

Review of Key Issues in relation to Equality in the HPSS

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Introduction

The aim of this paper is to highlight the key issues as expressed by representