021 – • The number of people aged 65+ in NI BY 4270, up 45% • The extra demand for care from statutory providers in NI will be 4,200, up 37%. • 565 extra people in NI will require residential or formal home care	Future Demand for Long-term care in Ireland – http://www.cardi.ie/userfiles/Long%20Term%20Care%20(Web)(1).pdf	2012
Increase in elderly population More of us are living longer and healthier lives and this is very good news. It is the best public health news of the last century. Babies born today have a life expectancy of 81 years for females and 77 years for males2. People who were born in 1950 had a life expectancy of 70 years for	The Older People Commissioner of NI will: Undertake and publish research that highlights the positive contribution of older people to Northern Ireland life. Raise public, professional and media awareness about this positive contribution. Challenge negative stereotypes of older	Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland, National Audit Office Northern Ireland Level Projections NISRA Census 2011	2012 2011

females and 68 years for males. It is among the so called “very old” that we see the biggest growth in numbers. By 2060, there will be five times as many people living beyond 100 years of age as there are now3. In 2011 there were 228 persons aged 100 years plus currently living in Northern Ireland4. In Northern Ireland there is the reality of economic pressures coupled with a period in our history when we are attempting to move away from conflict. There is an increase in older age health conditions and a rising demand for the need to provide care for our older population. As our Government strives to manage demographic and social change we see developments in policy and plans for the future such as the “Transforming Your Care” programme. We are also experiencing closures and changes to health care facilities, increased private sector provision, and benefit and pension reform. It is therefore important to recognise that for many this can be a time of anxiety as we move forward and attempt to shape the future better with and for our older generations.	people and ageing through her work.	Census 2011, NISRA	
Many older people want to continue to work, including those who want new types of employment. Others would consider extending their time in employment with more flexible working conditions or in circumstances where they could retrain for	Develop and implement an effective communication strategy. Regularly attend meetings and events around Northern Ireland to be available to older people.	Commissioner for Older People NI (COPNI) Corporate Plan	2013-2015

new roles. This is particularly relevant to those in careers that involve heavy physical work or sustained periods of physical and mental activity.	Actively seek the views of older people who find it harder to be heard. Lead debate among employers and older people about what is needed to increase support for an ageing workforce to find and remain in work. Publish and provide information to employers, older people and policy makers in Government on her findings.		
The current legal framework for social care is fragmented, complex and open to interpretation. As a result, older people and their carers are often unclear about entitlements to social care and providers are unclear about their responsibilities. Additionally, social care will change significantly when the Department of Health, Social Services and Public Safety's (DHSSPS) proposed change programmes take effect.	In collaboration with Age NI and other partners, review the current legislation underpinning the social care regime and make recommendations to Government for change as required. Monitor the implementation of DHSSPS change programmes and their impact on social care for older people.	Commissioner for Older People NI (COPNI) Corporate Plan 2013 - 2015 Transforming Your Care, A review of Health and Social Care in Northern Ireland, DHSSPS. http://www.dhsspsni.gov.uk/tyc.htm	2013 2013
It is essential that older people can be certain that they will receive the dignified, respectful care and support they need if they become frail, develop dementia or become otherwise vulnerable. Domiciliary care should meet the changing needs of older people who receive care at home.	Examine current standards required for domiciliary care and compliance with those standards. Examine the adequacy of the current inspection regime. Determine if any changes are needed to increase protection of older people, and call on Government to address these changes.	Commissioner for Older People NI (COPNI) Corporate Plan	2013

There is widespread concern and anger about the abuse of older people. However, there is often a lack of understanding about the legal protection available to older people who suffer abuse. The UK Study of Abuse and Neglect of Older People 200710 asserts that across Northern Ireland there may be some 10,000 older people who are the victims of abuse. Abuse can take place wherever older people live and when others exploit their vulnerability. Abuse can include neglect, sexual abuse, emotional cruelty, physical violence, financial coercion, fraud, and theft. Abuse can be carried out by anyone including families, neighbours, paid health and social care workers, volunteers, and others who have contact with older people	Examine existing adult protection legislation and its adequacy regarding older people. Produce a practical guide for older people and practioners about the law on protection from abuse. Determine if any changes are needed to better protect older people and call on Government to address them. Respond to the individual needs of older people The Commissioner's office provides information, support and assistance for older people. The Commissioner's staff will answer queries and support older people by: Putting them in touch with organisations best placed to assist them to obtain the support they need. Providing information about services in their locality. Assisting them where they have been experiencing difficulties with a public service body or provider. Supporting them to make a formal complaint and then monitoring how this is handled. In certain circumstances providing direct assistance. At all times, care is exercised to ensure that there is no duplication when work has already been carried out by, or	10 Kings College London Briefing Paper: The UK Study of Abuse and Neglect of Older People Commissioner for Older People NI (COPNI) Corporate Plan	2007 2013

	should be transferred to, an alternative or more appropriate body or organisation. When appropriate, the Commissioner may partner with another public body to ensure that concerns are fully addressed. The Commissioner will make referrals to other agencies when appropriate to do so. Provide direct support on specific issues. Identify new areas for investigation or of concern.		
There has been considerable research on the barriers to accessing services (especially among black and ethnic minority groups, through other groups will often be affected by similar issues). These barriers include: • difficulty in accessing information (including language barriers for some black people and members of ethnic minority communities); • difficulty understanding a complex, uncertain and locally varied system; • stigma, low expectation or lack of confidence in one's right to access services; • problems in accessing general practitioners and in obtaining an	• Evaluative studies that measure and compare experiences and outcomes among different equality groups from different models of care provision are generally lacking • There is a need to take account of the effect of frailty, disability or long-term illness on the experience of poverty for older people or their carers and a need to devote more attention to how we factor assets and debts into measurements of poverty and among older people • There is a lack of robust quantitative data about the numbers of minority ethnic older people living in UK care homes and extra care housing (and where those who are not but have high support needs are living and what alternative services they are	Equality & Diversity & Older People with high support needs. www.jrf.org.uk	2010

accurate diagnosis, assessment and referral from them and other gatekeepers; • a lack of appropriate, accessible and attractive provision; and • housing/financial circumstances and the extent to which private and/or family care may constrain individuals' options. There has been less research to date on the experiences which diverse older people have of services and their outcomes. Issues for different equality groups may include; • discrimination in services – from staff, other service users and from the way organisations operate; • failure of services to take a holistic approach (or to recognise that older people are likely to have different social, cultural, religious/spiritual, emotional or sexual needs), which can have a particular impact on the experiences of older people for equality groups; • a lack of voice, choice and control for all older people with high support needs but particularly those with dementia or who experience	receiving) • A knowledge gap exists regarding the different experiences and outcomes of older people with acquired and pre-existing disabilities and older disabled people who are ill and those who are not. There also does not seem to have been much focus on older people's perceptions of their 'disabilities' • There is a lack of studies comparing the experiences and outcomes of older men and women living in care homes and analysing the implications of the gender differences among older people with high support needs from a policy perspective • There is very little evidence on how personalisation or the independent living agenda would work for people with dementia, and the Royal College of Psychiatrists (2009) has identified a need to collect, develop and evaluate examples of good practice in working with older people from black or minority ethnic backgrounds who have dementia or other mental health problems • Older Gypsies and Travellers are mentioned briefly in a number of local and national studies, but this		

language barriers.	information does not seem to have been drawn together anywhere There is currently little evidence regarding self-funders in terms of numbers, demographics, experiences or outcomes		
For HSC Staff			
Carers are more likely to be found among older workers: Peak age for caring is between 55-59 when one in four people are a carer. Carers are more likely to give up work early in order to provide care: Particularly for workers just before end of employment. Carers find it more difficult to return to work after a period of caring.	Screening and Equality Impact Assessments are key in assessing whether employment policies have an adverse impact on carers.	Source to be provided	
Attitudes to nurses over 50. Specific needs, e.g., potential physical limitation, caring responsibilities, pension issues and professional development.	Training re: Ageism. Flexible working arrangements. Carers Leave. Return to Practice initiative takes account of needs of this group.	Watson, Manthorpe and Andrews Nurses over 50 – Options, Decisions and Outcomes - Joseph Rowntree Foundation	July 2003
People aged 45-54 had the highest risk of suffering from a psychological disorder, while those aged 65 and above were the least at risk.	None – statistical report only.	Equalities and Inequalities in Health and Social Care in Northern Ireland – A Statistical Overview - DHSSPS	2004
The incidence of cancer, diabetes, heart attack and stroke increases with age.	None – statistical report only.	Equalities and Inequalities in Health and Social Care in Northern Ireland – A Statistical Overview - DHSSPS	2004
The incidence of informal care was highest among those aged 45 to 64, with approximately a fifth of respondents acting as carers. Women aged between 45 and	None – statistical report only.	Equalities and Inequalities in Health and Social Care in Northern Ireland – A Statistical Overview	2004

64 were particularly likely to be carers.		- DHSSPS	
Negative assumptions about capacity which lead to discrimination are considered to be barriers for older workers.	Employment Equality (Age) Regulations (NI) 2006 only partly address the issues of age discrimination in employment.	ECNI - Awareness of Age Regulations 2006 and Attitudes of the General Public in Northern Ireland towards Age Related Issues	June 2008

What are the Equality/ Inequality Issues?	Potential solutions where these are offered in the literature Policy/Practice Issues?	Source of Evidence	Date
A. For Service Users			
Contraception.	Encourage open consultation between staff and patients to identify and address the needs of different religious groups.		
Dietary and clothing needs: Lack of appropriate meals in hospital settings (e.g. Halal or Kosher foods). Issues relating to modesty and the wearing of standard hospital garments.	Female staff as required. Many hospitals have been cited as now providing halal meat		
Lack of specific care places for older people from minority religious groups.			
Medications.			
Mental Health Issues.			
Circumcision: Particular concern for Jews and Muslims. The availability of the operation on the NHS tended to vary according to geographic location. Concerns over unlicensed GP's without proper insurance or authority.			
Burials and Cremation: e.g. Muslims reported being refused access to prepare the body of the deceased.	Co-ordinator in hospitals whose role would be to contact community members to administer the appropriate rites.		
B. For HSC Staff			
Blood Transfusion: Many Jehovah's Witnesses reported experiencing stigmatisation for their refusal, on religious grounds, to accept blood-based		Narrowing the Gaps Equality and Diversity - NHS	2008-2013

treatments.			
Chaplaincy and facilities for worship: Access to spiritual and religious care in hospitals, particularly for those of non-Christian faiths, is somewhat limited.	Conduct an audit of places of worship in hospitals and other health care settings. More multi-faith prayer rooms in health and social care settings. Develop guidelines such as those produced by the Scottish Executive.	Weller *et al.* Religious and Spiritual Care in a Health and Social Care Context Sheikh, A Hospital Chaplaincy Units show bias towards Christianity	2001 2004
Attitudes and behaviour of staff.	Staff training in religious equality. Continued emphasis on staff education and awareness programmes on the requirements of different faith groups delivered across H&SC, including primary, secondary and community.	Weller *et al.* (2001:71) Religious Discrimination in England and Wales, Home Office Research Study	2001
'Religion' is a contested term, in the sense that individuals and groups disagree over how and to whom it can be applied. There are often gains and losses associated with being defined as religious, depending on context.	• Introduce clearer definitions and measurements of equality of religion and belief • Further analysis of datasets and studies • Commission mixed method research designed to gather new data on discrimination by, and towards, religious communities • Monitor the working of religious discrimination case law • Monitor and evaluate the impact of recent legislation relating to religion	'Religion or Belief' Identifying issues and priorities - http://www.equalityhumanrights.com/uploaded_files/research/research_report_48__religion_or_belief.pdf	2009
To adopt a zero tolerance approach: To all incidences of, and reasons for, attacks motivated by sectarian, religious, racist, or hate prejudice, including those on symbolic premises, cultural premises and monuments. In light of the economic challenges that we		Programme for Cohesion, Sharing and Integration (CSI) Faith and Human Rights	Sept 2010 NIHRC 2010

all face, we must address the issue of duplication in the provision of health and leisure services. (14 of the 15 most deprived areas in Belfast are highly segregated). **Update the flags protocol:** Which was established in April 2005 by OFMDFM.			
This judgment affects employer responsibilities for policies and practices affecting religion or belief rights in the workplace, the rights of employees (including job applicants) and the rights of customers or service users.	• This guide aims to help employers understand the legal implications of the Court's judgment. It specifically addresses the following questions: • What laws protect rights to religion or belief? • What were the cases about? • What legal changes does this judgment make? • Will the law change again?	Religion or Belief in the Workplace - http://www.equalityhumanrights.com/uploaded_files/RoB/religion_or_belief_in_the_workplace_an_explanation_of_recent_judgments_final.pdf	2013

HSC AUDIT OF INEQUALITIES: EMERGING THEMES: POLITICAL OPINION

What are the Equality/ Inequality Issues?	Potential solutions where these are offered in the literature Policy/Practice Issues?	Source of Evidence	Date
A. For Service Users			
Research: More research is needed on the impact of political opinion on access and usage of health and social services.	**Research:** Dedicated research should be commissioned which can more definitively test the impact of the Troubles on levels of need. In-depth investigations should be conducted on the impact of segregation, paramilitary feuds, and population		

	intimidation.		
Location of some services: Both statutory and voluntary, are not considered very accessible. **Fears about confidentiality.** **Lack of information and awareness about available and existing services.** **Lack of trust in social services.**	Some individuals who rely on public transport feel uncomfortable travelling to services located in areas not regarded as 'neutral' in sectarian terms.	Living with the Trauma of the Troubles - Social Services Inspectorate	1998
Politically motivated ex-prisoners and their families. **Political ideology can often act as a barrier in access and uptake of services provided by statutory/voluntary agencies**. The authors suggest that the politically motivated ex-prisoners and their families have a **tendency not to use professional and voluntary organisations which do not take into account their status and political ideology**.	Mental and emotional health appears to be an important issue for ex-prisoners and their families. **Access to confidential services which provide emotional support** is a key concern for many ex-prisoners. Evidence continues to suggest that many ex-prisoners and their families are **suspicious of institutions which are supported or influenced by Government agencies**	McEvoy *et al.*	1999
Participation and accessibility of services. Those bereaved and injured by security forces may be mistrustful of state provision.	**Training, organisational development and specific organisational policies are required**	The Cost of the Troubles Study - Incore	1999
The author states that punishment beatings and shootings are often seen to be part of an 'acceptable level of violence' and that victims receive little sympathy. A deep suspicion and mistrust of the statutory authorities and the 'undeserving' character of victims currently militate against a 'joined-up'	Statutory bodies either minimise the problem of community violence or remain indifferent to it. The net result is a disjoined response at both inter-sectoral and inter-agency levels.	Knox, Colin Joined-Up Government: A Multi-agency Response to Violence in Northern Ireland	2000

approach.			
Violent Interface areas: Reluctant or unable to use health and social services in the "other" community area e.g. North Belfast residents continue to have restricted access to facilities and services which are perceived to be situated in the "other" community. The ministerial Panel will: urgently address the physical and community division created by interfaces with the support of communities.	Develop and build on links with voluntary and community groups operating in this area e.g. victims groups, community groups in interface areas. Location of future facilities – careful consideration should be given to the location of future regional facilities within the Board area. Location within North and West Belfast should be considered a priority. New facilities should be located on peace-lines and should be fully accessible to both communities. Reduce and eventually eliminate segregated services.	Smyth *et al.* Caring Through the Troubles Neil Jarman Managing disorder – Responding to interface violence in North Belfast - OFMDFM Research Branch Programme for Cohesion, Sharing and Integration (CSI)	2001 2002 September 2010
Service Inaccessibility: The impact of the Troubles and interface violence has a particularly profound impact upon North and West Belfast with high levels of need and yet regional services tend to be located in other areas such as South Belfast. These services are often perceived to be inaccessible for those living in North and West Belfast. It was further suggested that there was a higher than average need for adolescent mental health services in North and West Belfast but that very little in terms of service provision exists in the area.	Data Collection – it is recommended that the existing collection of data within Trusts is reviewed to ensure that data is collected which facilitates the monitoring and analysis of the impact of the Troubles. Social and psychological reconstruction – consideration should be given to establishing a dedicated facility or multi-disciplinary initiative for the reconstruction of communities affected by the Troubles in Northern and West Belfast. This should involve health, social services and community development and should offer advice, research, and training on a Northern Ireland wide basis.	Smyth *et al.* Caring Through the Troubles	2001
Victims and Survivors of the conflict: The DHSSPS evaluation revealed: There are only a relatively small number of dedicated services for victims across the general HSS.	One of the values underpinning the Northern Ireland Victims Strategy is that all victims (and their close relatives, partners and carers) should have equality of opportunity in regards to access to, and	DHSSPS NI Victims Strategy	2003

There was a need to increase awareness across the mainstream sector in respect of victim's issues, needs and services. That there were particular specialities in which victims accessed services most frequently including pain management, physiotherapy, mental health etc but that these services had long waiting lists. That services for victims often were developed as a response to tragedies with service developments taking place on an ad hoc basis.	participation in, and benefits of services (see OFMDFM Victim's Strategy, p.2). The present location of the Family Trauma Centre and its accessibility to the whole population of Northern Ireland remains an issue of concern in that it was not readily accessible to a large number of the population. Some of the dedicated services for victims lacked recurrent funding. That greater coordination and transparency in service coordination and planning was required.		
Children and Young People: The troubles and interface violence have a profound impact upon children and young people i.e. as victims and witnesses of violence and as children of ex-prisoners or members of the security forces. There is evidence to suggest they tend to be reluctant users of statutory services due to issues of trust and confidentiality. The ad hoc nature and under-funding of child and adolescent psychiatry services in Northern Ireland greatly impacts upon the provision of services to children and young people affected by the troubles. It was further suggested that there was a higher than average need for adolescent mental health services in North and West Belfast but that very little in terms of service provision exists in the area.	It is clear that there is a need for further research; policy and service development to meet the needs of this group.	Smyth *et al*. The impact of political conflict on children in Northern Ireland - Institute for Conflict Research, Belfast	2004

Another important area of concern is the impact of imprisonment on the children of politically motivated prisoners/ex-prisoners. Evidence suggests that many of these children experience bullying, deprivation, a breakdown in family relationships and loss of opportunity as a result of the imprisonment. These factors coupled with discrimination, stigma and overt hostility can often have a traumatic impact.	Shirlow (2001) maintains that it is obvious that the psychological and other difficulties experienced by ex-prisoners and their families cannot be addressed by conventional support structures. This is because many ex-prisoners and their family are suspicious of institutions which are supported or influenced by state agencies. It is therefore imperative that health and social care providers begin to build a relationship of trust and reciprocity with ex-prisoner based organisations in order to meet the needs of ex-prisoners and their families.	Dr Peter Shirlow The State they are Still In. Republican Ex-Prisoners and their Families: An Independent Evaluation - CAIN Project, University of Ulster	2001
B. For HSC Staff			
Violent Interface areas: Health and social care staff in North and West Belfast often work in volatile and stressful situations. **Restrictions on staff**: During the "marching season" and other disputes e.g. Drumcree often impede the normal and smooth delivery of services e.g. domiciliary services.	**Mainstreaming the Troubles for health and social care providers –** it is important that the challenges involved in delivering health and social services in communities affected by the Troubles become a mainstream concern. Staff operation under such circumstances should no longer be left to "get on with it".	Smyth *et al.* Caring Through the Troubles	2001
Duplication of services.			

HSC AUDIT OF INEQUALITIES: EMERGING THEMES: MARITAL STATUS

A person's `marital status` describes their relationship with a significant other. Some common statuses are: married, single, separated, divorced, widowed, engaged, annulled, cohabitating, deceased or civil partnership. As with most of the Section 75 groups, there is much overlap with other categories and those most synonymous with marital status would be gender and those with and without dependants. It would perhaps be most effective and meaningful to group these categories together since the issue of multiple identities can often exacerbate the inequalities experienced. Very often in cases taken to court, marital status and gender are used in conjunction as the proscribed grounds. The Sex Discrimination Order has made it illegal to discriminate against people in employment or service provision because of their marital status – it is only 30 years ago that a women could not enter into a hire purchase agreement without her husband's consent – if she was unmarried, she could not access contraception and she was obliged to give up work once she got married. Equal Pay legislation made it unlawful for someone to be paid less because of their gender or marital status. Since the 1970's the number of women in employment has increased by as much as a fifth. Working parents are now entitled to maternity and paternity pay and to request flexible working.

Much of the research for this audit has been done over the internet regarding marital status. Some of it applies to Northern Ireland and some of it nationally in the UK. The emerging themes are not just pertinent to marital status but predominantly exist as a result of multiple identities – i.e. with gender, dependants and/or ethnic minority and disability. Perhaps some of the most pronounced to suffer inequalities within the marital status category would be lone parents and this would be in terms of access to affordable childcare, younger lone parents may not have completed their education and thus their employment potential is affected. Mental health and domestic abuse are also emerging themes. Potential solutions to these inequalities would include more flexibility in terms of both service provision and employment, help with childcare, childcare facilities and general support mechanisms such as health improvement, sex education programmes and mental health awareness.

What are the Equality/ Inequality Issues?	Potential solutions where these are offered in the literature Policy/Practice Issues?	Source of Evidence	Date
General Issues			
Lone Parents: In Northern Ireland there are nearly 92,000 lone parents with 150,000 children, 25% of all families in Northern Ireland are one parent families, nearly half separated or divorced. In the UK 1 in 4 families is headed by a single parent, equating to 3 million	Single people who are service users/staff. Single parents, staff or service users. Potential staff.	Lone Parents Needs Assessment - Gingerbread NI/Northern Health and Social Services Board Census New TSN – The Way Forward Family Resources Survey	1996 2001 2004 2004/05

children. Statistics show that a high percentage of lone parents are likely to be living on a low income in rented accommodation without savings and may be in debt. 90% of lone parents wish to work outside of the home at some stage.		Matthew Hughes Social Trends - Office for National Statistics	2009
29% of children have no contact with their non-resident parent and for two thirds of children no contact has taken place since the separation of their parents.		Families in Britain come in all shapes and sizes; we should acknowledge and value their diversity - Gingerbread	2009
Carers' Assessments Completed During the quarter ending 30 September 2013, 1,137 Carers' Assessments were completed, an 8% decrease on the previous quarter (1,240); and 1,363 Carers' Assessments were declined, an 8% decrease on the previous quarter (1,483); Of all Carers' Assessments offered during the quarter, over half (55%) were declined; similar to that in the previous quarter. Of the 1,137 completed assessments, 96% (1,093) related to adult carers and 4% (44) to young carers under 18 years; Of the 1,093 adult carers with completed assessments, 65% were aged 18-64, 21% were aged 65 - 74, and 14% were aged 75 and above; In the quarter ending 30 September 2013, 23% of young carers assessed were caring for other children with 77% caring		The Department of Health, Social Services and Public Safety has published 'Carers' Statistics for Northern Ireland	(Quarter ending 30 September 2013)'.

for adults; Of the adult carers with completed assessments, 15% were caring for children and 85% were caring for adults; Of those cared for, the largest proportion of completed assessments in each Trust were in the Elderly POC. This ranged from 33% in the South Eastern Trust to 46% in the Southern Trust; **Carers' Assessments Declined** Across all HSC Trusts 1,363 carers declined an offer of assessment during the quarter ending 30 September 2013, 33% of those were in the South Eastern Trust, 22% in the Northern Trust and 15% in the Belfast, Southern and Western Trusts; Older adult carers were more likely to decline an assessment than younger adult carers, with 64% aged 65 and older declining an assessment, compared with 49% aged 18-64. Of the 666 adult carers aged 65 and over who declined an assessment, 258 (39%) were aged 75 and over; When carers were asked about the main reason for declining an assessment 49% reported that they do not need any support or additional support, 13% that it was not a suitable time for assessment, 11% did not view themselves as a carer, 8% did not feel that it would be beneficial, 7% wanted their issues as a carer to remain private, 2% had 'Other' reasons, less than 1% were concerned about an impact on their benefits and 9% gave no			

reason for declining an assessment. Reviews, Reassessments and Declined Reassessments During quarter ending 30 September 2013, 463 Carers' Reviews were completed, a decrease of 24% on quarter ending 30 June 2013 (611); Across Northern Ireland, the Western Trust completed the least number of reviews (28), while the Northern Trust completed the most (207); For the same quarter, 227 Carers' Reassessments were completed, of these 74% were by carers of adults and 26% by carers of children; Of completed Carers' Reassessments 44% were in the Northern Trust, 29% were in the Belfast Trust, 17% were in the South Eastern Trust, 9% were in the Western Trust and 2% were in the Southern Trust; During the quarter, 176 reassessments were declined, with 63% of those declining caring for adults, and 38% caring for children; 14% of Carers declining a reassessment provided no reason for doing so, 59% felt that they did not need and support or additional support, for 12% it was not a suitable time for assessment, 6% felt that it would not have been beneficial, 3% had confidentiality/privacy issues, 2% felt that the previous assessment was not beneficial and 2% felt that a previous assessment was too time consuming. 3%			

provided other reasons for declining a reassessment.			

Cross Cutting Issues with Other Section 75 Categories			
Age			
Less than 3% of lone parents are teenagers. 80% of lone parents are aged 25-49 years. The majority of grooms were aged 40 and over with the average age of the husband age 33.4, (2009). Percentage of Brides aged under 25 in 2009 was 16.5%. Percentage of Brides aged 40 and over in 2009 was 11.8%. The average age of the Bride in 2009 was 31.1.		Gingerbread NI Census	1998 2001
For male civil partnerships the average age of partners was just over 39 (39.4 years), this compares to just under 36 (35.6 years for female civil partnerships).		Northern Ireland Statistics and Research Agency (NISRA)	2009
Forced marriage frequently involves people under 18. Those with learning disabilities being forced in to marriage showed at least 18% were still at school, 11% were under 17, 22% 18-21 and 23% 22-25 years old.	Cultural: - Indian - Traveller - Muslim - Asian	Ann Craft Trust (ACT) Forced Marriage of People with Learning Disabilities	-
Sexual Orientation			
Civil Partnerships: For 79 civil partnerships both partners were single, in the remaining 17 civil partnerships at least one partner had previously been married.			
The percentage of civil marriages in 2009 was 29. Within civil partnerships there were 46		NISRA	2009

male and 50 female partnership ceremonies carried out in 2009.			
Religion, Faith, Belief			
2009 Marriages took place within these denominations: Civil: 2,330 (29.4%), Roman Catholic: 2,953 (37.2%) Presbyterian: 1,046 (13.2%), Church of Ireland: 805 (10.2%), Methodist: 202 (2.5%), Other denominations: 595 (7.5%) Mixed marriages and partnerships - 5% and 12% (Northern Ireland Life and Times survey (NILT), 2005). Each year around 10% of respondents to the Northern Ireland Life and Times (NILT) survey say their partner is a different religion to them.		NISRA Census NILT Survey	2009 2001 2005
Gender			
Forced marriage on people with learning disabilities showed that 38% were male and 45% female. In the general population women are forced into marriage more frequently than men.	Male and female with learning disabilities - cultural.	Ann Craft Trust (ACT) Forced Marriage of People with Learning Disabilities	-
In 2001-02 females accounted for 61% of undergraduate enrolments and 58% of postgraduate enrolments at NI Higher Education institutions.		Department for Education and Learning (DEL)	2001-02
40% of women who are divorced from their husbands are likely to show signs of a possible mental health problem. 22% of women who are either single or married show signs of a possible mental health problem	Women	NI Health and Social Wellbeing Survey Gender Matters - a consultation document - OFMDFM	2001 2005
In the UK, due to caring for children, more women work flexitime than men and more		Labour Force Survey (LFS)	2002

men than women work fulltime			
59% of those on income support are women.	Women	Department for Social Development (DSD)	2003
36% of men separated from their wives are more likely to have possible mental health problem, compared to 16% of married men.	Men	Gender Matters - a consultation document - OFMDFM	2005
Females comprised the majority of the population (51.3%) in Northern Ireland and the majority of lone parents (87%).	Women	Census 2001: Men and Women in Northern Ireland (2006) - Equality Commission Report	2006
Marital Status			
People with learning disabilities can be forced into a marriage through: harassment; suggestion; coercion; kidnapping; blackmail; lack of capacity to consent (40%). In 67% of cases the mother and father were involved in the forced marriage.		Ann Craft Trust (ACT) Forced Marriage of People with Learning Disabilities	-
Lone parents with a disability or a child with a disability and a lack of family support are vulnerable to stress which means that for these parents, participation in the labour market is all the more difficult.		Dr Helen McLaughlin on behalf of the Women's Centres Regional Partnership Women Living in Disadvantaged Communities: Barriers to Participation	-
Ethnic minority women have more difficulty accessing understandable information on benefits, services and childcare provision. Women from ethnic and other minority communities are particularly vulnerable to mental illness, with women of Asian descent having higher suicide and self-harm rates	BME women.	Dr Helen McLaughlin on behalf of the Women's Centres Regional Partnership Women Living in Disadvantaged Communities: Barriers to Participation NICEM's 2006 Report	- 2006
Lone parents and women that have arrived with partners can experience depression, post-natal depression,	BME lone parents.	Dr Helen McLaughlin on behalf of the Women's Centres Regional Partnership	

feelings of isolation, racial harassment, trauma in leaving their families in their home country, high levels of anxiety and stress among asylum seekers who have cases going on for long periods.		Women Living in Disadvantaged Communities: Barriers to Participation NICEM's 2006 Report	2006
University of Ulster showed in previous monitoring data that the majority of new entrants were single 10% of full time students were married		University of Ulster	2002-2005
Nearly twice as many single men (4,621) than single women (2,456) are homeless (NIHE), 2001-02).		NIHE	2001-02
In terms of the marital status of lone parents, women (30.7%) were more likely than men (7.7%) to be single (never married). Men in this group, however, were more likely to be widowed than their female counterparts (44.8% vs. 24.8%).		Census 2001: Men and Women in Northern Ireland (2006) - Equality Commission Report	2001
% of all single parents: White: 87.1, Black or Black British: 6.8 Asian or Asian British: 3.3, Mixed: 1.2 Chinese: 0.2 Other: 1.4	White single parents.	Office for National Statistics	2006
A 2006/7 survey indicated a higher proportion of single men smoked compared to married/cohabiting men.		Olivia O'Riordan and Paula Devine Men in Northern Ireland: Report 3a	December 2007
The following statistical data indicates the proportion of population (number of suicides) %. Married/cohabiting 58.8 (254) Single 30.2 (222) Separated/ divorced 6.9 (77) Widowed 4.1 (13)		British Journal of Psychiatry	2008
Suicide risks were lowest for women.		British Journal of Psychiatry	2008

Risks were also the lowest for people who were married or cohabiting with the excess risk associated with the single/never married and separated/divorced categories being maintained. Those living alone were associated with higher suicide risk.			
The number of marriages in Northern Ireland in 2009 was 7,931.	N/A	NISRA	2009
In Northern Ireland during 2009 there were the following number of divorcees by area of residence: Male: 1,959; Female: 2.092.	Men and Women	NISRA	2009
In terms of childcare facilities at the University of Ulster; the majority of students using the facilities are female with dependants, single, aged over 25 years and Catholic. The majority are white and two have a disability/long term health condition. The majority are full time students.		University of Ulster - Review of Childcare Provision	2009
Domestic Violence: due to lack of access to public funds, women are having to choose between - living in destitution; - or returning to abusive relationships; - or returning to their home country.	Those without recourse to public funds experiencing domestic abuse.	No Home from Home - Northern Ireland Human Rights Commission (NIHRC)	2009

POTENTIAL SOLUTIONS WHERE OFFERED at regional or local level
NB: these are listed over and above the potential for legislative change

- Flexible Working - Bereavement Counselling - Training for Managers - Provision of CAB	- Paternity Leave - School Nurses - Maternity Leave - Respite facilities

- Offer of Creche facilities or childcare - Childcare vouchers - Staffcare - Trade Unions - Summer Schemes - Career Progression Programmes - Offer of flexible service provision - Childcare vouchers - Offer of support mechanisms - Diversity training - Training for Managers - Acute Mental Health Services - Befriending Services - Addiction Services - Work with NIHE, Housing Association - HYPE Project - Cross sectoral working	- Suicide Prevention Strategy - Working with Diversity Website - Development of appropriate acute mental health provision - Community Outreach - Accessible information - Parenting classes - Include in training for staff/social workers/Health Visitors - Health Promotion - Work with Learning Disability services - Sex Education - Health Visitors - Work with Community Groups - Research to gain further information

HSC AUDIT OF INEQUALITIES: EMERGING THEMES: DEPENDENT STATUS

The material presented here provides a brief summary only of the issues facing carers and those with dependants. This section needs to be read in conjunction with the more detailed section on carers and dependants as it represents a brief selection of some of the key issues. Other equally important issues are identified in the more detailed section, available from the Equality Unit of your organisation.

Note: An "exploration of the literature and other materials relating to carers and those with dependants" is a more appropriate term for the activity undertaken rather than referring to a detailed literature review which would require a more thorough and academically driven exercise.

What are the Equality/ Inequality Issues?	Potential solutions where these are offered in the literature Policy/Practice Issues?	Source of Evidence	Date
General Issues			
Caring occurs across all groups in society. Particular issues emerge because of, for example, carers' ethnicity, financial position, their health status, and their caring relationships. Despite this diversity carers want the same thing, sensitive, tailored support designed with their personal and work life needs, circumstances and their values and beliefs in mind. Despite developments carers still have limited recognition in their own right and rather are seen as a resource to older and disabled people. Carers are themselves twice as likely to be permanently sick and disabled.	A social contract for care which places the care given by family, friends at its centre but on that recognition of the shared obligation on public authorities to put in place an effective and integrated infrastructure of local support. Local support that upholds a set of core values ethics and beliefs, and accords carers the dignity and respect and all agencies recognising and including carers.	Carers, employment and services: time for a social contract - Report Number 6 University of Leeds, Yeandle and Buckner A picture of caring. Carers' stories, Carers NI and Equality Commission Report as part of Carers Week 2010 Carer's employment and services: why we need a social contract for care Professor Sue Yeandle, University of Leeds Carers NI Conference	2007 2010 2010

Updated information on carers in Northern Ireland produced in 2011. 1 in every 8 adults is a carer. In Northern Ireland there are 207,000 carers. 150 663 of these carers are people of working age. Carers save the Northern Ireland economy over £4.4 billion a year. This is more than the annual Health and Social Care spending in Northern Ireland. The main carers benefit is worth just £55.55 for a minimum of 35 hours which is £7.94 per day. One quarter of all carers provide over 50 hours of care per week People providing high levels of care are twice as likely to be permanently sick or disabled than the average person Any one of us has a 6.6% chance of becoming a carer in any year By 2037 the number of carers could have increased to 400,000 Approximately 30,000 people in Northern Ireland care for more than one person		www.carersuk.org/northernireland Extracted from website facts about carers	2011

The 2010 Northern Ireland Life and Times (NILT) Survey is the most current information source on carers in Northern Ireland. Based on 1205 people interviewed 26% indicated they had caring responsibilities a rise from 23% in 2006. The rise may be the first sign of the impact of the increasing proportion of older people on social care need. The down turn in the economy may have left more people available to provide care or support to family members. The survey pointed out however that this is clearly not a case of unemployed individuals finding carers allowance a more attractive option than Job Seekers Allowance. The low level of Carers Allowance makes this unlikely and this benefit is not available to those providing less than 35 hours of care per week.	Carers need assistance in order to protect their own financial security, health and well-being, and to have the same chance as anyone else of an ordinary life.	An Ordinary Life? Caring in Northern Ireland Today Helen Ferguson and Paula Devine E.S.R.C.(Economic and Social Research Update) www.ark.ac.uk/nilt	2011
Financial Implications of Caring			
Evidence on financial impact was drawn from the 2010 Northern Ireland Life and Times (NILT) Survey where 26% of 1205 respondents surveyed indicated that they had caring responsibilities. Asked about the relationship between their household's income and prices just over half, 63% carers compared, to non-carers 55%, indicated that their		Northern Ireland Life and Times Survey 2010 www.ark.ac.uk/nilt An Ordinary Life? Caring in Northern Ireland Today Helen Ferguson and Paula Devine E.S.R.C.(Economic and Social	**2010** **2011**

household incomes fallen behind prices. This was an increase from a figure of 31% in 2000. Whilst this reflects the economic downturn generally, carers were still statistically significantly more likely to report that their incomes had fallen regardless of the wider economy.		Research Update) www.ark.ac.uk/nilt	
This backs up findings from the research conducted amongst carers in UK "Carers in Crisis" This UK research revealed that carers are living under extreme financial pressures with many cutting back on essentials to make ends meet. They are finding it particularly difficult as the economic crisis spreads across the economy. Carers have however always found it difficult as, due to caring responsibilities, they have fewer opportunities to earn and are forced to live on benefits. In addition carers face additional cost associated with caring roles due to higher heating, water and transport cost. Many do not get support from social care. Without publicly funded care many are forced to arrange their own care which creates additional expense. The 2008 survey indicated the	Main recommendations from this report included: The UK government should publish a plan and timetable for ensuring that its 2018 vision that no carer falls into financial hardship because of their caring roles, as promised by the National Carers Strategy, becomes a reality The UK Government must urgently review and overhaul Carer's Allowance and other benefits for carers.	Carers in Crisis A Survey of carers' finances in 2008 Carers UK www.carersuk.org/professionals/resources/research-library/item/496-carers-in-crisis	2008

following findings: Based on 1,7000 carers 86% said their financial position was worse than in the 12 months previously. 74% reported struggling to pay essential utility bills and 61% were living in fuel poverty spending more than 10% of their income on fuel. 52% reported cutting back on food to make ends meet 66% were spending their own income or savings to pay for care 32% of those carers paying rent or mortgage said they could not afford it. 24% cut back on essential car journeys to go shopping or visit their G.P. 54% are in debt with almost one third reporting that they owe more than £10,000			
A more recent study by Carers UK 2011 of 4,242 carers carried out between September 2010 and July 2011"*The cost of Caring" how money worries are pushing carers to breaking point"* included responses from 102 carers in Northern Ireland. Over all the survey results indicated that responses came from the higher	Carers UK urges the Government to step in to take urgent action to better support carers:- Radical reform of benefits for carers which currently stand at £55.55 per week. Welfare reform - assess the impact of welfare reform on carers. Regular information campaigns Cross government work Health and well-being strategies.	"The cost of Caring" how money worries are pushing carers to breaking - Carers UK	2011

end of caring with 75% caring for more than 50 hours per week. 23% were caring for more than one person. Caring can come as a real cost to carers. The costs of caring can push many carers into debt. Over 4 in 10 (43%) said they were in debt as a result of caring. Financial hardship, debt and worries about money take their toll on carers' health. The impact was greater amongst some carers including those from Black and Minority Ethnic Groups and those parents caring for disabled children. Over all the survey also indicated that 76% of carers had suffered mental ill health as a result of caring. Of those carers who were in fuel poverty 84% reported that their health had also been affected. Poverty and ill health can push carers to breaking point leaving them unable to care. A similar and more recent survey from Carers Trust indicates carers struggle without support All figures are from YouGov Plc. Total sample size was 503 adults	Support carers to juggle work and caring responsibilities. Fuel poverty – need to recognise carers as a vulnerable group. Funding of social care. The limited number of carers who had accessed additional support or were slow to do so suggest that there is still limited awareness amongst carers of the services available to support them in their own right as carers.	Unpaid carers struggle without support - Key findings Carers Trust http://www.carers.org/news/new-research-finds-unpaid-carers-struggle-without-support	May 2012

who are unpaid carers surveyed 15th - 20th March 2012. • Almost two thirds (64%) of those polled said that apart from family and friends they have never accessed any other support or services such as respite breaks or counselling. • Six in ten (60%) of those that have been caring for more than five years have done so without accessing any additional support. • Of those who have sought out extra help, almost half (46%) did so after they were made aware that assistance was available specifically for carers. • Almost six in ten (59%) carers said that being a carer had a negative impact on their working life. • Almost six in ten (58%) of the carers surveyed said that their mental health has been affected by being a carer. • More than a quarter (27%) said both their physical and mental health has been adversely affected by their caring role	Greater attention is required on increasing awareness.		
Employment Issues			
In a typical workforce 1:9 male	Underlying the social contract for care must be	Carers, employment and services:	2007

workers and 1:7 female workers are already looking after someone who is sick, disabled or frail. Men who are in paid employment are more likely to be caring for a spouse or partner and women more likely to be caring for a disabled child or an older person. Women who are working part time are more likely to report that they are struggling financially to make ends meet. Currently 1:5 people (majority women) give up work to care. Many find it difficult to re-enter the employment field because of difficulties finding a way to combine work and care. This is a major financial loss to the individual and to the organisation. Women in paid employment are more likely to work from home or close to home. Carers are clustered in lower paid jobs and are less well qualified than other employees. The evidence base of carers in the workforce needs to be radically improved to ensure that carers get a	a set of legal and fiscal frameworks which the state has a responsibility to put in place. These frameworks must guarantee carers the right to equal treatment and protect them from discrimination and social exclusion. It should create a financially secure environment which enables care to be given without asking carers to pay the unacceptable price of low income or poverty in return. It should respect the dignity of carers. Sound equalities legislation is required to challenge discrimination. See also the “discrimination by association” case law as evident in the Coleman Case. Carers should have access to one-one-one support from employment services which recognises complexity of their situation without the threat of punitive sanctions which can add to their stress.	time for a social contract - Report Number 6 University of Leeds, Yeandle and Buckner Tipping point for care. Time for a new social contract Carers UK Background to Coleman Case, Carers NI Real change not short change. Time to deliver for carers, Carers UK	 2010 2008 2007

fairer distribution of resources and services.			
Section 75 of the Northern Ireland Act 1998			
General			
In Northern Ireland unlike any other Section 75 Equality Category no other legal protection exists for carers. The diversity of carers is evident across the section 75 equality categories.	Direct and sustained Government interventions. Sound equalities legislation required which challenges discrimination.	Carers NI Effectiveness of Section 75 The Equality Bill and Carers - Carers UK	2007 2009
Carers give so much to society yet, over the years, research in Northern Ireland and beyond has shown that they are prone to poor health, social isolation and poverty because of their caring role.	The data confirm that carers need assistance in order to protect their own financial security, health and well-being, and to have the same chance as anyone else of an ordinary life.	An Ordinary Life? Caring in Northern Ireland today –Research Update – ARK – http://www.ark.ac.uk/publications/updates/update75.pdf	2011
During quarter ending 31 December 2012, 1,081 Carers' Assessments were completed, similar to that in the previous quarter (1,072), and 1,411 Carers' Assessments were declined, a 9% increase on the previous quarter (1,290);		Carers Statistics for Northern Ireland – http://www.dhsspsni.gov.uk/index/stats_research/stats-cib/statistics_and_research-cib-pub/adult_statistics/carers_statistics.htm	2012-2013
Age			
As a result of demographic changes recent figures suggest that we are seeing as expected a progressive increase in the proportion of carers in the older (55+) age group This progression is however slow and steady rather than dramatic with		An Ordinary Life? Caring in Northern Ireland Today Helen Ferguson and Paula Devine E.S.R.C.(Economic and Social Research Update) www.ark.ac.uk/nilt	2011

carer most often provided by those aged 35- 54 age.			
There are differences according to age in the proportion of men who are carers. The lowest proportion is men aged 25-34 years (135) whilst the highest is among men aged 55-64 (29%)		Paula Devine Men in Northern Ireland: Report 7 Men as carers E.S.R.C.(Economic and Social Research Update) www.ark.ac.uk/nilt	
Young carers who are adults aged 16- 24 have particular needs. This is a hidden and neglected group of carers.		Young Adult Carers in the UK. Experiences, Needs and Services for Carers aged 16-24 Years, Saul Becker and Fiona Becker	2011
The data from the 2010 Young Life and Times survey provides an extensive snapshot of et lives of young carers in Northern Ireland. A young carer was defined as a 16 year old whose life is significantly affected by caring for a family member who has an illness due to a mental health issue, disability or has a problematic use of drugs or alcohol. Caring by the young person related to washing, cleaning dressing,	Young carers' projects and adult carers need to consider how to provide seamless services to this group of carers. This is important for after they reach 18 years. Needs to be more evidence in carers' strategies of young adult carers.	Young Carers Too Paula Devine and Katrina Lloyd E.S.R.C (Economic and Social Research Council) www.ark.ac.uk	2008 2011

cooking or watching over some one. Caring can be one or a combination of these tasks. Of the 786 young carers who took part in the survey, 10% indicated that they provided care. A slightly higher proportion of females than males had caring responsibilities at the time of the survey (11% and 8% respectively though this difference is not statistically significant. There is an association between caring and income in that young carers are more likely to come from less well-off families. In addition young carers are more likely to attend secondary school rather than grammar school (51 % and 39% respectively) The person most frequently cared for is a grandmother (35%). A slightly lower proportion care for their mother (30%) and father 17%. But young carers were also caring in some instances for a number of people. Lack of support or outside help often means that young carers and their families may not be referred to relevant organisations.		Young Carers Too Paula Devine and Katrina Lloyd E.S.R.C (Economic and Social Research Council) www.ark.ac.uk	

This may reflect an unwillingness of young people to discuss their family life, or their caring role with others. Whilst 61% said that they had discussed it with an outsider this leaves 40% of young carers who kept it private. Whilst there are many positive aspects of caring young people identified that restricting their free time and worrying about the person cared for impacts them emotionally. Lack of clarity about what Social Services can offer or possibility a lack of willingness to engage social services was a feature in the study findings. A recent longitudinal study of young people aged 13-14 years who are carers was published in 2013. This was based on 15,000 pupils. This based on evidence from England it was suggested that in comparison with their peers there is huge differential impact. A summary of findings indicates: This is particularly felt in relation to educational attainment and future employment opportunities. This study revealed 1:12 care for more than 15 hours 1:20 miss school because of caring	Organisations to view young carers as people who may need support rather than a resource to fill in gaps in services. More evidence is required. Cross sectional data on young carers from surveys such as the Young Life and Times survey are useful they cannot tell us anything about the longer term consequences of caring. More longitudinal studies are required. The voice of young carers needs to be profiled More young carers in focus partnerships should be considered There needs to be Young Person's Champions to help young carers gain the skills, resilience and confidence	Hidden From View The experiences of young carers in England http://www.childrenssociety.org.uk/news-views/press-release/report-reveals-impact-young-carers	2011 2013

responsibilities Young carers are 1.5 more times likely to be Black, Asian or from other minority ethnic backgrounds and do not speak English as a first language They are 1.5 times more likely to have special educational needs The Average household incomes are on average £5000 less than those of their peers No evidence to suggest that they are more likely to be in contact with support agencies.	There needs to be more consolidation of adult and children's legislation A legal framework for the protection of young carers is needed		
	Of the 1,081 completed assessments, 96% (1,040) related to adult carers and 4% (41) to young carers under 18 years		
	All young carers with completed Assessments were aged 16-17, and of the 1,040 adult carers, 61% were aged 18-64, 27% were aged 65 - 74, and 12% were aged 75 and above		
	In the quarter ending 31 December 2012, 34% of young carers assessed were caring for other children with 66% caring on for adults;		
Gender			
In the total population in Northern Ireland 23% of men are carers compared with 30% of women Of all carers in Northern Ireland 60% of carers are female and 40% are male		An Ordinary Life? Caring in Northern Ireland Today Helen Ferguson and Paula Devine E.S.R.C.(Economic and Social Research Update) www.ark.ac.uk/nilt	2011

Similar proportions of men as women provide care for someone in the same household however women are more likely to care for some on living in another household Women have a 50:50 chance of providing care by the time they are 50. Men have this chance by the time they are 74. Male carers in the workplace are more likely to care for a spouse or partner. Women are caring for those with additional needs in additional to the usual family caring responsibilities. Different needs for services exist for male carers as for female carers.		A picture of caring. Carers' stories, Equality Commission and Carers Northern Ireland As part of Carers Week 2010	2010
There is a dearth of information on the needs of fathers who care for their disabled children including fathers from black and minority ethnic groups and single fathers. There is an inadequacy in service knowledge based practice within adults' services and children's services relating to groups of disabled parents.	Examination of the potential to redress the gap in policy and research with regard to the specific needs of fathers with caring responsibilities.	SCARE Briefing, Social Care Institute For Excellence	2005

As parents get older there is evidence that the caring role gets reversed. Parents with a learning disability are least likely to have access to accessible information about services and support.			
Disability			
There is an inadequacy in service knowledge based practice within adults' services and children's services relating to groups of disabled parents. More research is needed on groups of disabled adults who care, particularly adults with learning disability who care for their children or who care for older parents. As parents get older there is evidence that the caring role gets reversed. Parents with a learning disability are least likely to have access to accessible information about services and support. Negative attitudes or anticipation of negative attitudes can act as a barrier to people seeking support from social services. Parents with mental health problems, drug or alcohol or learning disabilities are reluctant to seek help for fear of having their children taken	More research is needed on groups of disabled adults who care, particularly adults with learning disability who care for their children or who care for older parents. Needs arising from impairment and illness and other disabling barriers should be addressed before making judgements about parenting capacity. Accessibility issues in provision of information need to be considered	Supporting disabled parents and parents with additional needs. Review number 11, Social Care Institute of Excellence Working together to support disabled parents, Social Care Institute of Excellence	2006 2007

into care. The secrecy of drug and alcohol misuse can mean that parents are not getting the support they need or and some children may be living in risk situations. There is also a stigma attached to HIV and Aids. This can mean that parents are reluctant to seek or say why they need support. Parents with learning disability and other disabilities least likely to have information provided in a way that meets their particular needs.			
Dependants			
The Northern Ireland Life and Times Survey invited carers to say who they cared for. It is important to note that carers are often caring for more than one person but the person most often cared for is a parent or a parent in law. Both men and women provide area for a wide range of family members which includes, spouse, partner or child including step and foster children.		An Ordinary Life? Caring in Northern Ireland Today Helen Ferguson and Paula Devine E.S.R.C.(Economic and Social Research Update) www.ark.ac.uk/nilt	2011

However a higher proportion of women than men care for a parent or parent in law. Caring is very much a family affair with just 6% of carers providing care to a friend or neighbour **Forthcoming study** The needs of carers of people with advanced heart failure will be the focus of new research carried out by University of Ulster academics University's Institute of Nursing and Health Research Dr Sonja McIlfatrick and Dr Donna Fitzsimons from the University's Institute of Nursing and Health Research have been awarded over funds to carry out the all-Ireland project. In support of the research Dr McIlfatrick suggested that there is compelling evidence, from local and international sources that end of life care should be improved for patients with heart failure and their carers," "We know that carers are likely to be disadvantaged and shoulder significant burdens, but the impact of these on the carer experience or patient outcomes have not been	Await the results of the study	**For further information, please contact:** University of Ulster Sinead Johnson Telephone: 028 9036 8390 Email: s.johnson@ulster.ac.uk	

identified. Therefore research in this area is urgently needed to inform practice. “In a recent review of family caregiving at end of life, 49 per cent of studies focused on cancer and none of the studies stated a focus on cardiac populations. “A recent study indicated that family caregivers for people with heart failure had not heard of the term ‘palliative care’ but would be receptive to an offer of palliative care at some point during the disease trajectory. Consequently, family caregiving has been identified as a top international research priority in end of life care.”			
Sexual Orientation			
(CMIT, 2010). Wintrip (2009) found that older LGB carers of people with mental health difficulties faced a lack of support from mainstream services. Networks and communities can be a useful resource for lesbian, gay and bisexual carers useful for emotional and practical support. However evidence suggests that existing networks cannot always be relied upon and additionally there may be unequal access to these networks.	More research into aspects of caring by gay, lesbian and bisexual people should be undertaken	Wintrip Report on Research about LGBT (Lesbian, Gay, Bisexual and Transsexual Carers) Count me in too, Nick McGlynn , Leela Baski and Kath Brown	2009 2010

Carers fear prejudice from service providers, service users or from other carers. Existing research suggests that a significant proportion of older LGB individuals may have caring responsibilities (25% of 50+years' respondents in a study by Hubbard and Rossington, 1995). Outside of HIV services the needs and experiences of LGB carers are under-researched in the UK In their work with older LGB caring couples, Cronin and King (2010) revealed dynamic relationships where the roles of carer and cared for were often blurred, consequently the authors argue for the importance of practitioners recognising the often interdependent nature of LGB caring relationships. More needs to be done regarding the position of LGB carers. An example is where lesbian carers may lack recognition of their partnership by services, and therefore face multiple issues in caring for their partners (Manthorpe, 2003). **LGB practitioners and services**	This paper points to recent changes and improvements in legislation, policy, research and practice that offer promise for improving service delivery for older LGB service users. The rise of the inclusion of sexual orientation in health and social care policies, surveys, administrative data and guidance, means that the assumption of heterosexuality is changing, as the diversity of sexual orientation is becoming recognised. For example, in policy on carers, there are signs of positive change: 'Caring with Confidence', funded by the Department of Health, part of the National Carers Strategy and the 'New Deal for Carers', makes explicit its commitment to LGBT carers by working with a range of LGBT organisations to provide 'Caring with Confidence' face-to-face sessions for carers in the north west and south east of England. The DH appointed a national Lesbian, Gay, Bisexual and Transgender Advisory Group,	CMIT- McGlynn (CMIT) Count me In Too. University of Brighton Cronin and King A Queer kind of Care : Some preliminary notes and observations Jill Manthrope Nearest and Dearest? The neglect of lesbians in caring relationships. British	2010 2010 2003

Some older LGB people would prefer exclusive LGB services, in the belief that in such an environment they would have more in common with other users of services. For other older LGB people, this is less often issue but they would still like their LGB identity to be recognised and valued within a 'gay friendly' environment. For others, their sexual orientation is private, and nothing to do with care providers (Gulland, 2009; CCSI, 2008). Fundamentally, these responses point to the issue of choice in service provision, which reflects their own sense of sexual identity, how they have lived their lives, and very importantly, how they wish to continue to live their lives. There is a need to open a dialogue over these issues in order to better understand the different needs and preferences of this diverse group. There is little evidence on the role of 'out' LGB practitioners within services to older people. In other areas of health and social care, the existing	and states that it places at the centre of its work LBGT people who use and deliver health and social care services, in order to ensure opportunities for their experiences to inform service development and improvement. There has been a rise in the provision of important guidance that focuses specifically on improving provision for older LGB health and social care users (e.g. Bayliss, 2000; Concannon, 2009; Price, 2008; Fenge *et al.,* 2008; Langley, 2001; Pugh, 2005; Pugh *et al.,*2007) although it is clear there is a need for further and more comprehensive guidance on LGB issues for those engaged in services to older people. Added to this a need to develop channels of communication for the sharing of good practice between different sectors and disciplines in respect to working with older LGB service users has been identified. .	Journal of Social Work 33, 6. 753-768 A Gulland Direct Payments -letting down gay services Commission for Social Care Inspection (CSSI) Putting people first: Equality and Diversity matters – Providing appropriate care for lesbian, gay and bisexual and transgender people. In Focus Issue Number 7	2009 2008

evidence on LGB practitioners points to their own experiences of discrimination in the workplace, for example by being advised not to come out to clients (Hunt *et al.,*2007; Abbot and Howarth, 2005). Yet,‘ out’ workers can be an important resource in supporting LGB service users (Quam, 2007), while formally appointed champions of LGBT issues can also help to influence positive change within care organisations (CSCI, 2008).		R Hunt and A Minskey Reducing Health inequalities for lesbian, gay and bisexual people: Evidence of health care needs. Stonwall London D Abbot and J Howarth – Secret Loves, Hidden Lives? Exploring issues for people with learning difficulties Commission for Social Care Inspection (CSSI) Putting people first: Equality and Diversity matters – Providing appropriate care for lesbian, gay and bisexual and transgender people. In Focus Issue Number 7 Also referenced in Richard Ward, Stephen Pugh and Elizabeth Price Don’t look back? Improving health and social care services delivery for older LGB users	2007 2005 2008 2011
Black and Minority Ethnic Groups			
Employed people both men and women in the Pakistani, Bangladeshi	Minority ethnic carers linked to gender and age.	Who Carers Win: The social and business benefits of supporting	2006

and Indian communities have particularly high rates of caring. Younger Pakistani and Bangladeshi men are three times more likely than white British men to be carers and among younger Bangladeshi. Overall the age profile differs between the Black and Minority Ethnic Carers where there is mostly a younger profile when compared with the white population. Socio economic factors impact on minority ethnic carers who on average have relatively low incomes not least because of the younger age profile.	More research may be needed in relation to Northern Ireland.	working carers, ACE National; Action for Carers; Yeandle, Bennett, Buckner, Shipton and Suokas Diversity in Caring. Towards equality for carers, Yeandle, Bennett, Buckner, Fry and Price, University of Leeds	2007
There are a number of particular challenges facing carers from black and minority ethnic groups These include: Stigma of caring. Language and literacy barriers. Cultural barriers which hinder access to services. Particular barriers faced by refugee-legal issues. Non-black and minority ethnic support groups - assumptions often made that groups would prefer support groups of people from own culture which is not necessarily always the case.	The screening and equality impact assessments are an ideal opportunity to look at the combined impact of caring and race issues. Commissioning of specialist services Made more use of outcomes of the National Carers Survey See Black and Minority Ethnic Tool Kit which offers a framework for commissioners of public services. Examples are London based but offer good practice which may have some relevance.	Black and Minority Ethnic Toolkit – interactive toolkit to look at how local authorities are working to improve the lives of black and minority ethnic carers in London Carers NI – Joint Improvement Partnership	2011

Many carers prefer mainstream services. Misconceptions about extended family support networks Faith is not always explored in relation to black and minority ethnic issues. Lack of strong black and minority ethnic carer voice so needs are often over looked.			

HSC AUDIT OF INEQUALITIES: EMERGING THEMES: DISABILITY

Within the health and social care field, much work has already been done to promote equality of opportunity amongst disabled people, through the continued implementation of the Disability Discrimination Act 1995, Section 75 of the Northern Ireland Act 1998 and the new 'Disability Duties'. However, ongoing engagement with representative groups and examination of key research and reports has indentified the following emerging themes. The ongoing engagement with representative groups has included RNIB, Action on Hearing Loss (RNID), British Deaf Association (BDA), Disability Action, Employers Forum on Disability NI, Disability Advisory Service, Mencap, Northern Ireland Union of Supported Employment (NIUSE).

What are the Equality/ Inequality Issues?	Potential solutions where these are offered in the literature Policy/Practice Issues?	Source of Evidence	Date
For Service Users			
Action on Hearing Loss (RNID) estimates there are 202,000 people with mild to moderate hearing loss in Northern Ireland. 140, 000 are over 60. 17,000 people in NI are severely or profoundly deaf. About 55% of people over 60 – in the UK – are deaf or hard of hearing.		www.rnid.org.uk/information resources/factsheets/deaf awareness/factsheets leaflets/facts and figures on deafness and tinnitus	
People with learning disability are 58 times		Extract from Mencap internal paper	Dates

more likely to die before the age of 50 than the general population and that they are more likely to die from things that could have been prevented. Life expectancy is shortest for those with the greatest support needs and the most complex or multiple conditions. Almost half of all people with Down's Syndrome have congenital heart problems, a much higher rate than the rest of the population, and they have a higher risk of developing Alzheimer's disease and a higher risk of gastrointestinal problems and concerns than the general population. People with a learning disability are more likely to have an associated physical or sensory disability and more likely to experience mental health difficulties. Whilst people with a learning disability have a similar overall rate of admissions they remain a shorter time in hospital compared to the rest of the population. People with a learning disability are less likely to access health screening services, people with a learning disability and diabetes have fewer measurements of their BMI and those who have had a stroke have fewer blood pressure checks.		refers to: Mortality in people with learning disability: risks, causes, and death certification findings in London' Hollins, Attard, von Fraunhofer and Sedgwick, Developmental Medicine & Child Neurology. 1998; (40): 50-6. State of Healthcare 2008, Healthcare Commission 'The influence of intellectual disability on life expectancy', Bittles et al, Journal of Gerontology Series A Biological Sciences and Medical Sciences, 2002; 57(7):470-472. 'Population based study of the prevalence and presentation of dementia in adults with Down's syndrome', Holland *et al*, British Journal of Psychiatry, 1998; (172):493-8. Cancer and learning disability, Cooke LB, Journal of Intellectual Disability Research, 1997; 41(4):312-316.. 'State of Healthcare 2008', Healthcare Commission 'Review: Sensory impairments, intellectual disability and psychiatry', Carvill, Journal of Intellectual Disability Research, 45, 467-483, 2001 Elliott J, Hatton C, Emerson E. The health of people with learning disabilities in the UK: evidence and implications for the NHS. Journal of Integrated Care. 2003; (11): 9-17 and Mental health nursing of adults with learning disabilities. Royal College of Nursing, 2007. Doody GA, et al. 'Pfropfschizophrenie' revisited. Schizophrenia in people with mild learning disability. British Journal of Psychiatry. 1998; 173(2): 145-153. Allington-Smith P. Mental health of children with learning disabilities. Advances in Psychiatric Treatment. 2007; 12(2): 130- 137. Mansell J. Services for people with learning disabilities and challenging behaviour or mental health needs. Department of Health. London. 2007. Healthcare Commission – State of Healthcare 2008 Messent PR, Cooke CB, Long J. Physical activity, exercise and health of adults with mild and moderate learning disabilities'.British	included with reference

People with a learning disability are less likely to be given pain relief and less likely to receive palliative care[1]. People with a learning disability have extensive reliance on health and social care services from birth There is historical segregation and underfunding of learning disability services and an increasing ineligibility of children, young people and adults with a mild and moderate learning disability to learning disability services People with learning disability, and their families, face difficulties in accessing and benefiting from mainstream and specialist services and support.		Journal of Learning Disabilities. 1998; 26:17-22 (and Disability and Rehabilitation. 20(11):424-7. Cochrane Register) and Emerson E. Underweight, obesity and exercise among adults with intellectual disabilities in supported accommodation in Northern England. Journal of Intellectual Disability Research. 2005; 42:134-143. Mir G, et al. Learning difficulties and ethnicity. Department of Health. London. 2004. Tuffrey-Wijne I, Hogg J, Curfs L. End of life and palliative care for people with intellectual disabilities who have cancer or other life-limiting illness: a review of the literature and available resources. Journal of Applied Research in Intellectual Disabilities. 2007; 20(4): 331-344. Ahmed N, et al. Systematic review of the problems and issues of accessing specialist palliative care by patients, carers and health and social care professionals. Palliative Medicine. 2004; (18): 525-542. Morgan C, Ahmed Z, Kerr MP. Health care provision for people with a learning disability: record-linkage study of epidemiology and factors contributing to hospital care uptake. British Journal of Psychiatry. 2006; (176): 37-41. Davies N, Duff M. Breast cancer screening for older women with intellectual disability living in community group homes. Journal of Intellectual Disability Research. 2001; (45): 253-7. Health needs assessment report: people with learning disabilities in Scotland. NHS Improvement Scotland. 2004. Count Me In Tuffrey-Wijne I, Hogg J, Curfs L. End of life and palliative care for people with intellectual disabilities who have cancer or other life-limiting illness: a review of the literature and available resources. Journal of Applied Research in Intellectual Disabilities. 2007; 20(4): 331-344.	
	• The screening programmes should work with internal and external stakeholders to engage with community groups representing “hard to reach” groups to promote screening and discuss accessibility of screening.		

	• The options for simplifying the bowel cancer screening process for people with physical or sensory disabilities should be reviewed. • Informed choice in cancer screening should be promoted through Sound Vision Ulster, a radio programme for blind people. • Cancer screening information should be available in alternative formats to meet the needs of blind and partially sighted participants. • The screening programmes should liaise with voluntary organisations, and their staff, who regularly meet with people with a physical or sensory disability to ensure they are aware of the cancer screening programmes and can pass on information and encourage uptake.		
Around 60% of those who become ill or disabled were in employment a year before onset of disability, which then fell to about 46% in the year of onset of the illness or disability, with the employment rate falling again one year after onset of illness/disability to approx. 40%.		Brenda Gannon and Brian Nolan, The Dynamics of Disability and Social Inclusion - Equality Authority and National Disability Authority, ROI (taken from the Living in Ireland Surveys 1995 to 2001)	1995 - 2001
Deaf community's need for improved communication.	Establish a working group to develop a regional sign language interpreting service - modelled on the good practice evidenced from the HSC Regional Interpreting Service (for minority language users). DAP Communication Workstream to	HSSPS Literature Review Access to Public Services for Deaf Sign Language Users (Action on Hearing Loss (RNID) and BDA)	2001 and 2004

	develop regional guidelines on accessible appointment processes.	Ongoing feedback from deaf community through DAP Communication Workstream	
Lack of accessible information on available services.	DAP Communication Workstream and Accessible Formats Groups to develop comprehensive guidelines on accessible information for disabled people.	HSSPS Literature Review Access to Public Services for Deaf Sign Language Users (Action on Hearing Loss (RNID) and BDA) Feedback from DAP Communication Workstream	2001 and 2004
Lack of available information for parents regarding child's disability.	Develop information base for all HSC websites on wide range of disabilities.	HSSPS Literature Review	2001 and 2004
High rates of mental ill health among LGBT service users.	Work in partnership through the Regional Sexual Orientation Working Group to improve specific training and development for health and social care staff.	HSSPS Literature Review Regional Sexual Orientation Working Group	2001 and 2004
Under representation of disabled people in current workforce.	All health and social care organisations to approve and implement the Regional Framework on the Employment of Disabled People.	ECNI Survey re: Public Attitudes to Disability in Northern Ireland Health and Social Care workforce monitoring Evidence gathered through DAP consultation processes Equality Commission Conference – 'Key Inequalities'	2001 October 2007
Roughly two thirds of respondents did not believe that employers do enough to meet the needs of disabled people		ECNI Survey re: Public Attitudes to Disability in Northern Ireland	2001
Most respondents disagreed that there is a fair representation of disabled people in more senior jobs.		ECNI Survey re: Public Attitudes to Disability in Northern Ireland	2001
Lack of understanding of disability and	Education for staff to recognise the diverse	HSSPS Literature Review	2001 and

diversity and multiple identities – access problems may be specific to certain types of disability e.g. learning disabilities, mental illness. The inability of health and social care providers to recognise the heterogeneity of people with disabilities often has a profound effect on the capacity of people with disabilities to access appropriate health and social services. Negative attitudes towards the person with the disability. Undeniably the HPSS have through their S75 duties made significant progress towards creating equality in access to health & social services for people with disabilities	needs of people with disabilities – renewed emphasis on disability awareness training. Involve people with a disability in the designing and service delivery – identify models of good practice – encourage membership of self-advocacy groups for persons with a learning disability in order to develop their self-confidence and their skills to talk and be listened to. Lack of clear, consistent and comprehensive information on the prevalence of disability in NI – the collation of detailed information is crucial in order to identify areas of inequality and needs and to target services accordingly.		2004
Lack of wheelchair access – lack of information on available services - lack of information in alternative formats e.g. Braille, audio cassettes and pictorial for people with a learning disability. lack of adaptations and equipment on the grounds of cost – inconsistencies in level of support e.g. less support for people with mental health difficulties. Inadequate transport to and from health care facilities – lack of consultation on policy and decision making. Inadequate information, advice and support on sexual health and reproduction – assumptions that disabled people are not sexually active – denied access to appropriate sexual health services e.g. cervical screening, information on sexually transmitted diseases, family planning services etc. Lack of sex education within day centres and special schools – inadequate access to services. Lack of	The HPSS should conduct a study and needs assessment in co-operation with Disability groups – design and deliver specific audience sex education and health programmes for people with disabilities to be delivered in special schools, day centres, health centres etc. – design and promote a range of materials on sexual health and disability in a range of formats with information on how and where to access appropriate services or further advice.	HSSPS Literature Review	2001 and 2004

ramp, inaccessible treatment rooms, toilet facilities, large print signs. Lack of advice in appropriate formats e.g. for people with a learning disability. Potential abuse of vulnerable adults, children and young people due to lack of knowledge and information – information for those who acquire a disability during their lifetime.			
Issues relating to learning disability: Attitudes of others about their ability to participate and contribute to policy making and decision making. Absence of information in alternative formats. Need to support people during and after participation. Lack of transport which prevents participation. Limited range of activities available in day centres – should involve mixing with non disabled people also. Embarrassment of marked transport to and from centres – transport problems of rural areas, Reduction of number of available places in day centres. Lack of information to make informed choices. Particular doctors not listening to their wishes about medication. Inaccessibility of accident and emergency procedures e.g. too long a wait for appointment, fear of blood, noise and crowds. Lack of advocacy and support to include people with learning difficulties into the economic and social life of the community. People with learning disabilities more likely to experience weight problems both obesity and low weight. Inadequate levels of funding for therapy services such as speech and	Review of day centres and assessment of activities provided. Review the accessibility of A&E and information in a range of formats e.g. Braille, large print, audio cassette and plain English etc. Encourage a culture of volunteering to support their inclusion into the community Develop healthy living packs in accessible formats tailored to meet the needs of both children and adults with a learning disability. Involving partnership with persons with a learning disability their families and carers in the planning and implementation. HPSS should work in partnership with people with learning disabilities their families and carers to develop a range of support living and leisure opportunities.	HSSPS Literature Review	2001 and 2004

language therapy, physiotherapy and occupational therapy.			
Mental Health Issues – services are not designed around the needs of the service user. Psychiatric services are often in non-therapeutic environments and negative ward environments. Lack of access to crisis intervention services and multi-disciplinary community based support. Lack of access to relevant information, diagnosis, treatment options, access to services, admissions, discharge, accommodation, benefits. Lack of access to mental health services for children and adolescences. Lack of access to appropriate support for victims of violence in NI.	Ensure service users are involved at all levels of decision making including planning of services. Admission to hospital should be last resort, effective community based alternatives should be explored. Access to appropriate information to make informed choices, targeted at people with mental health problems. Complaints procedure must be accessible. Develop specialist mental health services specifically targeted at children and young people.	HSSPS Literature Review	2001 and 2004
NI is increasingly becoming a multi-ethnic society which includes Travellers, Migrant Workers, Asylum Seekers and Refugees – disabled people from these groups are largely invisible. Disabled people are often presented as a homogeneous group and therefore ethnic and other differences are largely ignored - there is a tendency to perceive asylum seekers and refugees as able bodied. Many disabled people from BME groups are unaware of services available to them – inability to meet and interact with other BME disabled people – stigmatisation of disability within some BME groups may prevent disabled person from participating in society. Some BME families reluctant to access services believing the care of	HPSS in co-operation with disability groups and BME groups should commission a needs assessment and research and identify the health and social care needs of disabled persons from BME communities. Work to establish BME disabled groups in NI and refer clients to these groups for support and advice. Build a relationship of trust with BME disabled persons to encourage them to access services they require. Produce information packs and a media campaign in alternative formats. Conduct regular collection of data in order to plan and monitor service delivery.	HSSPS Literature Review	2001 and 2004

the disabled person was a family responsibility. Many reluctant to access health and social services due to fear, suspicion or distrust from past experiences in other countries (particularly asylum seekers and refugees). Asian people less assertive in accessing services, less likely to complain and less likely to reapply when service is initially denied.			
Children and Young People with a disability – parent's lack of knowledge regarding their child's disability or condition. Parental relationship strain and family breakdown – social isolation for children, young people and their parents – additional expense regarding special diets, clothing, equipment. Adaptations - more modern alternatives requested. Undue effort involved in obtaining appropriate services – access to services complicated. Services provided across different programmes of care. Need for more flexible, comprehensive and family based respite services focused on the needs and wishes of disabled children and young people.	Promote independent living. Conduct a needs assessment regarding domestic assistance to parents and carer's. Consultation with children and young people themselves to ensure services are acceptable to them. Develop robust information systems and registers to facilitate adequate assessment and planning of needs. Develop an information base, websites, information packs on a wide range of disabilities and impairments for parents and carer's. Assessment of needs and support for parents of newly diagnosed children with disability or impairment.	HSSPS Literature Review	2001 and 2004
"Coming out" to health and social care professionals is even harder for disabled people. Lack of understanding of health and social care staff. Lack of access to appropriate sexual health advice. Profound social isolation of LGBT disabled people living in residential accommodation	Improved training and development for staff to understand the experiences of LGBT disabled people. Provision of concise information. Support the capacity of grass roots networking organisation to bring together LGBT disabled people in order to identify and address their difficulties including the problem of social	HSSPS Literature Review	2001 and 2004

	exclusion.		
Disabled women are more likely to have low levels of physical activity than non disabled women – obesity is a significant problem. Little known about effects of menopause or the treatment of its symptoms on disabling chronic conditions. Lack of information on fertility problems. Less likely to receive information on sexual and reproductive health. Assumptions by health care providers that they are not sexually active. Less likely to receive breast or cervical cancer screening.	Health promotion campaign specifically targeted at disabled men and women focusing on encouraging an increase in appropriate physical activities and addressing the problems of obesity. Create information packs, leaflets, web pages providing concise information including information on services on disability and the menopause. Conduct a needs assessment of disabled women in relation to gynaecological and obstetric care. Review pre and post natal care and identify areas for improvement.	HSSPS Literature Review	2001 and 2004
There is an absence of research and monitoring information which would allow HSC organisations to identify and address the inequalities experienced by groups that remain largely invisible and hard to reach.		Audit of Learning Disability in Northern Ireland - University of Ulster at Jordanstown (UUJ)	2004
Children, young people and adults with a learning disability do not have access to the same range of services and opportunities as other people in NI.		Equal Lives; review of policy and services for people with a learning disability in Northern Ireland - DHSSPS	2005
Disabled women have particular difficulty accessing key service such as productive health care and screening		Statement of Inequalities NI - ECNI	2007
Disabled people continue to be confronted by real obstacles to participation in society … people with mental health difficulties are particularly vulnerable and can face isolation.		Mr B Collins - Keynote Speech at ECNI Annual Conference	2007
Access to transport is highly relevant to Health Inequality for Disabled People ...	Take this into account when planning services.	Statement on Key Inequalities in Northern Ireland	2007

they are less likely to have access to a car than other households. This has a particularly profound effect on those living in rural areas.		- ECNI WHSCT Audit of Sensory Support Services for People with Hearing Impairment	 2010
Inappropriate communication support for people with Learning Disability when accessing GP and Acute Services.	Be more proactive in this area	ECNI Investigation into Accessibility of Health Information in Northern Ireland for People with a Learning Disability	2007
The employment rate for those without disabilities (79%) is over twice that of people with disabilities (32%)		Mr B Collins - Keynote Speech at ECNI Annual Conference	2007
Although almost one in five persons (18%) of working-age are disabled in NI, in 2006 only 3% of appointees to government public appointments were disabled.		Mr B Collins - Keynote Speech at ECNI Annual Conference	2007
People with a learning disability and people with mental health problems need to have a say about the services they get. Their families and carers need to be part of this.	People must get the information they need to have choice and control in their lives. Involving people must be part of everything we do in health and social care services.	Bamford Review	2007
Health and Social Services Board and Health and Social Care Trusts need to have a way of asking people what they want. They need to have services that are local and meet people's needs. Services need to fit around people, not people fitting into a service because that is all there is in their area.	Health and social care services need to be reorganised to make sure this happens. In each region there will be someone who is responsible for making sure that services are set up in a way that works well for the people who will use them.	Bamford Review	2007
Poor communication between healthcare staff and people with a learning disability. A lack of understanding of the health needs of people with a learning disability.	A strategic approach to the development of a range of accessible written health information should be adopted and led by the DHSSPS. This will require:	ECNI Formal Investigation into The Accessibility of Health Information in Northern Ireland for People with a Learning	2007

A lack of relevant written information provided in an accessible format.	A standardised DHSSPS policy and procedure for producing and distributing written information which is accessible for people with a learning disability. Identification of priority areas of health information important to people with a learning disability. The development of an easily accessed central source for all such information. The development of a systematic approach to ensure that people with a learning disability and their representative organisations are involved from the beginning of the process of preparing such accessible information. Development of a specifically tailored appointment letter across the Health and Social Care Service for use when inviting a person with a learning disability to a medical appointment. In addition, consideration should be given to providing the person with further accessible information about the service when appointments are made. A passport system is developed to give people with a learning disability the option to identify their particular communication needs when accessing health services.	Disability	
People with mental ill health viewed most negatively compared with physical or learning disability, resulting in people with mental ill health being particularly vulnerable and isolated.	Effective implementation of Module 4 of Discovering Diversity and Regional Disability Etiquette Guide	HSSPS Literature Review Equality Awareness Survey - ECNI Bamford Review Equality Commission	2008 October 2007 October

		Conference – 'Key Inequalities'	2007
Both BDA and Action on Hearing Loss (RNID) receive feedback and complaints from members of the sign language community on a regular basis on access issues and past research carried out by Deaf organisations has pointed to the need for improved access to public services. For example, 77% of BSL users who had visited hospital could not easily communicate with NHS staff and 49% of Deaf and hard of hearing people who had used Jobcentre Plus found that staff were not Deaf Aware.	Frontline health professionals to receive Deaf Awareness training. The installation of visual display alerts in GP and hospital waiting rooms to notify patients of their name being called was recommended. The use of a pager system in a hospital setting should be explored – the Deaf person is given a pager upon arriving and when their appointment is called they are notified by a vibrating pager.	Access to Public Services for Deaf Sign Language Users (Action on Hearing Loss (RNID) and BDA)	2009
Across NI the Deaf community identified very similar issues, with health and employment being the main focus, followed by transport, benefits and services such as rates and council services. Two key problems emerged: the current lack of fully qualified sign language interpreters to provide communication support to enable people to access public services, and attitudinal barriers.	Health service providers to provide alternative methods of making contact, to include text messaging, email and fax and for these details to be promoted to patients. Also to provide an option to book an appointment by email.	Access to Public Services for Deaf Sign Language Users (Action on Hearing Loss (RNID) and BDA)	2009
Access to interpreting services for health related appointments – some Deaf people unaware of their rights under DDA which entitles them to communication support. Degree of confusion as to the role and remit of an interpreter as to whether they can be used to carry out related activities within the same booking period e.g. accompany to chemist for prescription after GP appointment. Some health service departments say they do not have	All interpreters used by the Health Service should be fully qualified and registered. Staff need to be aware of how to book interpreters, suggest a poster for frontline staff (flowcharts have been distributed within Southern Trust and 12 training sessions are running in June 2010). Perhaps Deaf people themselves should book the interpreter for a time that suits them. Staff in hospitals should have level 1 in BSL and wear a badge to alert Deaf	Access to Public Services for Deaf Sign Language Users (Action on Hearing Loss (RNID) and BDA)	2009

the funds to pay for interpretation costs or that the healthcare professionals are unaware that an interpreting contract exists in their area. Current lack of interpreters in NI makes to difficult to book one at short notice/in an emergency. Also difficult during GP home visits if no interpreter is made available and therefore often rely on family members.	people to this capacity. Interpreters should be booked in advance of doctor's appointments and appointment times for all health professionals should be extended by 20-30 minutes for Deaf patients. Action on Hearing Loss's (RNID) out-of-hours interpreter service should be promoted through information booklets. Awareness leaflets for Deaf community re: rights to interpreting support should be developed.		
Communicating with Sensory Disability Social Workers – Deaf people felt, in some areas, that social workers for sensory disability have variable signing skills with some only having Level 1 in BSL which is not adequate for the level of clear and fluent communication required.	Social Workers for Deaf people to be trained to Level 3 in BSL (Social Services Inspectorate to be informed of this).	Access to Public Services for Deaf Sign Language Users (Action on Hearing Loss (RNID) and BDA)	2009
Access to Emergency Services – while many Deaf people were aware of the emergency SMS service to contact the PSNI they were unaware that this also extends to the Northern Ireland Ambulance Service (NIAS) and Northern Ireland Fire and Rescue Service (NIF&RS). Were also unaware that NIF&RS can carry out fire safety checks in their homes to identify risk, particularly if household is deemed vulnerable. Again issue of accessing communication support in an emergency was highlighted e.g. in the event of a road accident or a fire.	Action on Hearing Loss (RNID), BDA and emergency services to work together to produce an information leaflet for the Deaf community on how to access the PSNI, NIAS and NIF&RS using the SMS emergency number.	Access to Public Services for Deaf Sign Language Users (Action on Hearing Loss (RNID) and BDA)	2009
General Health Issues – great deal of health related information is not imparted	Trust websites should offer a plain English option and link to BSL and ISL version.	Access to Public Services for Deaf Sign Language Users	2009

to members of the Deaf community in a fair and effective way. Intercom systems are not accessible to Deaf people. Hospitals do not supply an alerter system for Deaf mothers on the maternity ward – a Deaf woman had to bring her own equipment form home.	Opticians need to provide a cue card of the alphabet for Deaf clients to point to. Need to increase the number of communicator/guides for Deaf people with Ushers Syndrome (common syndrome that affects both hearing and vision). Staff in audiology services have variable signing skills; clinics are not always accessible with staff calling out patient's names. An audit of signing capacity needs to be undertaken and programme of appropriate training put in place. The Deaf community generally lack understanding about the importance of healthy lifestyles due to inaccessible information and suggest that information is made available via leaflets, signed DVDs, or an accessible A-Z guide on healthy living and relevant resources.	(Action on Hearing Loss (RNID) and BDA)	
Inappropriate Communication Support for people with hearing impairment. Lack of availability of sign language interpreters or absence of up to date loop systems.	Sign Language interpreting training for key staff. Keep up to date aids and equipment	WHSCT Audit of Sensory Support Services for People with Hearing Impairment	2010
Disabled people are recognised to be socially and economically excluded in many aspects of life in the United Kingdom. Disabled people are less likely than non-disabled people to be in paid work; in 2011, 49% of the disabled working-age UK population and 77% of the working age population were employed. Disabled people are disproportionately	• Individualistic approach to support employment will resolve the inequalities currently faced by disabled people.	National Audit Office Lewis, R., Dobbs, L., & Biddle, P. (2013). 'If this wasn't here I probably wouldn't be': disabled workers' views of employment support . Disability & Society.	2010 2013

reliant on benefits for their income; 2.63 million people (7.2% of the working-age population) currently receive incapacity benefits because of disability or ill-health. Disabled people are missing the opportunity to enjoy the financial, personal and social benefits of employment.			
Barriers to Accessing Optimal Healthcare for People with Sensory Disabilities Communication is the major barrier to accessing healthcare for individuals with hearing loss Staff fail to address the unique communication needs of people with sensory disabilities who experience linguistic and cultural barriers. Healthcare staff are unaware of the ways to improve communication with people with sensory disabilities. Lack of cultural competence concerning the Deaf community creates communication challenges. Inadequate training of healthcare staff in deaf/visual awareness and associated communication skills. Communication barriers – difficulties interacting with staff, often caused by limited awareness of the needs of people	Interaction with Staff • Basic & refresher training of health care staff in deaf/visual impairment awareness & associated communication skills. • Extent to which training is provided by deaf/visual impaired people. • Provision of appropriate adjustments (text phones & other auxiliary aids, lip reading & sign language). • Provision of assistance with paperwork in private locations. • Awareness by staff of services/resources & facilities for visual/hearing impaired & how to access them. • Engage in “good communication practice” • Provision of mechanism of recording communication needs for those with visual/hearing	A Review of the Literature on Promoting Access to Selected H&SC Services for People with Sensory Disabilities	December 2011

with sensory disability; (staff attitude) Information barriers - lack of available information in accessible formats (language and literature) Physical access barriers – difficulties getting to and around premises; (signage and way finding).	impairments & to be flexible in meeting recorded needs. • Provision of system for “disability identifier” should be recorded for all s75? To facilitate better planning. • IT system for meeting communication needs of visual/hearing impaired. Language/Literature • Existence of policies, processes & systems for assessing individual need. • Provision of information in alternative accessible formats (e.g. telephoning patients with appointments). • Provision/availability of qualified interpreters for when patient is communicating with health care providers. • Existence of risk assessment for unavailability of communication support (interpreter, loop system etc.). • Provision of assistive equipment. • System to support patients understanding medication instructions.		

	• Process for involving visual/hearing impaired in developing language & literature. Sign Language • Existence of step by step guide for staff booking interpreter. • Staff awareness of need to not use a family member to communicate. • Existence of remote interpreting services. • Existence of file with common phrases/closed questions and in plain English for deaf patients being admitted to service. Signage/Way finding • Braille/raised signage on office doors. • Easily located reception desks. • Accessible signage schedules e.g. font size; contrast; border size; location of signs. • Good lighting • Provision for emergency situations • Physical access barriers e.g. provision of visual display boards,		

	chair/desk positioned correctly. • Accessible pre-visit information re appointment letters, site maps. • Provision of specific way finding aids (e.g. talking signs)		
A number of cases decided by supranational bodies are used to demonstrate how failures to provide reasonable accommodations to disabled detainees may result in inhuman or degrading treatment, as well as in discrimination. Equality is an essential pre-condition of achieving an inclusive society in which disabled people are able to participate in the mainstream of life alongside their non-disabled peers. Despite efforts to ensure that disabled people have opportunities to live independently and participate in the life of their communities, they remain disproportionately at risk of being detained, against their will, in psychiatric hospitals, social care homes, orphanages and other institutions. They are also to be found in institutions such as prisons, police cells and refugee centres.	• More could and should be done to highlight the importance of ensuring that places of detention develop systems for guaranteeing that reasonable accommodation is provided to disabled detainees and that this would play an important role in reducing the risk of exposing disabled people deprived of their liberty to inhuman, cruel or degrading treatment. • It is a matter of priority concern that systems are changed so as to enable disabled people –particularly those who have or are perceived to have intellectual or psychosocial disabilities – to grow up with their families and live independently as adults in the community instead of behind the physical and social walls of institutions.	Lawson, A. (2012). Disability equality, reasonable accommodation and the avoidance of ill-treatment in places of detention: the role of supranational monitoring and inspection bodies. The International Journal of Human Rights, 16(6), 845-864.	2012
This action plan was developed to help promote informed choice in cancer	• Information on cancer screening programmes should be made	Informed Choice Action Plan	2013

screening in Northern Ireland. Actions relating to each of the cancer screening programmes are followed by actions relating to the specific population groups	available in a format that is appropriate for people with learning difficulties, e.g. DVD, tailored literature etc. • Community Learning Disability Nurses should be aware of the cancer screening programmes and be able to pass on information and encourage uptake amongst people with learning difficulties. • The potential for linking Trust and primary care information on people with learning difficulties with the breast screening call / recall service should be explored, in order to target the provision of appropriate invitation letters & information		
People with learning disabilities die on average 16 years earlier than they should, due to NHS failings, according to official research.	• The creation of a review body to investigate the deaths of people with learning disabilities • A named health professional to co-ordinate the care of those with multiple health needs • Improved guidelines on when a "do not resuscitate" order should be used	The Bristol University researchers who carried out the work looked at all deaths over a two-year period at five primary care trust areas in the south-west of England.	2013
A case study in Cape Town, South Africa, explores the right to health for signing Deaf patients attending health services and who are unable to communicate in a language they understand. It argues that, without language their dignity and right to health is violated, resulting in serious consequences such as incorrect diagnosis, improper treatment and	• Provide professional sign language services	Haricharan, H. J., Heap, M., Coomans, F., & London, L. (2013). Can we talk about the right to healthcare without language? A critique of key international human rights law, drawing on the experiences of a Deaf woman in Cape Town, South Africa. Disability &	2013

standard of care not being applied.		Society, 28, 54–66.	
People with disability may be the most in need of additional health related care and the least able to access it. Transport and financial considerations were found to limit the ability to access appropriate care.	• Rehabilitation and health services need to reach out through home-based care and appropriate forms of rehabilitation delivery to ensure that those who are most in need of care, such as the elderly and those with more neglected forms of disability, are provided with the services that they require.	Maart, S., & Jelsma, J. (2013). Disability and access to health care – a community based descriptive study. Disability and Rehabilitation.	2013
The number of health and social care services used by disabled older people and their number of areas of unmet need, differed significantly between six European countries. The number and type of services used across the countries show a strong association with geographic location and welfare state regime. A lack of integration between health and welfare sectors or through a failure to properly meet care needs owing to a non-holistic approach to long-term care. The people most likely to use home health care are older, with a high number of disabilities, living alone and having low informal support (although when informal support is present, the activation of formal services may be delayed until physical impairment is severe or carer burden is high). A negative relationship is observed	• Increasing the number of social services provided, together with better integration with health services, might best reduce the number of unmet care needs in disabled older people.	Bien, B., McKee, K. J., Dohner, H., Triantafillou, J., Lamura, G., Doroszkiewicz, H., et al. (2013). Disabled older people's use of health and social care services and their unmet care needs in six European countries. European Journal of Public Health, 1-7.	2013

between the number of social services used and the number of areas with unmet care needs.			
People with intellectual disability have a higher prevalence of physical health problems but often experience disparities in accessing health care. Negative staff attitudes and behaviour, and failure of services to make reasonable adjustments. Other barriers included problems with communication, and accessing services because of lack of knowledge of local services and service eligibility issues; lack of support and involvement of carers.	• Despite some improvements to services as a result of health policies and recommendations, more progress is required to ensure that health services make reasonable adjustments to reduce both direct and indirect discrimination of people with intellectual disability.	Ali, A., Scior, K., Ratti, V., Strydom, A., King, M., & Hassiotis, A. (2013). Discrimination and Other Barriers to Accessing Health Care: Perspectives of Patients with Mild and Moderate Intellectual Disability and Their Carers. 8(8).	2013
A lack of experience in dealing with people with learning disabilities means lawyers often struggle to provide this vulnerable client group with the specialist support they need. People with learning disabilities have a wide range of potential legal needs. Common issues include parents with learning disabilities fighting to keep care of their children, discrimination in the workplace, disputed benefit claims, and experiencing bullying and hate crime People with learning disabilities are unclear how legal services could help them and rely on people close to them for support. Family carers mostly rely on the	• Developing guidelines for all lawyers, which would help them better understand the support and communication needs of people with a learning disability. • Mencap will develop “easy read” materials on choosing legal services designed to support people with learning disabilities.	Guidelines needed to help lawyers provide a better service to people with learning difficulties. Mencap, Legal Services Board & Legal Services Consumer Panel	2013

internet, learning disability charities and support groups for help rather than go to a lawyer, which is seen as a last resort measure There is difficulty finding specialist advice and people worry that legal aid changes and funding cuts to Citizens Advice Bureaux could make this worse A lack of accessible advice and information is preventing people with learning disabilities from dealing with legal issues effectively. The research highlighted the positive effects of getting the right legal advice: relief, improved quality of life and a sense of empowerment.			
Work Capability Assessment – a revised and heavily criticised work-ready assessment – found to be a humiliating and degrading experience, with assessors who lacked 'understanding and knowledge' about their impairments or ill health and their capacity for employment. The assessment was considered 'unjust, inhumane and highly inaccurate in determining fitness to work' and the experience had a negative impact on some respondents' physical and mental health. One woman spoke of 'going without desperately needed equipment and treatment' as 'neither the NHS or local authority will fund them' and 'as a consequence, my health is deteriorating	• DPOs could help with by campaigning and providing peer support.	Rosa Morris (2013) 'Unjust, inhumane and highly inaccurate': the impact of changes to disability benefits and services – social media as a tool in research and activism, Disability & Society, 28:5, 724-728	2013

rapidly and significantly'. Another experienced eight months during which all her social care was withdrawn due to what turned out to be a wrongful assessment. This resulted in frequent falls and a deterioration of her physical and mental health. Amongst the questionnaire respondents there was a low awareness of local DPOs and few people had been in contact with them. Generally people wanted advice, information and advocacy services, and also for DPOs to campaign on their behalf and challenge negative attitudes. Disabled people were facing not just a cut in their income but also a reduction in support services and/or an increase in charges. People spoke of the effect not just on their finances but also on their physical and mental health. There was a strong desire expressed to have better access to advice information and advocacy, all things a DPO can help provide. Fears were expressed about the increasingly negative attitudes towards disabled people.			

On average, men and women with a learning disability die, respectively, 13 years and 20 years earlier than the general population. It found that the most common reasons for premature deaths were problems with diagnosis or treatment together with problems in identifying needs and providing appropriate care in response to changing needs. Equality includes access to information about health as an essential starting point to enable individuals make informed choices about their health. Both Mencap and the Patient Client Council have identified access to information as a problem for people with a learning disability. This includes information about health services and advice about health issues.	• The Confidential Inquiry recommended that health care professionals become more aware of how they can make adjustments to meet the specific needs of people with a learning disability. It endorsed the implementation of systems which would improve liaison between health services and help to identify people with a learning disability within health care settings. • Providing health information in a meaningful way to the individual can help to ensure that existing illnesses are diagnosed and treated appropriately. • Improving equality of access to health care through implementation of the Bamford Review Action Plans. • Action must be taken to equip heath care practitioners with the skills needed to meet the communication needs of the people with a learning disability they come into contact with.	Equality Commission for Northern Ireland - Review of the Formal Investigation into the Accessibility of Health Information for People with a Learning Disability in Northern Ireland	June 2013

HSC AUDIT OF INEQUALITIES: EMERGING THEMES: ETHNICITY

The following issues have been extracted from the Compendium of Race Health Inequalities prepared by the Southern Trust over the past 5 years. This Compendium listed recommendations from over 60 research documents and pre-consultation took place in October 2010 with the following organisations: NICEM, Craigavon Intercultural Programme, Traveller Safe and Well Project, Wah Hep, Craigavon Women's Muslim Association, Newry and Mourne Ethnic Support Centre, South Tyrone Empowerment Programme (STEP) and Challenge of Change.

What are the Equality/ Inequality Issues?	Potential solutions where these are offered in the literature Policy/Practice Issues?	Source of Evidence	Date
A. For Service users. *It has been reported that Migrant Workers (MW's) arrive in the UK with relatively good health which tends to deteriorate over time. Many of the health issues faced by MW's can be viewed as symptoms of poverty, poor access to services, work related issues, poor accommodation and dietary changes. Source: The Health of BME (Kings Fund London).* **The majority of the issues below are also found in the NICEM Report 'Black and Minority Health and Wellbeing Development Project for North and West Belfast', September 2006.**			
Health and Education practitioners noted the **lack of background information on newcomer children,** which can make treatment and service provision difficult. For reasons associated with eligibility children from A2 countries Bulgaria and Romania, particularly Roma children, are vulnerable and hence represent a significant challenge to health professionals. Major implications for children's health, including routine health assessments, inoculations, health visiting for newborn and young children as well as ancillary services such as dental treatment or eye	Age assessments and age disputes are a major issue for social services. Being over or under 18 has major implications for the way social services assess and address needs. The loss of extended family networks and friend often result in feelings of isolation. For asylum seeking children, however, the sense of loss was usually more intense in that family members may have actually been killed or may still be living in danger in the country of origin. The asylum seeking process had a negative effect on children's emotional and mental health, with anxiety and a fear of	New to Northern Ireland - A study of the issues faced by migrant, asylum seeking and refugee children in Northern Ireland	October 2010

tests. Determining a child's age is very difficult if no record exists of their date of birth.	deportation being common. The health needs of the Roma population require special mention, although small, was incredibly complex. Due to increased incidence of TB among Roma children health assessments are necessary but problematic.		
	• Promoting informed choice in cancer screening should be included in the work plan of the Traveller Health & Wellbeing Forum. • Breast screening units, as part of their action plans to promote informed choice, should engage with relevant local groups to promote informed choice in breast cancer screening in the local Travelling community. • The PHA should identify the processes by which the travelling community receives correspondence relating to screening, as well as its effectiveness and timeliness.		
This community has been, and still is, the subject of hostility and discrimination in Ireland, and has 'suffered disadvantage and discrimination in all fields of life' (Council of Europe, 2008). This discrimination has resulted in Travellers being 'impoverished, under- educated, often despised and ostracised.' (Economic and Social Research Institute, 2009). Socio-economic disadvantages are	Interaction with Staff • Existence, circulation and use of a multicultural handbook. • Staff attendance at training – cultural awareness. • Traveller participation in delivery/designing training for staff. • Resources for HFA/CD principled peer educator training. • Existence of primary health care		

reflected in high levels of unemployment, low educational attainment and poor health. Significant health inequalities exist in the Travelling community both in the North and South of Ireland (Farrell, 2008). Travellers have significantly poorer health status than the general population, particularly in terms of mortality, life expectancy, higher burdens of chronic diseases, higher rates of non-accidental injury and higher measures of risk factors, such as smoking, high blood pressure, cholesterol and dietary consumption of fried food. The most common causes of deaths include heart disease/stroke and respiratory disease with external causes of death (including alcohol and drug overdoses) being particularly prevalent among Traveller men. Inequalities relating to access are strongly attributable to socio-economic conditions, particularly in the realm of education and access to employment. Psycho-social factors, such as discrimination can impact negatively on health outcomes. Thus research has recognised that there is a social gradient to health behaviour (Kelleher, 2007; Lynch et al, 1997), an issue underlined by numerous health surveys illustrating that smoking, alcohol consumption and unhealthy diets are strongly 'socially patterned'. Poor living conditions affect Travellers	type models. • Initiatives to support Travellers to work as advocates. • Extent to which staff challenge each other for inappropriate attitudes/discriminatory language. Language & Literature • Culturally appropriate health literature developed in partnership with Travellers. • Existence of alternatives to written word (texting, telephone calls). • Ethnic identifier to establish levels of service use by ethnicity. • Ways/systems for encouraging understanding of medication e.g. use of visual symbols. • Outreach with local support groups for home visits etc. Signage/Way finding • Use of pictorial systems. • Accessible pre-visit information re appointment letters, texting etc.		

ability to access services in the following areas; • The nomadic lifestyle results in difficulties receiving correspondence relating to appointments or invitations to health initiatives (for example, breast screening). • Lack of public transport from temporary sites affects their ability to attend appointments. • Awareness of their poor living conditions affects their 'receptiveness' to health initiatives. The indigenous minority Travelling community experiences wide ranging inequalities including inequalities in accommodation and educational attainment, both of which impinge on their access to health services.			
B. For HSC Staff			
Professionals involved in front line services felt that there was a **lack of clear guidance and policies** in place. Different interpretation or application of guidance leading to uncoordinated practice. Strategic leadership is required to influence policy development and oversee effective planning of services.	Front line workers felt that they could only have a limited impact if their organisation did not provide strategic leadership. **Interagency work vital to meet the needs.** Every practitioner noted their concern and their need for improved levels of information and resources. Diversity and cultural awareness training is	New to Northern Ireland - A study of the issues faced by migrant, asylum seeking and refugee children in Northern Ireland	October 2010

There is a need for an information hub, to map existing resources, offer a signposting service, collate evidence of good practice, be alert to emerging trends and support the implementation of strategic plans. A network of practitioners should be developed. This network would include all practitioners from the public and voluntary sector who work with migrant, asylum seeking or refugee children and would encourage information sharing, confidence building and advocacy. The network would also encourage cross-sectoral working by building relationships and good practice. Barriers may be created by the prejudice of some working within health and social care organisations and by a lack of unwillingness on behalf of service providers to facilitate access to services. (Animate and others, 2007). This is particularly the case regarding access to primary healthcare, meaning that children from migrant families are not registered with a GP. These problems are exacerbated by issues such as communication difficulties and the lack of correct documents required for registration. (ECNI, 2009). The increased risk of mental illness among child asylum seekers in NI has	required focusing on these groups of children. An interim co-ordinator should be appointed, to lead on the implementation of the recommendations. There is a need for greater awareness among migrant populations of their right to health and social care services and how to gain access to them. (SHSSB/NICEM/NHSSB 2007) Similar barriers as well as institutional racism have also been highlighted by ECNI and DHSSPS in the Racial Equality in Health Good Practice Guide 2002. In 2007 NHSSB and NICEM recommended the establishment of **tailored family support services for migrant families and the necessity to address the issue of GP registration**. For Trust workers this has meant that working with these families is resource intensive in terms of health professional's time e.g. arranging interpreters, more frequent home visits and more time spent		

been highlighted by NICCY 2008. The lack of expertise among primary care and social care staff in identifying the severe mental health difficulties experienced by some asylum seeking children. (Chase and other, 2008). Health Visitors in the SHSCT identified children from over 60 countries. They also identified the following barriers that may prevent the parents of such children from accessing health services: • language difficulties; • families are mobile and have no permanent address; • heightened expectations of service; • lack of awareness of how to access GP services and so access A&E services; • lack of confidence accessing child health clinics and mother and toddler groups; • low levels of car ownership; • lack of current localised information on services in specific languages; • social isolation and missing extended family support.	arranging appointments. Cultural issues were identified that potentially inhibit access and uptake of services e.g. weaning and feeding practices, child rearing practices. Post natal depression and social isolation are a particular issue for mothers while speech and language needs, developmental concerns and child protection issues for children.		
Institutional Racism - ensure **equality of opportunity** for BME people in assessing and benefiting from all public services. Promote dialogue between and **mutual understanding** of the different faiths and cultural backgrounds. **Build capacity** of BME groups to develop a sustainable BME sector.	Training and awareness initiative for policy makers and frontline staff will focus on eliminating the potential of incidents of "unwitting", "unconscious" or "unintentional" racism as well as deliberate and intentional racism. **Focus on those groups who still suffer particular disadvantage**, rather than	OFMDFM Race Equality Strategy 2005-2010 Racism and the Recession McPherson Report on the Stephen Lawrence Case	2005-2010 Unison 2009 1993

Increase number of **BME volunteers**. Combat racism and provide effective **protection** and **redress**. Eliminate unlawful racial discrimination and promote equality of opportunity. Need to address **institutional racism** and a clear knowledge of its continued existence. **Strategy needs actions** attached to it. To build a society where cultural diversity is embraced and celebrated and to promote pride in who we are and confidence in our different cultural identities.	treating al minority ethnic groups as having the same needs. **Outreach initiatives and devising new and innovative ways of engaging minority ethnic people and involving them**. **Capacity building** - not just with funding but include training, organisational and personal development and resource building. **Target efforts and resources towards those experiencing greatest disadvantage.** **Surveys** to provide a specific focus on minority ethnic people – improving the base line data must be a target	ECNI Response to OFMDFM Race Equality Strategy Programme for Cohesion, Sharing and Integration (CSI)	2005 September 2010
Mainstreaming - is the key to ensuring equality of services. Mainstreaming involves the application of equality proofing, guidelines, participation of groups experiencing racism, positive actions, data collection, proactive monitoring and impact assessment. It involves each organisation accepting its own responsibility for promoting racial equality and challenging racism. **Bi-Lingual BME Advocacy Workers –** Social Worker, SW Assistant, Community Development Worker, Family Support Worker, Therapists, Counselors. **Teach staff the language.**	**Health priorities identified during consultation:** The need for Traveller specific health strategies The issues and needs of minority ethnic people in the area of **mental health.** **The employment rights and protection from harassment of overseas nurses working in the health sector.** **Low levels of GP registrations.** **Identify any gaps in information and service provision and produce an**	OFMDFM Race Equality Strategy 2005-2010 Audit of Unmet Need Armagh and Dungannon area Programme for Cohesion, Sharing and Integration (CSI)	2005-2010 April 2007 September 2010

Welcome differing cultures and minority ethnic groups. The **psychological** needs of refugees and asylum seekers.	**Action Plan which will address immediate, medium and long term needs.**		
United Nations Findings last 10 years • **Travellers Rights** • **Violence against women** • **Protection of Religion of Minority Groups** • **Child Poverty** • **Trafficking** • **Participation of vulnerable adults in decisions that affect them** • **Contracting out** – Procurement criteria not just value for money but quality for service users Feedback from the Traveller Awareness Training Programme highlighted some emerging themes: • **Domestic Violence;** • **Sexual Health;** • **Drugs and Alcohol;** • **Mental Health.**		The future of Human Rights in the UK – NIHRC Conference SHSCT Traveller Awareness Training	16.09.10 22.09.10
Maternity Services: Lack **of face to face information** when attending maternity services postnatal care - language barrier patients with very limited English - culture shock - **negative attitudes of staff -** lack of information regarding maternity benefits - translated information needed on the menopause, breast cancer, smear tests, family planning, diet, childcare and immunisations.	**Identify a key worker** in statutory organisations who could be the first point of contact when information is being sought. This would give a human face to public bodies and service to make them more approachable. **Translated health promotion leaflets.** Health promotion needs to be more proactive with this potentially high risk	Out of the Shadows - An action research report into families, racism and exclusion in NI Ethnic and social inequalities in women's experience of maternity care: Results of a national survey (2007) Review of Literature on Equality of Opportunity Issues in Health	1997 2010 March 2001

Maternal and infant mortality are higher among BME groups. BME women were more likely to access services late e.g. not have a scan by 20 weeks, attend antenatal classes, have a post natal check up and were more likely to experience complications. **Difficult to complain.** **Lack of knowledge of Social Services and its functions.**	group and they need **greater support and care from maternity services during pregnancy and afterwards**. **Complaints forms in other languages.**	and Social Services	
Cultural Needs: Provision for prayer and religious observances. **Diet:** halal/kosher meat – customs around death, birth and diet. As well as ethnic origin need to know religious and cultural needs, language needs, advocacy needs, specific health beliefs and use of other health care systems. **Proactive steps need to be taken**.	**Female doctors.** **Increase cultural competency** of staff through cultural awareness training and anti discrimination training. Customise services to meet cultural needs - address dietary requirements - accommodate special customs at times of bereavement and birth.	Out of the Shadows - An action research report into families, racism and exclusion in NI A Guide to the Main Equality in Health Issues	1997
Language and Communication Barriers: Concerns about potential misdiagnosis and confidentiality - unaware of the availability of **interpreting and translation services** - consent issues. Receiving letters detailing **appointments in English** is problematic resulting in people missing appointments.	There should be a more **proactive approach in targeting materials** to BME groups e.g. community newsletters, language broadcasts, materials placed in areas frequented by BME people such as supermarkets, cafes, workplaces and places of worship.	The Health of BME - King's Fund, London Philomena de Lima *et al*. A Study of Migrant Workers in Grampian - Communities Scotland (Zachlebem) - NICEM Ethnicity, Equality and Human	March 2001 2007 2009 October

		Rights: Access to H&SS in NI Mapping Exercises - Down and Lisburn	2010
Health specific issues: Sickle cell disorder - depression - stress - suicide - schizophrenia - diabetes - heart disease - racism - lack of confidence - hepatitis B - HIV - tuberculosis. **TB – non-completion of treatment** **Substance abuse – addiction – isolation – depression -** limited access to rehabilitation centres and educational programmes **Low awareness and uptake of Respite Services:** Asian carers had low awareness and usage of specialist services for people with learning disabilities.	**Be aware of distinctive patterns of ill health.** **Specific BME health promotion policies.** **Additional time required for appointments/consultations.**	The Health of BME - King's Fund, London Review of Literature on Equality of Opportunity Issues in H&SS Netto Ward, 1998 BME Health and Wellbeing Report N&W Belfast - NICEM	March 2001 1998 1998 2009
Trafficking: Women coerced into prostitution – domestic violence – sexual abuse. Sexually transmitted diseases – higher percentage than indigenous communities		The Health of BME - King's Fund, London 'The Nature and Extent of Human Trafficking in NI NIHRC	March 2001 NIHRC 2009
Financial Constraints: Lack of resources for interpreting and translations - the need for funding for Interpreting and Translation services was the most pressing issue for service providers.	Need for strategic planning. Predict future trends.	The Health of BME - King's Fund, London Philomena de Lima *et al*. A Study of Migrant Workers in Grampian	March 2001 2007

		- Communities Scotland	
Ethnic Monitoring - transient and **ever changing profile** of MW's make it difficult to plan services - some public authorities reported feeling overwhelmed - some services ad hoc and reactive and dependent on the commitment of individual staff - lack of data - **limited or non-existent monitoring** - service providers lacked systematic and coordinated communication routes - **no overall outreach strategy** for providing advice and information about accessing services. A proper system of **ethnic monitoring** will allow service providers to: highlight possible inequalities; investigate their underlying causes; and remove any unfairness or disadvantage. It will let service providers know which groups are using their services and how satisfied they are with them.	**Ethnic monitoring** (the process used to collect, store, and analyse data about people's ethnic backgrounds) by service providers of key areas of service provision is essential to achieve racial equality. **To have a racial equality policy without ethnic monitoring has been likened to aiming for good financial management without keeping financial records.** **Consider ways of reaching under-represented groups** and make sure those services are relevant to their needs and are provided fairly. **Lack of accurate statistics.**	The Health of BME - King's Fund London OFMDFM Race Equality Strategy 2005-2010 New to Northern Ireland - A study of the issues faced by migrant, asylum seeking and refugee children in Northern Ireland	March 2001 2005-2010 October 2010
Employment: Lack of recognition of qualifications obtained abroad - low levels of English - MW's tend to be working in occupations well below their actual level of skills and experience - working conditions **- health and safety issues** leading to higher mechanical injuries, environmental and infectious diseases, pesticide exposure and social and psychological problems - lack of awareness of employment rights - fear of	To avoid discriminating against migrant workers, employers should not simply specify that candidates must have qualifications that can only be obtained in UK educational systems (e.g. GCSE's or A-Levels). Employers should have a procedure for evaluating the comparative value of qualifications gained overseas with those gained in the UK. Employers can obtain advice on these	The Health of BME - King's Fund, London A Unified Guide to Promoting Equal Opportunities in Employment - ECNI Life as a Stranger - The personal stories of Migrant Workers to Northern Ireland	March 2001 March 2009 September 2010 2009

asserting rights - control issues with employers - exploitation - long hours, low pay - job insecurity - restrictive contracts and refusal of employers to honour entitlements including holiday and sick pay - English language classes - banking services - internet access. **Employment is a key driver of economic and social wellbeing and presents one of the key routes to social mobility and inclusion. Health and social care is fundamental to a person's quality of life and well-being.** **Immigration rules:** Employers must comply with immigration laws. For example, it is unlawful for an employer to employ a person who is subject to immigration control, unless that person has current and valid permission to be in the United Kingdom, and has valid permission to do the type of work on offer.	matters from any of the following: **• Council for the Curriculum, Examination and Assessment: www.ccea.org.uk** **• UK National Recognition Information Centre www.naric.org.uk** **• UK National Reference Point: www.uknrp.org.uk** The Border and Immigration Agency is the public authority responsible for enforcing the immigration laws and is the best source of information and guidance about them.	(Zachlebem) - NICEM Racism and the Recession - Unison Statement on Key Inequalities in Northern Ireland - ECNI **Border & Immigration Agency's website: www.bia.homeoffice.gov.uk**	2009 October 2007
Policy and Planning: How the organisation formulates, deploys, reviews and turns policy into strategies, plans and actions. The process involves the organisation identifying and managing reviews and periodical improvements to these processes.	1. Senior managers lead the organisation in developing and using Racial Equality policies and practices. 2. Issue written policies which incorporate a high profile public commitment to racial equality. This should be developed with an anti-racist ethos and perspective for diversity and inclusivity in its content and style, policies and strategies. 3. The organisation should practise and endorse racial diversity externally and	Race Equality Audit for Northern Irela nd - NICEM Pre-consultation with NICEM 11.10.10	2004 2010

	internally in all its activities. This should be supported at Board Level or Permanent Secretary Level in the case of Government Departments. 4. Consultation, involvement and participation take place with Ethnic Minorities communities on the content of the Policy. 5. Review and revise appropriately. 6. Feedback and update outcomes to the Ethnic Minorities communities. 7. Issue guidance *for* policy makers which would include a statement of your commitment to racial equality. The guidance produced should contain clear instructions and worked examples of what the commitment to racial equality means in practice and what is expected of policy makers. 8. Train staff involved in policy making, in impact assessment and policy, appraisal on racial equality. 9. Provide customised anti-racist and diversity awareness training to all staff. 10. Equality Policy Appraisal and Impact Assessment should be regarded as core skills for policy staff and should form part of annual performance appraisals. 11. Racial policy is supported by an implementation plan of on-going staff development, familiarisation and		

	regular reviews. 12. Plan from the outset and allocate resources to ensure that the implementation and evaluation of the impact of policy initiatives are monitored with reference to their intended outcomes and to their effects on different communities. 13. Ensure that Racial Equality principles are integral to the policy and planning process. This should include consultation, research, monitoring and evaluation. 14. Provide further guidance to policy makers on how to appraise policy in the light of impact assessments on what to do when proposed policies appear likely to result in adverse differential impacts on different groups in society. 15. Provide guidance on strategies for dealing with proposed policies which have adverse impacts on different groups in society. 16. Integrate Racial Equality into strategies to tackle social exclusion, such as the New Targeting Social Need initiative. 17. Address issues of Racial Inequality through policy development research. 18. Assess the needs of all Ethnic Minority communities and population profiles. 19. Incorporate Racial Equality objectives		

	into the job descriptions of all levels of senior management and ensure that these are subject to annual performance appraisal and review. 20. Produce documentation for implementation of the Audit and integrate corporate and service objectives into this. 21. Draw up an action plan for implementation of the Audit. 22. Make explicit the responsibilities of all staff in relation to the policy. 23. Establish local performance indicators which clearly reflect the local diversity of community needs, aspirations and disadvantaged position. 24. Incorporate Racial Equality practices, standards and targets into quality assurance controls. 25. Incorporate Racial Equality principles in Codes, guidance documents and manuals. These should be developed where they are not currently available. 26. Review the content of induction packs to ensure that on and prior to appointment all staff receive suitably strong messages on the importance the organisation attaches to racial equality. 27. Train staff to promote ownership of the policy across all areas of the organisation.		

	28. Ensure that adequate resources are available to implement effectively Racial Equality commitments. 29. Develop at a corporate level a strategy and programme of annual Racial Equality Action Plans. These should be developed collaboratively in order to strengthen the integration of equality issues into mainstream management and practice. 30. Publish performance result in internal annual reports, as well as for reports which satisfy Section 75 of the Northern Ireland Act.		
Service Delivery and Development: Service delivery and development if a key aspect of any public authority's commitment requirements and challenges. This approach ensures that the racial diversity and distinct needs of our racial groups are recognised and met. An underlying commitment to meet diverse needs is integral to the success of this process.	1. Ensure that Impact Assessment and policy appraisal on equality are central to all new programmes and projects affecting Service Delivery. 2. Work with and consult with Black and Ethnic Minority groups within NI. 3. Have regular contact between Departmental Managers and Ethnic Minority communities to consult on Action Plans, Service Development and Implementation, Policy Development and Needs Assessment. 4. Produce Action Plans which detail priorities, targets, timetables and outcomes for each service area to challenge racism and racial harassment. 5. Identify the differentials between communities.	Race Equality Audit for NI - NICEM Pre-consultation with NICEM 11.10.10	2004 2010

	6. Produce data to support identified differential needs. 7. Develop responses to meet those needs. 8. Develop corporate and outreach strategies to target marginalised and socially excluded Black and Ethnic Minority groups to ensure equal access to all services. 9. Collect information about the services, networks and resources which are available to meet the needs of Black and Ethnic Minority communities. 10. Organisations which are grant-aided by a public authority should be required to have Racial Equality policies and procedures in relation to the delivery of their services. 11. Organisations which are grant aided should provide evidence of practices which promote social inclusion of racial groups. 12. Provide anti-racism training for all staff who deliver services to Black and Ethnic Minority groups to ensure appropriateness of service and sensitivity to users. 13. Establish mechanisms for dealing with complaints of racial discrimination and/or racial harassment from service users from Ethnic Minority groups. 14. Establish mechanisms for dealing with		

	complaints from service users from Black and Ethnic Minority groups which take into account language and communication difficulties. 15. Monitor services for racial equality in access, delivery and outcomes. 16. Include Racial Equality objectives in the Job Descriptions and Personal Development Plans of all staff involved in service delivery. 17. All staff should be appraised against these plans annually.		
Community Participation: Community Participation and Planning are key components to building relationships between excluded groups and organisations. This will enable authorities to combat social exclusion and deprivation that affects Ethnic Minority Communities disproportionately. This process should assist organisations to develop strategies to assist them. Consultation forms an important part of the process improving the social well being of communities. The process should involve community planning partnerships, development of long term visions focusing on outcomes and the assessment and monitoring of progress for the achievement of goals and priorities. The next stage is to feed back to your communities on your progress and intentions.	1. Establish consultation mechanisms to establish regular contact with Black and Ethnic Minority communities. 2. Promote self-help initiatives and encourage the communities to develop their own mechanisms to meet their needs. 3. Recognise the impact of institutionalised racism on service delivery to Ethnic Minority communities. 4. Aim to overcome communication, cultural and religious barriers in service delivery by regularly reviewing the profiles of your communities and ensuring adequate resources are in place. 5. Provide information to local communities about the range of service provision made by the organisation or public authority.	Race Equality Audit for NI - NICEM Pre-consultation with NICEM 11.10.10	2004 2010

	6. Ensure Black and Ethnic Minority are able to input into the preparation of Action Plans and the development and delivery of services, policy development and needs assessment. 7. Develop a partnership approach between the organisation and the Ethnic Minority communities. 8. Work towards participation in decision making and in particular take account of citizenship and the views of service users. 9. Contribute to capacity building within Black and Ethnic Minority groups through support, training and grant aid. 10. Utilise the experience and skills of ethnic minority groups to conduct staff training at all levels on anti-racism and racial inequality in the organisation.		
Positive Action Initiatives: Initiatives, whether they be community based or related to employment, acknowledge the presence of disadvantage and discrimination. Positive Action attempts to redress the imbalances Ethnic Minorities face internally as employees and externally as service users.	1. Tackle the under-representation of Ethnic Minority workers within organisations by the maximum use of the Positive Action Provisions in the Race Relations legislation, including pre-recruitment and trainee schemes in order to redress imbalances in the workforce. 2. Introduce a range of pre-entry and post-entry initiatives to redress racial imbalances within the organisation. 3. Tackle identified unmet or new needs of Black and Ethnic Minority communities through Positive Action	Race Equality Audit for NI - NICEM Pre-consultation with NICEM 11.10.10	2004 2010

	Programmes. 4. Target resources and grant aid to Ethnic Minority Voluntary Sector Organisations to tackle Social Exclusion as part of a capacity building programme. 5. Organisations should develop an on-going research programme to address issues of inequality, such as the changing nature and complexity of disadvantage, unequal access and unequal impact. 6. Require all contractors and those to whom functions are out-sourced to follow effective racial practice in employment and service delivery. 7. Develop monitoring and compliance systems for the purchase and contracting of services and works. 8. Encourage contractors who breach equality and diversity policies to improve their performance. A range of lawful sanctions can be applied where appropriate up to and including the termination of the contract. 9. Be aware of the range of sanctions you can apply and practise diligence at all times. 10. Regularly review and update your supplier list and publicise its existence especially in the Ethnic Minority Communities.		

	11. Develop mechanics to address under-representation not only in terms of access but also retention and progression. 12. Adopt a proactive and creative approach to communities in relation to strategies to combat disadvantage.		
Workplace Developments: Organisations should deploy **all** their human resources in a way that supports Racial Equality policies and plans. Organisations can then assess their policies for recruitment, training, review and promotion of all staff.	1. Take positive steps to increase the numbers of staff from under-represented Ethnic Minority Groups at all levels of the organisation. 2. Ensure all recruitment and selection procedures are bias free, equality-proofed and do not discriminate unfairly or unlawfully. 3. Target publicity in appropriate media for vacancies and opportunities in order to reach the widest possible pool of candidates. 4. Ensure all recruiters and selectors are trained to carry out the process in an equitable manner and are given refresher training. 5. Establish a Register of Recruiters and Selectors. 6. Ensure recruiters and selectors are representative of the Ethnic Minority Communities you serve. 7. Build in criteria to all job descriptions to assess understanding and commitment to racial diversity issues. 8. Test for understanding of racial	Race Equality Audit for NI - NICEM Pre-consultation with NICEM 11.10.10	2004 2010

	diversity issues in assessment and selections process. 9. Establish appropriate Racial Equality objectives and targets for all grades and professions in your organisation. 10. Analyse racial background data for applications and appointments for use in the review of progress on Racial Equality targets. 11. Manage and support Ethnic Minority staff through a range of mechanisms: • Appropriate Cultural Support • Ethnic Minority Worker Support Groups • Build capacity of Ethnic Minority Support Groups to sustain and develop their role and profile • Develop a mentoring scheme for Black and Ethnic Minority staff • Develop consultation mechanisms to elicit feedback and ideas from Ethnic Minority staff • Develop interventions which combat disadvantage and provide strategies for progression for all levels of Ethnic Minority staff • Develop innovative and appropriate interventions to allow for career progressions of the Ethnic Minority workforce		

	• Develop innovative positive action training for Ethnic Minority staff. 12. Ensure that staff induction programmes and manuals for new staff include information about racial equality and the organisation's anti-racism commitment. 13. Develop a Comprehensive Training Plan that delivers differentiated racial awareness training to staff at all levels within your organisation. 14. Audit all existing training development interventions for bias in content, style and delivery. 15. Incorporate a racial equality dimension in all training and staff development programmes. 16. Develop a multi-racial working environment by examining the following procedures to ensure that they are fair and effective: • Grievance procedures • Disciplinary procedures • Racial harassment and policies and procedures • Staff appraisals • Religious and cultural needs • Health and safety policies. 17. Launch the Racial Harassment Policy and publicise it to all Stakeholders.		

	18. Train and develop harassment contacts that reflect the racial diversity in your organisation. 19. Develop a framework for Racial Harassment Contacts. 20. Equip managers to produce, implement and monitor action plans. 21. Train managers on the detailed implementation of Action Plans and racial equality programmes. 22. Monitor data on Ethnic Minority staff retention and turnover rates. 23. Monitor grievance and disciplinary procedures involving staff from Ethnic Minority backgrounds. 24. Build Racial Equality Objectives into job descriptions at manager level and above. These should be subject to annual performance appraisals. 25. Monitor all aspects of employment and identify areas for follow up action.		
Marketing and Communications: An essential element in any organisation's activities is its external and internal communications. Demonstrating racial equality in our communications in content, style and approach is essential to successful interactions. Internal and external lines of communication and accountability should be bias free, racially sensitive and inclusive.	1. Review the accessibility of all major publications and publish in all appropriate formats. 2. Review the accessibility of the formats your communications are produced in. 3. Reflect diversity in all public communications about services in order to counter and avoid stereotypical or prejudiced attitudes. 4. Make staff aware of the Racial	Race Equality Audit for NI - NICEM Pre-consultation with NICEM 11.10.10	2004 2010

	Equality policy through a range of internal media (internet briefings / updates). 5. Promote greater involvement of all sections of the community at organisation events. 6. Work to ensure that your organisation is seen as a standard setter for equality in its communications. 7. All marketing staff should develop marketing strategies that are inclusive of race. 8. 8 Assess / audit all literature for stereotypical representations or misrepresentations of any groups. 9. Use minority media, in its widest sense, in placing advertisements and news coverage. 10. Update lists and resources on minority media periodically. 11. Make full use of appropriate services, e.g., translation, interpreting and advocacy. 12. Involve appropriate staff from disadvantaged groups at high profile public events in a meaningful way. 13. Ensure community events that are organised are of direct relevance to a variety of groups, including those who are disadvantaged. 14. Senior staff should act as		

	‘ambassadors’ to promote Racial Equality objectives, and share good practice at external events, for example, Conferences, Media Interviews, Public Statements etc. 15. The range of community events sponsored or funded by the authority should reflect the commitments and values of the racial policy. 16. Use recall surveys to assess your performance in promoting awareness of Racial Equality Policy and Activities. 17. Feed in recall surveys to media and communications policy effectiveness review, and policy development.		
Older people from BME communities: Often experience higher levels of **isolation in hospitals.**		Realising Integration - MRCI	2006
Eligibility and Access to Services: **GP Registration** - unfamiliarity with system - employers not letting time off to register - GP quotas for MW’s - **attitudes of frontline staff** - MW’s are a ‘burden’ - insensitivity to cultural needs - stereotyping - patronising attitudes - **low registration with Dental services**. **Medication instructions not translated** Lack of clear explanation of what is happening during medical examinations. GP receptionists act as barriers to some services. **Challenging the role of Receptionists** within GP surgeries. Currently they	**Specialist services** needed to meet the needs of specific ethnic groups. Ensure that all management development training programmes include **cultural diversity training**. **Long term training** to ensure medical staff are culturally competent. **Training on cultural nuances** for all primary care staff to include GP’s, Receptionists, Nurses and Health Visitors. Regular specific surgeries with a **bi lingual health professiona**l in attendance.	ANIMATE OFMDFM Race Strategy 2005-2010 OFMDFM ‘A Shared Future’ Life as a Stranger - The personal stories of Migrants to Northern Ireland (Zachlebem) - NICEM New to Northern Ireland - A study of the issues faced by	2007 Sept 2010 2009 October 2010

appear to be gatekeepers for access to certain services such as Interpreters. **More flexibility in the use of Interpreters**, they should not be restricted to when clinicians feel they are necessary, but should be offered as a matter of course. It was noted on numerous occasions that children should not be used as Interpreters. Lack of understanding or facilities for people whose culture dictates that their newborn sons should undergo **circumcision**. Often it's not done immediately due to red tape etc. and the child ends up being circumcised when older, causing much distress to the child.	**Adequate Resourcing:** The telephone interpreting service is of very limited use where house calls are concerned, yet budgetary constraints do not allow for widespread face to face interpreting. **Funeral rites**: Body to be treated according to their religion/culture.	migrant, asylum seeking and refugee children in Northern Ireland BME CERD Framework Convention on the Elimination of Racial Discrimination Working Group	February 2010
Emergency Support - Social Services (There is **no safety net** for undocumented workers – financial assistance in times of dire need) - restrictions on social security benefits for non-EU MW's – homelessness. **Habitual Residence Conditions New Points Based System -** Healthcare professionals unaware of MW's entitlement to services - **lack of clarity on the rights and entitlements of the different categories of MW's**. **Check progress of OFMDFM Crisis fund**.	Need for **guidance and leadership from DHSSPS** in updating guidance incorporating references to human rights. Restricting access to health to someone on the basis of their ethnic origin could constitute institutional racism. A key issue exists for those individuals who are here but have **"no recourse to public funds"**. Concerns about foreign nationals who "slip through the safety net" have been around for some time and these concerns are growing. "*Within the context of UK legislation, we are determined to examine what support we can give to people who, through no fault of their own, fall into difficulty*".	ANIMATE Diverse Dialogue - Report of the North South Intercultural Forum The Health of BME - King's Fund, London (Zachlebem) - NICEM Programme for Cohesion, Sharing and Integration No Home from Home - NIHRC	2007 2005 - 2008 March 2001 2009 Sept 2010 2009

Mental Health: Culture shock - job insecurity - **isolation** in rural areas particularly among pregnant women - family reunification sometimes very hard - financial insecurity - **stress - reduction in self esteem - take up of mental health services very low** - **suicides** - **self harm**. **Interpreters** cannot act as advocates in counselling sessions. Counsellors said working in sessions with an Interpreter from clients own community led to issues of **confidentiality** Low satisfaction levels among BME communities	**Counselling services** need to be provided in their own language. **Mental health promotion**. **Establish a directory of services** to enable MW's to access information on health services. **Peer advocacy** or active strategies to employ **bi lingual health professionals in particular MH counsellors**.	ANIMATE The Health of BME - King's Fund, London www.mind.org.uk Western Health and Well-being Sub-Group - Race Equality Life as a Stranger - The personal stories of Migrants to NI (Zachlebem) - NICEM	2007 March 2001 September 2010 2009
Child Health **Childcare facilities:** Absence of childcare providers operating in hours of shift work - Language skill deficit within the existing provision - **difficulties in recognition of childcare qualifications obtained abroad** - absence of family networks - ineligibility for childcare element for non-EU MW's - **child protection risk issues** - lack of childcare during school holidays. The health of the BME child – growing up in a bilingual/bicultural environment, taking on adult responsibilities, bullying. Access to dental treatment, obesity, low income families resulting in increased health concerns in later life. Gastroenteritis due to living conditions.	**Ensure childcare provision is inclusive of all children** A health visitor reported that on gaining access to a child's home, other issues become apparent such as: • poverty that is the result of the lack of basic provision; • accommodation problems such as significant overcrowding with whole families in one room; • lack of stimulation for younger children at home – they have no toys or books; • teenagers babysitting other children; • children of school age missing school; • children left unattended; • children working underage (busking);	ANIMATE New to Northern Ireland - A study of the issues faced by migrant, asylum seeking and refugee children in Northern Ireland Pre-consultation with Southern area BME Representatives	2007 October 2010 October 2010

Childhood obesity – risk of developing diabetes There appears to be a misunderstanding among some professionals as to migrants' eligibility to register with GP's. According to the Law Centre NI "entitlement to free treatment in the health service is not determined by nationality or whether a patient has paid NI contributions – it is based on whether a person is 'ordinarily resident' in NI (2008).	• parents failing to attend appointments with their children; • Non registration with GP's is a huge issue for Roma families – they have to pay £50.		
According to DHSSPS Equalities and Inequalities in Health and SC in NI the 3 main determinants of health inequality are related to **socio-economic/ environmental circumstances; lifestyle and health behaviour; and access to effective health or social care**.	**There is an emerging pattern of inequalities experienced by MW's in particular unequal access to basic health care. There are significantly poorer levels of health amongst Travellers.**	Statement on Key Inequalities in Northern Ireland - ECNI	October 2007
Travellers: Poor environmental/ accommodation affecting health - lack of recognition of Travellers specific needs - **lack of basic amenities such as water, electricity and sanitation** - **continuity of care** as Travellers are often on the move. Travellers are of particular importance to the ECNI. Crucially the strategy must reduce inequalities that Irish Travellers have experienced for centuries providing greater equality outcomes in key impact areas such as health and education. **Improving life chances for Travellers**	Need to keep the effectiveness of current provision to Travellers under review. See OFMDFM Racial Equality Forum 13 Key Principles January 2008. **Lay Health Worker for Travellers.** **More health promotion.** More **inter-agency working** to monitor, co-ordinate and facilitate services for Travellers.	Reeves Associates - Assessing the Impact of Section 75 Promoting Social Inclusion of Travellers - OFMDFM ECNI Response to NI Race Equality Strategy Ethnicity, Equality and Human Rights: Access to Health and Social Services in NI	February 2007 2000

will be a critical success factor and a major challenge for government. **Negative attitude towards Travellers particularly in hospital.** **Low mortality rate.** **Information not always clear due to low levels of literacy**. Lack of awareness amongst Travellers of preventative health services e.g. immunisation, screening programmes. **Mental health:** Social isolation - stress - uncertain of tenure - not having a proper home overcrowding in confined places - denial of depression often in Traveller men - unemployment - domestic violence. Support and promote the **employment of Travellers in healthcare**. Work with the Travelling community to plan and provide services designed to improve their health and wellbeing. The key health issues for Travellers identified during the consultation process were as follows: • environment and poor living conditions; • issues related to equality of access to, participation in, and outcome of service delivery; • rights of Travellers to appropriate	Work in **partnership** with Traveller support organisations to deliver services. **Develop specialist services e.g. family planning.** **Awareness training for staff.** Culturally appropriate healthcare needs to be provided. **Monitor** the outcomes for Travellers. Raise awareness about physical and mental health issues and work to reduce stigma about mental health. Develop and implement an awareness raising strategy re: domestic violence and provide access to preventative programmes for men, women and children within the Traveller community. **Volunteering** opportunities for Travellers. **There are 4 priority health care needs:** **1. mother and child services merit top priority;** **2. men's health issues need to be addressed specifically;** **3. there is a concerted need to address cause-specific issues for respiratory and cardiovascular disease;** **4. priority should be given to a new model of primary care delivery for Travellers dovetailed in the**	Western Health and Well-being Sub Group Race Equality A Guide to the Main Equality in Health Issues' All Ireland Traveller Health Study Southern Area Action with Travellers (SAAT): Outcomes for Children: Outcome Monitoring Report 2010/11	September 2010 2011

access to services based on culture and way of life; • lifestyle issues; • lack of culturally appropriate provision; • lack of data on Traveller health and health needs; • lack of recognition of Traveller culture and identity; • individual and institutional level racism; • social exclusion. Some of the key recommendations of the All Ireland Traveller Health Study Report include: • a **strategic Action Plan** should be developed; • adequacy of **accommodation** is essential; • all aspects of **mother and child services** merit top priority; • **men's health issues** need to be addressed specifically; • there is a concerted need to address cause-specific issues for **respiratory and cardiovascular disease**. **Life Expectancy** Traveller male life expectancy now is 61.7 years which is identical to what it was in 1987. This life expectancy in Traveller males is at a similar level to that of the	**Republic of Ireland with the emergence of Primary, Continuing and Community Care Services, and in partnership with the Primary Healthcare for Travellers Project Networks.** Better monitoring of nomadic Traveller children to ensure and encourage all immunisations are up to date through close working of Health Visitors and local Traveller Support Workers. Recommend as part of good practice, GPs check immunisation records of adult Travellers. Given their high mortality, likely high incidence, and low appreciation of the risk factors in the community, it is appropriate to mount an opportunistic **cardiovascular disease risk factor detection programme for Travellers**. Given the mortality findings in the vital statistics sections, particularly for men and in relation to respiratory and cardiovascular disease, it is important also to get **earlier and more active engagement, especially in primary care,** and to address the need for more engagement by Travellers in **preventive services and follow-up**, particularly for management of chronic disease, such as for respiratory and cardiovascular conditions. The poor health of male Travellers documented in our other		

general population in 1945 - 1947 when it was 60.5 years. Traveller female life expectancy has increased from 65.3 years in 1987 to 70.1 years. This is of a similar level to the general population in 1960 – 1962 when it was 71.9 years. For men in particular the mortality pattern is bleak. **Infant mortality rates have deteriorated since 1987.** Traveller infants today are **3.6** times more likely to die than infants in the general population. In 1987 Traveller infants were **2.4** times more likely to die than in the general population.	reports, and the perception that they present particularly late for care, suggest need for **urgent action to engage** with this group of people. **Health promotion skills programmes** must therefore be sensitive and culturally specific, for instance addressing the traditional value placed on salt and butter in the diet, the strict hygiene codes in Traveller kitchens and the limits of cooking equipment in homes. There are negligible numbers of Travellers **over 50** years of age. This is not explained by migration, is not explained by integration into the general population, and not explained by denial of Traveller identity. **The only realistic explanation is of premature death. Suicide rates of both young men and women are high and in men many fold higher than their contemporaries in the general population.** **63% of Travellers are under 25 compared with 35% nationally.** **42% of Travellers are under 15 compared with 21% nationally.** **3% of Travellers are over 65 compared with 13% nationally.**		
Certain women may be victims of domestic violence or rape and are unable to seek protection in their home country, or they may be threatened with forced sterilization or genital mutilation because of cultural practices in their country of	Discretionary Leave can be considered for people that have not been considered for international protection.	Forced to Flee; Frequently asked Questions about Refugees and Asylum Seekers in Northern Ireland (3rd Edition) (MCRC/Bryson Intercultural)	Oct 2008

origin. Similarly, gay men or women who would be persecuted in their home country because of their sexual orientation may flee to the UK to seek asylum. Save the Children and the Law Centre have expressed serious concerns over the lack of training within local health trusts to deal with children (seeking asylum) in Northern Ireland. Only one health trust in Northern Ireland has had experience in dealing with such vulnerable children and the one centre for traumatised children is in London. Suffering caused by a government policy that cuts off support for refused asylum seekers and has led to a new wave of widespread destitution. Amnesty International is concerned that the government may be deliberately using destitution in an attempt to drive refused asylum seekers out of the country. Despite being authorised by the UN Refugee Convention people have been criminalised in the UK for carrying false documents and some are serving prison Sentences As the UK and the EU impose ever tighter border controls to stop asylum seekers from reaching their territories, it becomes increasingly necessary for those wishing to flee to use traffickers and clandestine	It is vital for the government to maintain contact with refused asylum seekers and that financial support should continue until their cases can be resolved.		

migration as the only way of fleeing here. In May 2007, the Chief Inspector of prisons, Anne Owers, published a report in which she criticised the fact that asylum seekers are often held overnight in poorly equipped police cells in Belfast prior to the journey to Dungavel. She further expressed concerns that asylum seekers were handcuffed while being transported and, perhaps most worryingly, were not always given access to proper legal advice. The Border and Immigration Agency (BIA) have announced plans to open an enforcement unit in Northern Ireland in the near future and a number of officers have already joined the unit. The method of transporting people to Great Britain represents a failure; asylum detainees are being held in poorly equipped PSNI cells, handcuffed while being transported to detention centres in Britain and not given access to proper legal advice. Home Office asylum decisions are based on inaccurate and out-of-date country information, unreasoned decisions about people's credibility and a failure to properly consider complex torture cases. In Northern Ireland we are particularly affected by the lack of a Public Enquiry	UNHCR has also issued specific guidelines on detention, which provide that detention of asylum seekers may only be resorted to, if necessary, in the following narrow circumstances: to verify identity; to determine the elements on which the claim for asylum or refugee status is based; to deal with the cases where refugees or asylum seekers have destroyed their travel and/or identity documents or have used fraudulent documents in order to mislead the authorities of the State; or to protect national security or public order. Also, where detention is considered necessary the guidelines state that this should only take place where it is reasonable to do so and without discrimination. The Refugee Action Group would prefer to see claimants housed in hostel-style accommodation where they can maintain contact with family and legal representation in Northern Ireland. The Home Office needs to be reminded that these individuals are not criminals. From March 2007 the Home Office began implementing its New Asylum Model (NAM) with the aim of creating a faster, more tightly managed asylum process.		

Office, which was closed in 2001. The Immigration Service's only current presence is at the International Airport with a limited responsibility. There are problems with the constant flow of legislation in this area, which can be viewed as kneejerk reactions to what is an on-going, complex issue.	There is a need for a concise, single piece of legislation that clearly lays out the procedure of seeking asylum whilst protecting the rights of all individuals concerned.		
This report summarises the findings of a research study commissioned by the Department for Employment and Learning (DEL) on the economic, labour market and skills impacts of migrant workers in Northern Ireland. The study was undertaken during 2009 by Oxford Economics with support from FGS McClure Watters, Perceptive Insight Market Research and Professor Bob Rowthorn (University of Cambridge). Assessing the impacts of migrant workers on regional economies is challenging. However given the high profile nature of the topic, particularly now as the national and local NI economy is in recession, it is important that policy attempts to study the recent impact and considers the likely future impact of migrant workers.	Overall, we find that in recent years, migrant workers in Northern Ireland have made a significant positive contribution to the NI economy, filling labour shortages during a 'golden era' period for the economy (when unemployment was at a historic low and the majority of non-employed natives were not applying to work in the jobs migrants were taking) and bring a strong work ethic welcomed by their employers.	The Economic, Labour Market and Skills Impact of Migrant Workers in NI (DEL)	December 2009
Influence of folk religion – confidence in herbal treatment	Mixture of herbal treatment and GP prescriptions	Pre-consultation with BME representatives	October 2010
Establish **multi-agency partnerships** between indigenous and minority ethic and migrant worker communities to	A Ministerial Panel chaired by OFMDFM, Ministers, key statutory and community partners	Programme for Cohesion, Sharing and Integration (CSI)	September 2010

address the specific needs of the young people in those populations. E.g. C&B Interagency Migrant Workers Support Group and the Southern Area Race Equality Forum.	A Senior Officials Steering Group An Advisory Panel A Funders Group OFMDFM	***Promoting respect*** *for newcomers, Irish Travellers and children from the Roma community is a particular priority for OFMDFM*	
Procurement: The Central Procurement Directorate within the Department of Personnel includes an **equality clause** which places the onus on suppliers to meet obligations under S75. The CPD also continues to work with the Construction Industry Forum NI to bring forward proposals that address the issue of Migrant Workers to **ensure their fair treatment**.		Programme for Cohesion, Sharing and Integration (CSI)	September 2010
Obesity – Members advised that foreign nationals coming here from example Portugal were not eating healthy food as they did back home and many of them had put on a considerable amount of weight here (average 2 stone) due to change in diet. **Health Information for Travellers** should not be in written form and should be culturally sensitive as not all Traveller families are the same. Service providers need to be aware of **Group cultural differences and cultural needs.** More **outreach work** was needed and **relationships needed to build with men** around men's health. Receptionists act as gatekeeper to services **and training was needed on staff attitudes.**	**More translated health promotion for BME communities around healthy living.** **Targeted health promotion** **Health Outreach Programmes** **Treat people with respect**.	Pre-consultation with local BME representatives in the Southern Trust Area 14.10.10	2010

There appears to be an unequal footing between the Interpreter and the Practitioner **Promote participation** by training community and voluntary groups on how they can influence the Trust decision making process. **Volunteers and health mentors needed from the Travelling community**. **Employment –** difficulty in getting references, need for interview preparation skills. Sample questions and answers. Where are posts advertised? Need for Job Fairs. The focus on electronic applications has created huge barriers. Internal trawls do not help in employing migrant workers. **Benefits trap** discourages Travellers to apply for posts. Front line staff should reflect the local community. Need for Bi Lingual Speech Therapists and Psychologists, Counsellors. As these services do not work through Interpreters. Need to concentrate on new communities coming in e.g. increase in Latvian community. Also rise in Roma community – poverty – no recourse to public funds. Health is not a concern for Migrant Workers until they become ill.	**Skill up the community sector.** **Employment –** specifically employ reflecting the local community. **Help on filling out application forms** **Posts need to be advertised through the local network of community and voluntary organisations and not the press** **Realistically look at Interpreter training and upskill interpreters.** **Racial profiling?**		

Illegal immigrants not entitled to register with GP. They have to pay for GP consultation. It used to be you just had to provide an address now need to bring passport. Recruitment companies are still recruiting in other countries even though there is a recession here. **Older BME communities** have multiple disadvantages. They come here to look after grandchildren, no English language, socially isolated. **This is a major concern – they are not integrated into anything outside the home** **Still births** – no Islamic services – very Christian. **Need for minority chaplains** Trust needs to consider - **How do you get your information out to MW's?** Importance of registering with GP and completing census forms so that Trust are able to reflect numbers in service planning.	**Need to engage with older BME communities – look at research on Polish community in Australia** **Patients should be asked what they need** **Need to go through local employers induction and BME support groups** **Help with completing census**		
Individuals from a small number of national or ethnic backgrounds (Chinese, Filipino, Roma) appear to be particularly vulnerable to exploitation in Northern Ireland and exploitation in some employment sectors was more likely to be gender specific than others Most people who were being seriously	Emphasis should be placed on raising awareness of the issue, identifying further examples of coercive and exploitative employment practices and providing support, advice and assistance to people who have been, and continue to be, subjected to forms of forced labour The research on forced labour in Northern	Forced labour in Northern Ireland: exploiting vulnerability	June 2011

exploited were employed by members of the indigenous Northern Irish population who were willing to abuse the vulnerability that some new migrants experience on arrival in a strange country People's vulnerability to exploitation through forced labour was more likely to be associated with factors such as an individual's legal status, their English language skills, a lack of access to advice and information and an absence of appropriate community-based support networks Forms of exploitation experienced: ➢ Threats or actual physical harm to the worker ➢ Restriction of movement and confinement, to the workplace or to a limited area ➢ Debt bondage, where the worker works to pay off a debt or loan, and is not paid for his or her services ➢ Withholding of wages or excessive wage reductions that violate previously made agreements ➢ Retention of passports and identity documents so that the worker cannot leave or prove his/her identity and status. ➢ Threat of denunciation to the authorities, where the worker is in an irregular immigration status	Ireland should be considered in conjunction with the recommendations contained in the 2010 report by the Anti-Trafficking Monitoring Group in order to ensure there is a co-ordinated and effective response to both trafficking and forced labour OFMDFM should raise the issue with the various representative groups from the minority ethnic sector through the Race Equality Forum in order to begin to identify a strategy to address matters of exploitation and forced labour and review its funding strategy to ensure that issues of forced labour are included within their priorities. DEL should: ➢ set up a working group to follow up the issues associated with forced labour raised in this report. ➢ identify the key partners from the statutory, community and voluntary sectors to participate in the working group and develop a strategy to begin to respond to the issue of forced labour. ➢ liaise with the Office of the First Minister and Deputy First Minister about organising and supporting a campaign to raise awareness of forced labour. ➢ bring together the relevant bodies with responsibility for regulating and inspecting workplaces, ➢ fund an organisation from the community and voluntary sector to act		

	as the primary point of contact for anyone reporting cases of forced labour. ➢ review the issue of access to industrial tribunals The Migrant Workers Forum convened by the Belfast City Council Good Relations Unit should monitor issues related to the exploitation of migrant workers through forced labour The NIC-ICTU should convene a working group within the trade union movement in Northern Ireland to raise awareness of forced labour issues and develop a programme of action to respond to the problem.		
Almost 110,000 international migrants are estimated to have arrived in Northern Ireland between 2000 and 2009. In the process, Northern Ireland has moved from a position of net migration loss to one of annual population gain. This paper outlines the key elements of this remarkable, demographic change. A study by Oxford Economics on behalf of the Department of Employment and Learning (DEL) concluded that overall, migrant workers have made a significant positive contribution to the Northern Ireland economy. However, the unprecedented wave of migration since 2004 has created additional pressures on health and social care resources, housing and education.	In 2009 the total number of new GP registrations in Northern Ireland from outside the UK was 12,700 people. This number has fallen from a peak of 19,400 registrations in 2007. Latest figures for the first six months of 2010 indicate a further decrease. The fiscal impact of international migration on public services is complex, with statistical data being either absent or inconclusive. Nonetheless, at a time when the population is continuing to grow, Figure 11.2 illustrates the potential for an additional workload on the primary care system in Northern Ireland. However, the cost occurred when migrants utilise health and social care services is only one part of the equation. Set against this are the	Migration in Northern Ireland: A Demographic Perspective - Northern Ireland Assembly	June 2011

	benefits accrued from employing overseas doctors and nursing staff in local hospitals and clinics. In oral evidence to the House of Lords Select Committee, Dr Borman of the BMA explained: "Migrants are carrying their primary qualifications and their expertise to the United Kingdom effectively for free. It costs in the order of ... a quarter of a million pounds to qualify a doctor within the United Kingdom medical school system and clearly, having a doctor who has qualified abroad, bringing those qualifications means a net gain to the United Kingdom" (p.37). A similar case can be made for the employment of foreign-born nurses.		
The recent growth of the Filipino Community in NI is a result of local employers, particularly health, recruiting from the Philippines to fill skilled labour shortages. Immigration rules, particularly those governing the work permit/Tier 2 category, are the heart of many problems Filipinos experience. Despite paying taxes, work permit/Tier 2 workers have no recourse to public funds such as social security. This leaves the workers and their families vulnerable to destitution.	UK Borders Agency (UKBA) is responsible for immigration in Northern Ireland (NI). The NI administration is responsible for many areas of service and policy, for example in employment, health and education, which directly affects the wellbeing of immigrants. NICEM believe that the NI Assembly should have more power to adjust immigration policy in accordance with local circumstances. Recommend removal of financial criteria on Tier 2 workers, independent audit of minimum salary thresholds for Indefinite Leave to Remain applicants, and independent audit of fees which UKBA impose on applicants. Following pilot of 'Crisis Fund' OFMDFM should establish a long-term policy to assist migrants facing destitution, rectify current deficiencies of	Bayanihan! The Filipino Community in Northern Ireland - NICEM	January 2012

	Race Relations Order 1997, etc.		
Current UK immigration rules leave many Filipinos in N.I. vulnerable to exploitation by employers and recruitment agencies; Conservative-Liberal Democrat coalition is seeking to remove the possibility of Tier 2 migrants attaining settlement after 5 years; Many (Filipino's) fear that they will be victimised if they refuse or complain about working long hours; Culture of racial harassment and abuse in the workplace. In order to bring their spouse and children with them, a Filipino on a work permit/Tier 2 must have savings exceeding £800 plus £533 for their spouse and for each child, for a continuous period of 3 months – detrimental to family life. Many Filipino workers are unable to apply for Indefinite Leave to Remain because the minimum wage requirement set by the UKBA exceeds the standard rate of pay for the majority of Filipino workers. Public sector budget cuts, particularly in	N.I. Government should have a greater say in immigration and introduce legislation to govern all gang masters in any area of labour and an independent audit of minimum salary thresholds, taking into account regional differences, and fees should be carried out; OFMDFM should establish a long-term safety net policy to provide migrants facing destitution with assistance; OFMDFM should set up a legislative timetable to rectify the current deficiencies of the Race Relations (NI) Order 1997 so as to bring the legislation in Northern Ireland in line with the rest of the UK; UKBA should remove the financial criteria on Tier 2 workers bringing their spouse and children over to the UK; DEL should introduce compliance with the Agency Workers Directive and a training scheme to upgrade the skills of current senior care assistants to become registered professional nurses; DHSSPS, DEL and OFMDFM should	BAYANIHAN! The Filipino Community in Northern Ireland (NICEM)	January 2012

health, create an uncertain future for the Filipino community; As many Filipinos have large families there is a high risk of child poverty; low levels of income and rising living costs are likely to leave many Filipinos with little or no disposable income.	monitor any unfair redundancies and instances of discrimination against migrants as a result of job cuts in the health care system; Anti-poverty measures should extend to all migrants and the OFMDFM should commission further research on the poverty of the ethnic minority community in N.I. and there should be consideration of rent capping and restricted rent increases;		
• This action plan was developed to help promote informed choice in cancer screening in Northern Ireland. Actions relating to each of the cancer screening programmes are followed by actions relating to the specific population groups	• The new "One Stop Shop" health service for newly arrived migrants should promote cancer screening and provide information on accessing screening services. • Information on screening and how to access screening services provided as part of "One Stop Shop" health service. • The screening programmes should work with internal and external stakeholders to engage with community groups representing "hard to reach" groups to promote screening and discuss accessibility of screening.	Informed Choice Action Plan	2013
Lack of recognition of overseas skills and qualifications, immigration status, language difficulties and problems in negotiating support services	Tackling underemployment to ensure that career progression is possible; Pursuing opportunities to engage people with employment through vocational training, language courses or	Poverty and Ethnicity in Northern Ireland *(Joseph Rowntree Foundation (research by a team at the University of York and Queen's University, Belfast))*	February 2013

	self-employment; Ensuring that people from minority ethnic groups are not disproportionately affected by benefit delays; Examining how staff in Jobcentre Plus and benefits offices support unemployed people from minority ethnic communities back into work.		
A number of focus group participants argued that the word 'mental' was highly stigmatised and that BME people would be more receptive to softer language such as 'emotional well-being'. Targeted advertising campaigns would also help to build *trust* among BME communities. BME people would be more comfortable with using health services if they believed that professionals were sensitive to and aware of their culture.	Need for advertising campaigns targeted at BME communities and translated into languages other than English Need to develop the *cultural capability* of service providers – that is, their ability to deliver an appropriate and effective service to people of different cultures. At a more practical level, one option is to appoint a community development worker to take this work forward.	Barriers to Accessing Mental Health Services (Eoin Rooney in partnership with Ballymena Inter-Ethnic Forum & NIHSCT)	March 2013
In practice accessing specialist support services for victims has been ad hoc and inconsistent. Many victims are not ready to engage with specialists so soon after escaping from their traffickers and while they are in a period of reflection and recovery. Once a victim is identified and referred to the NRM process, exactly how and when social services should become involved	The engagement of social services alongside current support provision in the NRM should enable a fuller assessment of victim's needs and make sure that they are supported in both the short and longer term. Need for support planning in each individual case including on-going risk assessment and management to ensure that victims can access the full range of	HUMAN TRAFFICKING New working arrangements for adult victims of trafficking in Northern Ireland. (Law Centre NI Information Briefing)	March 2013

with a recovered victim is not actually specified. The guidance (for working with victims of adult trafficking in Northern Ireland, published by Department of Justice in October 2012): ▪ fails to address or refer to those victims who have been trafficked internally including British/Irish nationals. ▪ does not clarify the position for victims with no immigration status in the UK who are either awaiting an initial NRM decision from UKBA or are challenging a negative NRM decision through the courts. ▪ does little to clarify the often erroneous assumption that if the authorities accept that someone has been trafficked into or within the UK, s/he will automatically be granted Discretionary Leave to Remain in the UK	health and social care services Need to use 'trained' staff when collecting evidence from a victim, as well as the need for sensitivity in these types of situations Importance of obtaining independent and specialist legal advice at the earliest opportunity; victims should be accompanied by a solicitor at police interviews all HSC Staff and particularly those engaged in adult protection work and Out-of-Hours Teams should be familiar with the indicators of human trafficking A new specialist centre for victims of sexual assault, due to open in Northern Ireland at Antrim Area Hospital by March 2013. This new Sexual Assault Referral Centre (SARC) will provide services to children and adults, including those who have been trafficked for sexual exploitation.		
In July 2012, the government introduced significant changes to the Immigration Rules which includes, the requirements that must be satisfied for a child's case to succeed and an assertion that the changes will protect children's best interests.	In the policy section on the UKBA website (**www.ukba.homeoffice.gov.uk**), caseworkers are given guidance relating to factors which should be taken into account when considering an application based on paragraph EX1 of the Rules. In a case involving a child, you should 'picture build' the circumstances of her/his private and/or family life in the UK,	The Best Interests of Children in Immigration Law (Law Centre NI Information Briefing)	March 2013

	incorporating evidence such as photographs, birth certificate, letters from social workers and schools, medical reports, etc. Courts must consider in detail where the best interest principle should sit when carrying out the necessary balancing exercise Need for the decision maker to endeavour to ascertain the views of the child The decision-maker must balance the reason for expulsion or refusal against the impact upon the child Best interests of the child must be a primary consideration which should be considered first		
There currently exists an inadequate understanding of the size of the migrant Roma population resident in the United Kingdom (UK) and, despite some notable examples, a parallel lack of awareness of the significant issues and experiences faced by members of this community across the country. In 2012 the Sustainable Housing & Urban Studies Unit (SHUSU) at the University of Salford undertook research, funded by the Joseph Rowntree Charitable Trust, across the UK in order to address this knowledge gap. The overall objective of this study was to provide an evidence-base with the aim of informing a	Recommendations from local authorities and partners for future work with Roma Question C3 asked responding local authorities for their top three recommendations for actions which could better assist them and their partners. It was unsurprising that many focused on the need to develop a better understanding of migrant Roma communities, their culture and needs. Variations on this theme were the most frequent recommendation by a considerable margin. A desire for improved statistics, intelligence and information was expressed on 47 separate occasions. Closely linked to this was the need for cultural awareness or similar training (26),	Report to estimate the population of migrant Roma in the UK and document some of the experiences local authorities and key partners have when working with members of these communities http://www.shusu.salford.ac.uk/cms/news/article/?id=51 The report from the University of Salford's Sustainable Housing & Urban Studies Unit (SHUSU), is based on a survey of all UK local authorities and interviews with professionals in selected	Oct 30, 2013

more comprehensive and accurate development of measures to support the inclusion of migrant Roma in the UK. There were two specific objectives: 1. To obtain hard data about the number of migrant Roma at a national, regional and local authority level. 2. To identify particular service areas where local authorities, partners and Roma communities may need additional support to enable positive outcomes. **Estimated size of the migrant Roma population in the UK** We estimate that as of 2012 there are at least 197,705 migrant Roma living in the UK. Based on the responses from key informants this is considered a conservative estimate of the population. It is likely that this population will continue to increase. The population estimate for England is 193,297 individuals. It is suggested that Scotland has at least 3,030 migrant Roma individuals with 878 in Wales and 500 in Northern Ireland. The data indicates that the population of migrant Roma is predominantly urban and located in existing multi-ethnic areas. This study suggests that in England populations are concentrated in the North West and London with significant populations in Yorkshire and the Humber, East Midlands and West Midlands. There is a significant degree of uncertainty from	while better engagement and consultation (including by elected members) featured 17 times. More funding and resources in general, both targeted and an expansion of existing services, appeared on 30 separate occasions ranging from: Need for more colleagues to be employed for hands on multi-agency support with Roma families to gain their trust and help them access what is open to them i.e. accompany them to meetings, etc.(Metropolitan council in the North West of England) Roma people frequently approach us with several different queries and issues, yet often the person they speak to can only deal with one of these issues, and has to signpost them to someone else for help. We need to find a way of being able to offer an integrated support service. (Metropolitan council in the North West of England) Support for schools to assist set up Roma community focus complementary schools. (Metropolitan council in the North West of England) In addition, there were a handful of recommendations citing the need for greater support in relation to language and interpretation. Multiple recommendations also occurred on the development of migrant Roma communities themselves (nine occasions), myth busting and improving community relations (seven occasions) and the importance of partnership working (thirteen	case study areas	

key informants about the implications the end of transitional rights for Roma from Romania and Bulgaria will have for migration flows. The estimate of approximately 200,000 migrant Roma individuals is similar in number to projections for the population of indigenous Gypsies and Travellers in England and Wales which is estimated to be between 200,000 – 300,000 individuals. When combined together the population of migrant Roma and indigenous Gypsies and Travellers would equate to around 400,000 – 500,000 'Roma', as defined by the Council of Europe, living in the UK. **Settlement in the UK** The pattern of why migrant Roma settled in particular areas was seen as complex. Key informants reported many reasons which may explain settlement decisions by migrant Roma. Having direct or secondary experience of an area and having members of a wider family network present in the area was seen as important, as was having access to affordable accommodation. **The engagement of migrant Roma with service areas** A number of authorities reported that they were aware of migrant Roma living in their areas that rarely came into contact with the authority in any way. This was largely attributed to migrant Roma tending to be	occasions). A wealth of detail was supplied in the recommendations, more than in any other open question, but the majority of comments were characterised more by pleas for support than examples of good practice, suggesting a strong demand from local authorities for help in working with migrant Roma communities.		

accommodated in private rented housing and not engaging, in any perceptible way, with local authority services or with key statutory partners. Authorities reported that the main way they came into contact with Roma was through educational issues/children's services. This was often as a result of some sort of crisis within the household or when issues were reported by the general public or referrals made by other agencies (e.g. housing services, environmental health, police etc.). **Mobility of migrant Roma** Where authorities were aware of Roma living in their areas, levels of mobility within migrant Roma populations were commonly reported as high. **Addressing migrant Roma settlement** Migrant Roma were often seen as arriving with varied and complex needs. Particular issues discussed related to the presence of poverty, experience of entrenched discrimination resulting in an absence of trust and lack of literacy abilities (in any language). Local authorities reported that they found catering for the diversity and complexity of needs challenging. Occasionally this was linked to the heterogeneity of the Roma population, meaning that ensuring appropriate and meaningful service provision could be demanding. Reductions in funding available for local			

authorities and partners were often cited as contributing to the challenges faced. Posts were being lost within many organisations (statutory and nonstatutory) including in those services which usually led and undertook engagement with Traveller and/or diverse communities. This had the impact of reducing the capacity available to deal with Roma (including Gypsy and Traveller) issues at a time of rising demand, as well as eradicating institutional memory about how to address such issues when they were presented. **Views on challenges** At the time of the research local authorities were subject to reductions in funding as a result of wider public sector funding cuts. Those authorities who were aware of migrant Roma in their area, and who had been actively working with members of the migrant Roma communities, were asked to comment on whether the reduction in public sector spending had changed the way they approach work with Roma communities. Only 18 local authorities (12 per cent of all respondents) felt that the reduction in public spending had definitely affected services to Roma communities. **Challenges and barriers to successful work with migrant Roma** No one issue was seen as a defining barrier to successful work with migrant	For instance, one responding local authority commented on the lack of staff capacity within existing structures to deal with the complex needs often presented by Roma communities: We recognise to actually understand Roma and related issues we need some dedicated Council staff time...this is proving difficult. We recognise that some good sustained community development support is necessary to help Roma 'catch up' and to prevent future issues but our VCS commissioning funds have been reduced. Education Service has to help deal with school placements but is constantly finding whole families who need support. They cannot meet the need. Advice workers are struggling to cope with the general population and the Roma present with some very specific issues and language and complete lack of awareness can be a barrier. As a District we seem to		

Roma – most responses were evenly spread. The most significant barrier surrounded the issue of funding and finance followed by a lack of representation by Roma on relevant local fora. These were followed by the impact of negative media portrayal of Roma. The least significant issue appeared to revolve around barriers posed by [dis]engagement of senior management or elected members in the issue.	be reacting to emerging need, rather than planning well in time. (Local authority in the Yorkshire and Humber region)		

The table below attempts to summarise issues highlighted in some of the more recent literature relating to sexual orientation, published since 2005. It is not the result of any systematic literature searches nor does it critically review any of the sources.

What are the Equality/ Inequality Issues?	Potential solutions where these are offered in the literature Policy/Practice Issues?	Source of Evidence	Date
1. Employment			
Atmosphere and culture of discrimination, homophobia and heterosexism (language, jokes, comments, graffiti). 40% in public sector had experienced negative comments about LGB by colleagues; 15.1% directed at them; 21.6% banter	• Zero tolerance policy regarding homophobic bullying and harassment; clear message to all staff on what constitutes inappropriate behaviour and to managers about their responsibilities. • Use neutral language in communication • Training (building capacity and confidence to challenge inappropriate behaviour). • Conduct research on perceived conflicting freedoms. • The LGB&T sector, in partnership with Trade unions, should develop detailed LGB equality and diversity workplace guides. These guides should include information and advice regarding; the establishment of LGB&T network support groups, anti homophobic bullying policy guides, guides on how to monitor the sexual orientation of staff and equality and diversity statement	British Medical Association (BMA): Sexual Orientation in the Workplace NHS Scotland: Fair for All – The Wider Challenge. Good LGBT Practice in the NHS. Stonewall Hansson, Ulf, Hurley-Depret, Molly, and Fitzpatrick, Barry: Equality Mainstreaming. Policy and Practice for LGB People - Institute for Conflict Research Hunt, Ruth, Cowan, Katherine and Chamberlain, Brent Being the Gay One: Experiences of Lesbian, Gay and Bisexual People Working in the Health and Social Care Sector. Stonewall BMA: A Celebration of Lesbian, Gay, Bisexual and Transgender Doctors' Contribution to the NHS: a Collection of Members' Experiences. London	2005 2006 2007 2007 2009

	and policy guides. • The LGB&T Sector should develop Sexual Awareness Training to be delivered to employers that includes best practice advice on why LGB equality should be implemented in the workplace and how it should be done; including roles and responsibilities of line managers, senior managers and staff. • The LGB&T sector, supported by government and in partnership with the Equality Commission for Northern Ireland (ECNI), should design and develop an online advice and assistance 'toolkit for employers' which gives advice and assistance on how to implement LGB equality in the workplace. • The LGB&T sector, in partnership with ECNI should develop a Northern Ireland specific LGB&T Workplace Equality Index, similar to Stonewall UK's model, but relevant to the experiences and realities of workplaces in Northern Ireland. • Employers should review, renew, or develop, robust equality and diversity policies and practices throughout their organisation.	McDermott: Through our eyes. Experiences of Lesbian, Gay and Bisexual People in the Workplace. Belfast Ellison, Gavin and Briony Gunstone: Sexual Orientation explored: a study of identity attraction, behaviour and attitudes in 2009. Manchester: EHRC	2011 2009

	This should include an Equality and Diversity Statement, Policy and Action Plan, Anti-Bullying and Harassment Policy, family friendly policies, network support groups and monitoring policy.		
Lack of confidence in reporting and disciplinary procedures. 66% of LGB people who made a complaint were unhappy with outcome; 26% of LGB people in public sector not comfortable approaching managers if bullied; 15% not confident they would be supported	• Confidential reporting process to protect individuals not out. • Create support systems (through unions, associations, staff networks). • Communicate rights of LGB staff with payslips or information leaflets.	BMA Hansson *et al.* Hunt *et al.* *McDermott*	2005 2007 2007 2011
Lack of visibility of LGB people in the health and social care workplace.	• NHS to acknowledge its LGB staff, create a safe environment (peer support, mentor system, highlighting successful careers, role models, display of positive posters, information leaflets targeted at LGB staff and identified contact person for LGB issues). • Create support systems (through unions, associations, staff networks). • Monitoring – collect data on LGB employees and their experiences in tandem with creating safe space to disclose. • Work-life balance policies need to explicitly state that they apply to LGB people also; harassment and bullying policies to be	BMA NHS Scotland Hunt *et al.* BMA Discussion with Rainbow Discussion with Strabane and Lifford LGBT Group McDermott	2005 2006 2007 2009 2011

	specific about homophobia. • develop or review family friendly policies (as to flexible leave, same sex adoption leave, maternity/paternity leave) and partner/civil partner benefits		
Negative impact on delivery of services		BMA Hunt *et al.*	2005 2007
2. Services			
Reluctance to disclose sexual orientation to GPs and delays in seeking care due to fear of attitudes and discrimination.	• Require GP practices and hospitals to develop and prominently display equality policies explicitly including sexual orientation. • Guidelines for GPs and hospitals about confidentiality and patient notes. • Display positive images of gay couples in appropriate settings. • Booklet for GPs how to sensitively and effectively communicate with LGB people. • 5 Steps for GPs: Stay Informed about LGB health issues – Don't assume all patients are heterosexual (using open language) – Respond positively when patients disclose – Be	BMA NHS Scotland Hansson *et al.* Discussion with Rainbow Allen, Odhran: Lesbian, Gay & Bisexual Patients: The Issues for General Practice.	2005 2006 2007 2008

	aware and challenge anti-LGB bias – Demonstrate that your practice is inclusive of LGB people (language, LGB leaflets/posters, include LGB in general health info,)		
Negative experiences of health services.	• Raise awareness of staff about need for neutral language; booklet for GPs how to sensitively and effectively communicate with LGB people; challenge inappropriate language. • Training (building capacity and confidence to challenge inappropriate behaviour), developed in collaboration with LGB groups, possibly focus on team leaders first. • Require GP practices and hospitals to develop and prominently display equality policies explicitly including sexual orientation. • Guidelines for GPs and hospitals about confidentiality and patient notes. • Display positive images of gay couples in appropriate settings. • Build on existing partnerships to engage closely with local LGB groups to identify areas for change and support for raising	BMA NHS Scotland Hansson *et al*. Discussion with Strabane and Lifford LGBT group	2005 2006 2007

	complaints. • Service providers to find out about local support groups and services for signposting to LGB service users. • Start monitoring in small service areas and expand to all services over time; publish monitoring results and demonstrate impact of monitoring on service improvement. • Consider introducing champion (with specialist knowledge).		
Specific needs for mental health services: (higher incidents of eating disorders and self-harm, higher alcohol consumption, drug use, smoking – often in response to experience of homophobia). Rooney (2012): 44% LGB&T smoke vs. 24% in NI population; 91% LGB&T drink alcohol vs. 74% NI population, women more than men (reverse in NI population), 57% drink to hazardous level vs. 24% adults in England; 3x as likely to have taken illegal drug (LGB&T 62% vs. NI population 22%); types of drugs mainly anti-depressants rather than stimulants; substance abuse a factor in self-harming and thinking about and attempting suicide; less likely to access support services	• Comprehensive health strategy for LGB people, taking account of multiple identities. • where appropriate, GPs can play positive role by screening LGB patients for mental health and suicide risk factors • improve evidence base • public health campaign to target LGB people • develop gay-friendly venues outside drinking establishments • train addiction service providers on LGB issues • develop LGB affirming addiction services	Hunt, Ruth and Minsky, Adam: Reducing Health Inequalities for Lesbian, Gay and Bisexual People: Evidence of Health Care Needs. Stonewall Discussion with Strabane and Lifford LGBT Group Allen Rooney, Eoin: All partied out? Substance use in Northern Ireland's Lesbian, Gay, Bisexual and Transgender Community. Belfast: The Rainbow Project.	2006 2008 2012

	• steering groups for drugs and alcohol to include LGB representation		
General lack of recognition of domestic violence amongst same-sex couples.		Hunt et al	2006
Reluctance to raise a complaint.	• Address LGB issues in induction training for newly appointed doctors. • Mandatory training for staff. • Participation in LGB awareness raising to be part of Continuing Professional Development.	NHS Scotland Hansson *et al.* Discussion with Strabane and Lifford LGBT group	2006 2007
Some preventative public health messages only target heterosexuals.		Hunt *et al.*	2007
Lower participation in cancer screening.	• Comprehensive health strategy for LGB people, taking account of multiple identities.	Hunt *et al.* Discussion with Strabane and Lifford LGBT Group	2007
Persistent omission of sexual orientation from mainstream research and data gathering re: service provision e.g. older people's services.	• Sexual identity needs to be recognised as a significant factor influencing access to use of health services. Needs to be included in research and data gathering.	Don't Look back? Improving Health and Social Care for Older LGB Users - Equality and Human Rights Commission (England)	2011
Concern that GPs are not covered by Section 75.		BMA Hunt *et al.*	2005 2007
Monitoring • Many consider "sexual orientation "to be more private than other characteristics. • Disclosure requires safety and protection against discrimination. • Needs to be sure that information will remain anonymous and confidential.	• Organisations need to prepare the ground for monitoring through consultation and communication with their workforce and users • Need to develop culture where an exchange of information between organisations, their staff	Improving Sexual Orientation Monitoring - Equality and Human Rights Commission (England)	2011

• Good practice examples.	and their service users is understood to have benefits for all. Anonymity and confidentiality is critical in this area. • Good examples of monitoring questions that facilitate disclosure.		
LGB&T people are 3 times more likely than the Northern Ireland population to have tried an illegal drug in their lifetime while 91% of LGB&T community drink alcohol compared with 74% of the Northern Ireland population	• Addiction service providers should monitor the sexual orientation of clients • Public health campaigns on substance abuse should target the LGB&T community. • Addiction service providers should receive training in LGB&T issues • Service providers should advertise the fact that they are LGB&T friendly.	All Partied Out – Substance Abuse in Northern Ireland's Lesbian, Gay, Bisexual and Transgender Community - http://www.rainbow-project.org/assets/publications/All%20Partied%20Out.pdf	2012
The experiences of people with disabilities who identify as Lesbian, Gay, Bisexual and Transgender people living in Northern Ireland	• Awareness raising • Relationship and sexual education • Statistics and data collection • Ensuring Equality of Service	Multiple identity; Multiple Exclusions and Human Rights - http://www.rainbow-project.org/assets/publications/Multiple%20Identity%20Multiple%20Exclusions%20and%20Human%20Rights.pdf	2012
This action plan was developed to help promote informed choice in cancer screening in Northern Ireland. Actions relating to each of the cancer screening programmes are followed by actions relating to the specific population groups	• Informed choice in cancer screening should be promoted through groups representing the LGBT population. Rainbow, NI Gender Identity Service	Informed Choice Action Plan	2013
3. Cross Cutting Issues with other Section 75 Categories			

Age			
Gender			
Lesbian Women • Even less visible than gay males. • Less research on lesbian women than gay men. • Debate around higher risk of breast cancer (due to smoking and poor diet; less likely to have children). • Specific health issues relating to fertility, pregnancy, sexual health, mental health; weight issues, eating disorders, relationships, smoking/drugs/alcohol abuse. • Generally unhappy with level of service received. • Lack of dedicated counselling service for lesbian and bisexual women. • Access services less frequently than other women including lower uptake of cancer screening • 2-3 times more likely to attempt suicide; higher levels of self-harm; 1 in 2 chance of mental illness at age of 16 in NI. • Service providers are often misinformed and underinformed about lesbian health issues. • US lesbian women have higher prevalence of overweight and obesity than other females	• Research on health needs and health care experience of lesbian women. • Include information specifically for lesbian service users to address misconceptions about 'immunity' in follow up letters. • Develop health strategy for LGB people (e.g. Australia, state of Victoria). • Make lesbian women and their families visible in health promotion campaigns. • Incorporate specific needs into undergrad and postgrad training. • Further research on specific groups amongst lesbian and bisexual women. • Establish dedicated resource centre. • weight reduction interventions targeted at lesbian women	BMA Hunt *et al.* Marie Query Invisible Women. A review of the impact of discrimination and social exclusion on lesbian and bisexual women's health in Northern Ireland Lesbian Advocacy Services Initiative (LASI) Fish, Julie: The UK Lesbians and Health Care Survey – A summary of findings. Hughes, Clare and Amy Evans: Health needs of women who have sex with women. BMJ Vol. 327, 939-940. Boehmer, Ulrike and Deborah J. Bowen and Greta R. Bauer: Overweight and Obesity in Sexual-Minority Women: Evidence from Population-Based Data. American Journal of Public Health June 2007, Vol 97,	2005 2007 2007 2007 2003 2007

		No.6, 1134-1140.	
Young People • Homophobic bullying at school, access to support networks, lack of positive role models. • Even less likely to be out to GP for fear of disclosure to family; might be more likely to attend STI clinic.		Hansson *et al.* Hunt *et al.* Allen	2007 2007 2008
Older People • Concerns about provision of social care (more likely to live alone and without children; concern about access to appropriate care). • Society and health messages assume LGB people are young and active. • Actual or fear of discrimination and negative treatment. • LGB specific HSC issues. • Often invisible and assumed heterosexuality.	• Need for affirming environments to ensure older LGB people are comfortable to disclose their sexual orientation. • Service providers need to recognise families of choice and involve in consultations about care. • Direct Payments. • Proper provision of care and support to older people should become a key indicator of how well HSC agencies engage with minority groups and deliver non discriminatory services. • Need to ensure that LGB older people are involved in the planning of services. Engage with LGB users as "Experts by experience".	Hansson *et al.* Hunt *et al.* Primrose Musingarimi Older Gay, Lesbian and Bisexual People in the UK. A Policy Brief. London: ICL-UK Don't Look Back? Improving Health and Social Care for Older LGB Users - Equality and Human Rights Commission (England)	2007 2007 2008 2011
Gay Men • Concerns about issues relating to mental health, sexual behaviour, safety, weight issues, eating disorders, lack of role models, and relationships, smoking/drug/alcohol abuse. • Gay men at greatest risk of HIV infection; higher risk from sexually transmitted diseases. • Sometimes at higher risk (partly because they	• GPs to encourage sexually active Men who have Sex with Men (MSM) to be screened regularly for STIs • GPs with a role to motivate patients to reduce risky sexual behaviours	Hunt *et al.* Weatherburn, Peter *et al.* Multiple Chances. Findings from the UK Gay Men's Sex Survey 2006 - Sigma Research Allen	2007 2008 2008

don't respond to public health messages, partly because of lifestyle and reaction to social issues). • Living with diagnosed HIV more common among Black men rather than other ethnic groups, men with lower levels of former education, men who have sex with men only rather than bisexual men, men who have more sexual male partners. • lower level of HIV testing of those resident in NI than England			
• Some cohorts experienced severe oppression by institutions hence aversion to accessing services. • Greater fear of safety of home being invaded if care provider is homophobic. • In comparison to younger LGB people less experience of LGB community. • Older LGB people may feel that organisations providing support to LGB people are less in tune with their particular needs. • main themes of research on experiences of older LGB: discrimination and anticipation of neg. treatment due to experience; invisibility and assumed heterosexuality (diversity addressed less so in training for older people services; general reluctance to raise issues of sexuality with older service users; very limited understanding); specific health issues (mental health, HIV, vulnerability, dementia care, end	• specifically address sexual orientation in guidance / education / training / surveys / monitoring • HIV infection programmes to target older gay men • befriending and support networks • resource packs for professionals in care homes • inclusive planning – annual roundtable • strengthening advocacy • further research into experiences, perceptions and desired care by LGB people in NI • improve monitoring	Primrose Musingarimi Health Issues Affecting Older Gay, Lesbian and Bisexual People in the UK. A Policy Brief. London: ICL-UK Primrose Musingarimi Social Care Issues Affecting Older Gay, Lesbian and Bisexual People in the UK. A Policy Brief. London: ICL-UK Heaphy, Brian, Yip, Andrew and Thompson, Debbie Lesbian, Gay and Bisexual Lives over 50 - Nottingham Trent University, Department of Social Sciences Ward, Richard and Stephen Pugh and Elizabeth Price: Don't look back? Improving health and social care	2008 2008 2003 2010

of life care and bereavement care, LGB carers) • estimate of 23,600 older LGB in NI (women 60+ men 65+) • initial assessments of needs do not consider sexual orientation • rural care home providers in particular concerned about reaction of residents, families and staff • staff not specifically equipped for addressing needs of LGB people • lack of links between homes and LGB community; staff lack knowledge of community support	• provide training for staff • make information resources available to staff and develop tools to support staff explore with RQIA integration into inspection remit	service delivery for older LGB users. Manchester: Equality and Human Rights Commission The Rainbow Project & Age NI: Making this home my home. Making nursing and residential more inclusive for older lesbian, gay, bisexual and/or transgender people. Belfast: The Rainbow Project & Age NI	2011
Bisexual Women • Compared with women who have sex exclusively with men: more likely to have higher numbers of male partners and higher levels of unsafe sex; to have induced abortions; to have diagnoses of sexually transmitted infection.		Musingarimi	2008
Bisexual men and women • differ from lesbians and gay men in their identity, behaviour, attraction and experiences of disadvantage	• studies should report findings for bisexual people separately from lesbians and gay men	Ellison et al.	2009
Marital Status			
Dependants			
LGBT carers • not being out can increase stress; oldest and youngest carers least likely to be out; motivation includes		McGlynn, Nick, Bakshi, Leela and Kath Browne: Report on research about LGBT Carers. Count me in	2010

protecting those cared for, gaining legitimacy and preventing bad reactions • LGBT parents can be excluded from mainstream LGBT networks or in turn devalue non-parents • familial responsibilities can lead to conflict with partners • dual stigma in cases where LGBT people are caring for person with HIV/AIDS		too – LGBT research information desk. Brighton	
Disability			
• People with disabilities often considered to be asexual. • Many disabled LGB people have not received relevant sex education. • Lack of appropriate information about sexual health and fertility issues. • May encounter difficulties in accessing mental health services. • Difficulties in meeting other disabled LGB people. • Lack of acceptance in mainstream LGB scene. • main barriers re integration in LGB community are attitudes, lack of knowledge, poor accessibility of venues, lack of accessible information, lack of visibility, body-beautiful culture • lack of consideration of disability issues by LGB&T providers and of LGB&T issues by disability providers (voluntary	Need for clear policies and guidance and training for social care staff to offer appropriate support. work with carers and parents about sexual rights use wider range of images statutory sector to promote equality in tendered services review provision of relationship and sexual education and extent to which needs of disabled children who are LGB &T are met	Hunt *et al.* Department of Health: Disabled Lesbian, Gay and Bisexual People. Briefing 13 McClenahan, Simon: Multiple Identity; Multiple Exclusions and Human Rights: The Experiences of people with disabilities who identify as Lesbian, Gay, Bisexual and Transgender people living in Northern Ireland. Belfast: Disability Action and Rainbow Project.	2007 2007 2013

sector)			
Ethnicity			
• Compared with white gay men, African-Caribbean men twice as likely to be living with diagnosed HIV, South Asian men less likely. • BME domestic violence service mainly targeted at meeting needs of heterosexual women. • BME LGB people even more likely to be victim of homophobic violence than white LGB people. • BME LGB people less likely than white LGB people to have considered suicide, possibly due to cultural and religious taboos. • LGB groups feel less confident themselves in meeting needs of BME (language barriers).		Department of Health: Lesbian, Gay and Bisexual People from Black and Minority Ethnic Communities. Briefing 12 Discussion with Rainbow	2007
Rurality			
• People in rural areas even less likely to be out to GP for fear of disclosure to community. • Lack of research. • rural isolation may compound minority stress and stress experienced by young LGB people		Hansson *et al.* Discussion with Strabane and Lifford LGBT group Allen	2007 2008
4. Lack of information			

Employment
• Needs and experiences of
  • LGB people in non-medical HSC and public safety professions (nurses, AHP, social care workers / social workers);
  • HSC or Public Safety employees in NI;
  • bisexual people.			

Services
• Health needs/experiences of LGB people
  • w/dependants; (outside HIV/AIDS care work)
  • married/widowed/ divorced;			

- older;
- political opinion;
- religion;
- disability;
- ethnicity;
- rurality.

Generally less literature on social care needs/ experiences of LGB people.

	Other Issues		
What are the Equality/ Inequality Issues?	**Potential solutions where these are offered in the literature Policy/Practice Issues?**	**Source of Evidence**	**Date**
There is increasing evidence of the health inequalities experienced by patients and service users as a result of their sexual orientation They face documented structural, personal and cultural barriers when attempting to access healthcare services (Clover, 2006; Diamant et al., 2000; Jillson, 2002). These barriers tend to alter their behaviour and attitudes towards healthcare providers and may adversely affect their willingness to access services and supports	• By understanding the specific health needs of the targeted groups and the barriers they may face in meeting these health needs, health providers can ensure the provision of an appropriate, inclusive and accessible service. • The provision of optimal care to LGB & T people requires a welcoming environment that promotes good communication and allows individuals to feel comfortable discussing matters of sexual identity and any conflicts they may be experiencing. All staff should be trained to speak with patients in a non-judgmental, gender appropriate and professional way. • A comprehensive and thorough training programme (induction and on-going training) to increase knowledge of LGBT people's health care needs, develop	A Review of the Literature on Promoting Access to Selected H&SC Services for LGB&T	Decem ber 2011

(Mayock, Bryan, Carr and Kitching, 2009). Many health professionals do not know the difference between sexual orientation and gender identity (Rainbow, 2010). There are specific concerns for transgender people accessing healthcare services; one example is that transgender men may be missing out on cervical cancer screening. Limited access to services, institutional racism, language barriers, religious and cultural insensitivity of services are some of the social factors that restrict minority LGB & T from accessing healthcare provision Healthcare providers' anti-gay bias and heterosexism – structural and attitudinal Lack of knowledge on the part of healthcare providers Fears, real or perceived of negative consequences; concerns about confidentiality and experience of or fear of	cultural sensitivity and competence in communication and care • On-going awareness raising on LGB & T issues through team meetings and presentations in order to create environments that convey respect, acceptance and welcome to all, regardless of their sexual orientation. • Competency training specific to LGB & T populations should be a standard component of all health professional training curricula and be made available to healthcare workforce through continuing education institutes. Prioritisation of staff groups for targeting of training. • All job descriptions should have a diversity statement. **<u>Interaction with Staff</u>** 1. Staff training (induction & on-going) delivered in partnership with LGBT community (i.e. they are involved in design & delivery). 2. Staff attendance at training. 3. Extent to which staff challenge each other for inappropriate attitudes. 4. Levels of knowledge/understanding of LGBT health issues e.g. cervical smears (maybe need questionnaire).		

homophobia when dealing with healthcare staff Lack of knowledge of transgender issues among healthcare staff LGB & T can experience negative or mixed reactions from mental health professionals and low levels of trust accessing mental health services Discrimination and prejudice may result in distress, isolation and depression in the LGB & T community	5. Existence of staff support forums. 6. Use of “sexuality identifier” to facilitate better planning. 7. Specific staff training on mental health issues relevant to LGBT population. **<u>Language & Literature</u>** 1. Existence of welcoming leaflets, posters & statements. 2. LGBT friendly language in health care literature including admission/clinical record forums. 3. Extent to which job description of managers include requirement to challenge discriminatory language. • Specific training and resources for		

	mental health professionals on increased risk of mental health difficulties in the LGB & T community		
• One fifth of the 366 people said they missed an appointment in the past due to issues with transport and almost a quarter said they had cancelled an appointment due to problems with travel • Missed appointments due to transport could be costing the health service 2.2million each year	• Many of the calls for action made by the Jury reflect the issues identified in the report, including calls for greater joined-up working, for future changes in service delivery to take account of transport needs and for information about transport to be included with all health and social care appointment letters.	Transport Issues in Accessing Health and Social Care Services – Patient and Client Council and the Consumer Council http://www.patientclientcouncil.hscni.net/uploads/research/TRANSPORT_TO_HEALTH_AND_SOCIAL_CARE_REPORT_Mar_2013.pdf	2013
The Emergency Department is many people's first choice for urgent care; however a number of concerns about this service are raised in the report. Waiting time to see a doctor or for treatment, as well as concerns about the environment in which they had to wait, including safety, comfort, cleanliness and patient facilities were all outlined in this document.	• Good communication is identified as crucial in an urgent care situation. • Some people did report experiences of poor communication, negative staff attitudes, questionable treatment or misdiagnosis and a lack of dignity and respect, particularly at the Emergency Department and GP out of Hours service. • The report concludes that information and education about how to use urgent care services during a period of change for health and social care services in Northern Ireland is essential.	A Report on Urgent Care Services – Patient and Client Council http://www.patientclientcouncil.hscni.net/uploads/research/Urgent_Care_Report_22_March_2013_final.pdf	2013

Appendix 2 – Bibliography

Gender

Statement on Key Inequalities in Northern Ireland, ECNI, 2007

Men's Action Network, Derry, 2010

Other Borders, 2005

Women's Health in Ireland, 2006

Women in Disadvantaged Communities, 2009

DHSSPS Literature Review, 2006

Ethnic and Social Inequalities in Women's Experience of Maternity Services, Care Quality Commission, 2007

NI Women's Aid Federation, Domestic Violence and Health Professionals, 2003

Western Interagency Domestic Violence Partnership, 2010

Unison and Western Interagency Domestic Violence Partnership, 2010

Levelling Up: Securing Health Improvement by Promoting Social Inclusion, Derry Well Woman, 2008

Priority issues which need to be addressed in the Men's Action Plans, Men's Action Network; Work with Young Men Unit; The Men's Project, 2009

McEvoy and Richards: cited in DHSSPS Literature Review, 2006

Men's Action Network, 2010

Fathers Direct: cited in DHSSPS Literature Review, 2006

Health Inequalities CAWT Report, 2005

Fair for All: NHS Scotland, 2008

The Luck of the Draw - a Report on the Experiences of Trans Individuals reporting Hate Incidents in NI, Institute for Conflict Research, 2010

Health Care Issues for Transgender People Living in Northern Ireland, Institute of Conflict Research, 2011

Trans Community Statement of Need (England), April 2011

Equality Commission Northern Ireland

United Nations Convention on the Elimination of all forms of Discrimination Against Women.

Submission to the UN Committee on the Elimination of All Forms of Discrimination Against Women pre-sessional working group to the fifty-fifth session, 2012

Young Men and Suicide Project – A Report on the All-Ireland Young Men and Suicide Project 2013

Age: Young Persons and Older People

OFMDFM, Consequences of Childhood Disadvantage in Northern Ireland at Age 5, June 2010

NICCY's 2008 Review of Children's Rights in Northern Ireland, 2008

Children's Rights in Northern Ireland – NICCY in association with Queens University Belfast, 2004

Children in Poverty, Anti-Poverty Network, 2008

Save the Children – What we do in Northern Ireland, 2007/2008

Northern Ireland NGO Alternative Report, March 2008

Submission to the United Nations Committee on the Rights of the Child for consideration during the committee's scrutiny of the UK Government report (July 2007), March 2008

Cousins *et al.,* The Care Careers ofYounger Looked After Children: Findings from the Multiple Placement Project, Institute of Child Care Research, Queen's University Belfast, 2003

ARK NI Research Update Number 61 – Attitudes to Age and Ageing in Northern Ireland, June 2009

Equalities and Inequalities in Health and Social Care in Northern Ireland – A Statistical Overview, DHSSPS, 2004

ECNI, Statement on Key Inequalities in Northern Ireland, October 2007

Making Older People Equal, February 2009
Reforming the Law on Access to Services In Northern Ireland
- Report for the Changing Ageing Partnership (CAP) by the Institute of Governance, School of Law, Queen's University Belfast

Northern Ireland Women's European Platform – 12 Critical Areas

Older People's Experience of Health Services in Northern Ireland, Help the Aged, OFMDFM and NIHRC, July 2004

A Sure Start to Later Life - Ending Inequalities for Older People, Social Exclusion Unit Final Report, January 2006

Social Inequalities in Later Life: the socio-economic position of older people from ethnic minority groups in Britain, Kings College London, Autumn 2000

Age NI Briefing Paper – Evidence to DSD Committee on the Welfare Reform Bill, May 2010

David Bell and Alison Bowes, Financial Care Models in Scotland and the UK, Joseph Rowntree Foundation, 2006

Care and Compassion? Report of the Health Service Ombudsman on Ten Investigations into NHS Care of Older People, February 2011

Making Older People Equal: Reforming the Law on Access to Services in Northern Ireland, February 2009

Older Women's Lifelong Experience of Domestic Violence in Northern Ireland, January 2010

Northern Ireland Statistics and Research Agency (NISRA) 2009 Mid-Year Population Estimates

Age NI Response, March 2011

The Human Rights of Older People in Health Care, 18th Report of Session, 2006/07, Joint Committee on Human Rights, 2007

DHSSPSNI (2010) Adult Community Statistics

Northern Ireland Life and Times Attitudes to Older People, ARK, Belfast, 2008

Emilie Roberts *et al*., Old Habits Die Hard – Tackling Age Discrimination in Health and Social Care, The King's Fund, London

Evaluation of Ageing Well Reach Project, Community Evaluation Northern Ireland, Belfast, 2009

Blake Associates Evaluation of First Connect Service, Age Concern Help the Aged NI, 2009

The National Evaluation of Partnerships for Older People Projects, Personal Social Services Research Unit (PPRSU), Department of Health, London, 2010

The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee, November 2010

Centre for Ageing Research and Development in Ireland (CARDI), Insights into Elder Abuse, June 2011

Protecting Our Future: Report of the Working Group on Elder Abuse, 2002

Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guide, 2006

Second World Assembly on Ageing, United Nations, 2002
World Health Organisation (WHO) Global Response to Elder Abuse and Neglect, 2008

Naughton *et al.*, Abuse and Neglect of Older People in Ireland: report of the national study of elder abuse and neglect, Health Service Executive (HSE) and University College Dublin (UCD), 2010

Making This Home My Home: Making Nursing and Residential More Inclusive for Older Lesbian, Gay, Bisexual and/or Transgender People, Age NI, September 2011

Diversity: Sexual Orientation in Home and Community Care,
Canadian Research Network for Care in the Community (CRNCC), Age NI, September 2011

Health and Social Care Act, 2008

ECNI - Awareness of Age Regulations 2006 and Attitudes of the General Public in Northern Ireland towards Age Related Issues, June 2008

Watson, Manthorpe and Andrews, Nurses over 50 – Options, Decisions and Outcomes, Joseph Rowntree Foundation, July 2003

The Mental and Emotional Health of 16 year olds in Northern Ireland, 2010

OFMDFM - Consequences of Childhood Disadvantage in Northern Ireland at Age 5, 2010

Children and Young People's Health Outcomes Forum - INEQUALITIES IN HEALTH OUTCOMES AND HOW THEY MIGHT BE ADDRESSED, 2013

Religion

Narrowing the Gaps Equality and Diversity, NHS, 2008-2013

Weller *et al.*, Religious and Spiritual Care in a Health and Social Care Context, 2001

Sheikh, A, Hospital Chaplaincy Units show bias towards Christianity, 2004

Weller *et al.*, (2001:71), Religious Discrimination in England and Wales, Home Office Research Study, 2001

Programme for Cohesion, Sharing and Integration (CSI), September 2010

Faith and Human Rights, NIHRC 2010

The Forgotten Age – Understanding Poverty and Social Exclusion in Later Life. An Interim Report by the Older Age Working Group, Chaired by Sara McKee 2010

Political Opinion

Smyth *et al*., Caring Through the Troubles, 2001

Neil Jarman, Managing disorder – Responding to interface violence in North Belfast, OFMDFM Research Branch

Programme for Cohesion, Sharing and Integration (CSI), September 2010

Smyth *et al*., Caring Through the Troubles, 2001

Smyth *et al*., The impact of political conflict on children in Northern Ireland, Institute for Conflict Research, Belfast, 2004

Dr Peter Shirlow, The State they are Still In. Republican Ex-Prisoners and their Families: An Independent Evaluation, CAIN Project, University of Ulster, 2001

McEvoy *et al*., 1999

DHSSPS NI Victims Strategy, 2003

Living with the Trauma of the Troubles, Social Services Inspectorate, 1998

Colin Knox, Joined-Up Government: A multi-agency response to violence in Northern Ireland, 2000

The Cost of the Troubles Study, Incore, 1999

Marital Status

Lone Parents Needs Assessment NHSSB, Gingerbread NI, DHSSPS, 1996

Census, 2001

OFMDFM, Towards an anti-poverty strategy, New TSN – The Way Forward, 2004

Family Resources Survey, 2004/05

Matthew Hughes, Social Trends, Office for National Statistics, 2009

Families in Britain come in all shapes and sizes; we should acknowledge and value their diversity, Gingerbread, 2009

Gingerbread NI, 1998

NISRA, 2009

Ann Craft Trust (ACT), Forced marriage of People with Learning Disabilities,

Northern Ireland Life and Times Survey (NILT), 2005

Census 2001: Men and Women in Northern Ireland (2006). (Equality Commission Report), 2001

Department for Social Development (DSD), 2003

Labour Force Survey (LFS), 2002

Department for Education and Learning (DEL), 2001-2002
Gender Matters - a consultation document, OFMDFM, 2005

Northern Ireland Health and Social Wellbeing Survey.
(Gender matters – a consultation document, OFMDFM, 2001

British Journal of Psychiatry, 2008

Men in Northern Ireland: Report 3a - Olivia O'Riordan and Paula Devine., December 2007

NIHE, 2001-2002

University of Ulster, 2002-2005

University of Ulster - Review of Childcare Provision, 2009

Women Living in Disadvantaged Communities: Barriers to Participation, Dr Helen McLaughlin on behalf of the Women's Centres Regional Partnership

No Home from Home, Northern Ireland Human Rights Commission (NIHRC), 2009

Office for National Statistics, 2006

Dependent Status

Yeandle and Buckner, Carers, employment and services: time for a social contract - Report Number 6, University of Leeds, 2007

Professor Sue Yeandle, Carer's employment and services: why we need a social contract for care, University of Leeds

A Picture of Caring. Carers' Stories, Carers NI and Equality Commission Report as part of Carers Week 2010

Carers NI Conference, 2010

Helen Ferguson and Paula Devine, An Ordinary Life? Caring in Northern Ireland Today, E.S.R.C. (Economic and Social Research Update)

Northern Ireland Life and Times Survey (NILT), 2010

Carers in Crisis – A Survey of Carers' Finances in 2008, Carers UK, 2008

The Cost of Caring – How Money Worries are Pushing Carers to Breaking Point, Carers UK, 2011

Tipping point for care. Time for a new social contract, Carers UK, 2010

Background to Coleman Case, Carers NI, 2008

Real change not short change. Time to deliver for carers, Carers UK, 2007

Carers NI Effectiveness of Section 75, 2007

The Equality Bill and Carers, Carers UK, 2009

Paula Devine, Men in Northern Ireland Report Number 7 – Men as Carers, E.S.R.C. (Economic and Social Research Update)

Young Adult Carers in the UK. Experiences, Needs and Services for Carers aged 16-24 Years, Saul Becker and Fiona Becker, 2008

Paula Devine and Katrina Lloyd, Young Carers Too, E.S.R.C. (Economic and Social Research Council), 2011

SCARE Briefing, Social Care Institute for Excellence, 2005

Supporting disabled parents and parents with additional needs, Review Number 11, Social Care Institute of Excellence, 2006

Working together to support disabled parents, Social Care Institute of Excellence, 2007

Report on Research about LGBT (Lesbian, Gay, Bisexual and Transexual Carers), 2010

Nick McGlynn, Leela Baski and Kath Brown, Count Me In Too, University of Brighton, 2010

Wintrip, 2009????

Cronin and King, A Queer Kind of Care – Some Preliminary Notes and Observations, 2010

Jill Manthorpe, Nearest and Dearest? The Neglect of Lesbians in Caring Relationships, British Journal of Social Work, 33, 6, pp.753-768

A Gulland, Direct Payments – Letting Down Gay Services, 2009

Putting People First: Equality and Diversity Matters – Providing Appropriate Care for Lesbian, Gay, Bisexual and Transgender People, In Focus, Issue Number 7, Commission for Social Care Inspection (CSCI)

R Hunt and A Minskey, Reducing Health Inequalities for Lesbian, Gay and Bisexual People: Evidence of Health Care Needs, Stonewall, London, 2007
D Abbot and J Howarth, Secret Loves, Hidden Lives? Exploring Issues for People with Learning Difficulties, 2005

Who Carers Win: The social and business benefits of supporting working carers, ACE National; Action for Carers; Yeandle, Bennett, Buckner, Shipton and Suokas, 2006

Diversity in Caring. Towards equality for carers, Yeandle, Bennett, Buckner, Fry and Price, University of Leeds, 2007

Black and Minority Ethnic Toolkit – interactive toolkit to look at how local authorities are working to improve the lives of black and minority ethnic carers in London, Carers NI, Joint Improvement Partnership

Disability

HSSPS Literature Review, 2008

Equality Awareness Survey, ECNI, October 2007

Statement on Key Inequalities in Northern Ireland, ECNI, 2007

Mr B Collins Keynote Speech at ECNI Annual Conference, 2007

Access to Public Services for Deaf Sign Language Users (Action on Hearing Loss (RNID) and British Deaf Association (BDA)), 2001 and 2004

Access to Public Services for Deaf Sign Language Users (Action on Hearing Loss (RNID) and BDA), 2009

Regional Sexual Orientation Working Group, 2001 and 2004

WHSCT Audit of Sensory Support Services for People with Hearing Impairment, 2010

ECNI Investigation into Accessibility of Health Information in Northern Ireland for People with a Learning Disability, 2007

WHSCT Audit of Sensory Support Services for People with Hearing Impairment, 2010

ECNI Survey re Public Attitudes to Disability in Northern Ireland
Health and Social Care workforce monitoring, 2001

Equality Commission Conference – Key Inequalities, October 2007

Brenda Gannon and Brian Nolan, The Dynamics of Disability and Social Inclusion, Equality Authority and National Disability Authority, ROI (taken from the Living in Ireland Surveys 1995 to 2001)

ECNI Formal Investigation into The Accessibility of Health Information in Northern Ireland for People with a Learning Disability, 2007

Ethnicity

ANIMATE, 2007

OFMDFM Race Equality Strategy 2005-2010

OFMDFM - A Shared Future

Life as a Stranger - The personal stories of Migrants to Northern Ireland, September 2010

(Zachlebem), NICEM, 2009

New to Northern Ireland - A study of the issues faced by migrant, asylum seeking and refugee children in Northern Ireland, October 2010

BME CERD Framework

Convention on the Elimination of Racial Discrimination Working Group, February 2010

Philomena de Lima *et al*., A Study of Migrant Workers in Grampian, Communities Scotland, 2007

The Health of BME, King's Fund, London, March 2001

Ethnicity, Equality and Human Rights: Access to Health and Social Services in Northern Ireland, 2006

Mapping Exercises Down & Lisburn, October 2010

Diverse Dialogue - Report of the North South Intercultural Forum, 2005 -2008

Programme for Cohesion, Sharing and Integration (CSI), September 2010

No Home from Home, Northern Ireland Human Rights Commission (NIHRC), 2009

Pre-consultation with Southern Area BME Representatives, October 2010

The Economic, Labour Market and Skills Impact of Migrant Workers in NI (DEL), December 2009

Migration in Northern Ireland: A Demographic Perspective, Northern Ireland Assembly, June 2011

Out of the Shadows - An action research report into families, racism and exclusion in Northern Ireland, 1997

Ethnic and Social Inequalities in Women's Experience of Maternity Care: Results of a National Survey (2007), 2010

Review of Literature on Equality of Opportunity Issues in Health and Social Services, March 2001

Realising Integration. MRCI, 2006

Racism and the Recession, Unison, 2009

McPherson Report on the Stephen Lawrence Case, 1993

ECNI Response to OFMDFM Race Equality Strategy, 2005

Programme for Cohesion, Sharing and Integration (CSI), September 2010

Review of Literature on Equality of Opportunity Issues in Health and Social Services, Netto, 1998

Ward, 1998

BME Health and Wellbeing Report N&W Belfast, NICEM, 2009

The Nature and Extent of Human Trafficking in Northern Ireland, NIHRC, 2009

Statement on Key Inequalities in Northern Ireland, ECNI, October 2007

A Guide to the Main Equality in Health Issues

Reeves Associates, Assessing the Impact of Section 75, February 2007

Promoting Social Inclusion of Travellers, OFMDFM, 2000

All Ireland Traveller Health Study, September 2010

Southern Area Action with Travellers (SAAT): Outcomes for Children: Outcome Monitoring Report 2010/11

The Future of Human Rights in the UK – NIHRC Conference, September 2010

Southern Health and Social Care Trust Traveller Awareness Training, September 2010

Bayanihan! The Filipino Community in Northern Ireland, NICEM, 2011

Pre-consultation with BME representatives, October 2010

Audit of Unmet need Armagh & Dungannon area, April 2007

A Unified Guide to Promoting Equal Opportunities in Employment, ECNI, March 2009

Racism and the Recession, Unison, 2009

Race Equality Audit for Northern Ireland, NICEM, 2004

Pre-consultation with NICEM, 2010

Pre-consultation with local BME representatives in the Southern Trust Area, October 2010

The Economic, Labour Market and Skills Impact of Migrant Workers in NI (DEL), December 2009

Migration in Northern Ireland: A Demographic Perspective, Northern Ireland Assembly, June 2011

Sexual Orientation

British Medical Association (BMA), Sexual Orientation in the Workplace, 2005

NHS Scotland: Fair for all – The Wider Challenge. Good LGBT Practice in the NHS, Stonewall, 2006

Ulf Hansson, Molly Hurley Depret and Barry Fitzpatrick, Equality Mainstreaming: Policy and Practice for LGB People, Institute for Conflict Research, 2007

Ruth Hunt, Katherine Cowan and Brent Chamberlain, Being the gay one: Experiences of lesbian, gay and bisexual people working in the health and social care sector, Stonewall, 2007

BMA: A celebration of lesbian, gay, bisexual and transgender doctors' contribution to the NHS: a collection of members' experiences. London, 2009

Matthew McDermott, Through Our Eyes - Experiences of Lesbian, Gay and Bisexual People in the Workplace, Department for Social Development (DSD), The Rainbow Project, 2011

Ruth Hunt and Adam Minsky, Reducing health inequalities for lesbian, gay and bisexual people: evidence of health care needs, Stonewall, 2007

Don't Look Back? Improving Health and Social Care for Older LGB Users, Equality and Human Rights Commission (England), 2011

Improving Sexual Orientation Monitoring, Equality and Human Rights Commission (England), 2011

Primrose Musingarimi, Older Gay, Lesbian and Bisexual People in the UK: A Policy Brief. London: ICL-UK, 2008

Primrose Musingarimi, Health issues affecting older gay, lesbian and bisexual people in the UK: A Policy Brief. London: ICL-UK, 2008

Primrose Musingarimi, Social care issues affecting older gay, lesbian and bisexual people in the UK: A Policy Brief. London: ICL-UK, 2008

Brian Heaphy, Andrew Yip and Debbie Thompson, Lesbian, Gay and Bisexual Lives over 50, Nottingham Trent University, Department of Social Sciences, 2003

Marie Query, Invisible Women: A review of the impact of discrimination and social exclusion on lesbian and bisexual women's health in Northern Ireland, Lesbian Advocacy Services Initiative (LASI), 2007

Peter Weatherburn *et al*., Multiple chances: Findings from the UK Gay Men's Sex Survey 2006, Sigma Research, 2008

Department of Health, Disabled Lesbian, Gay and Bisexual People, Briefing 13, 2007

Department of Health: Lesbian, Gay and Bisexual People from Black and Minority Ethnic Communities, Briefing 12, 2007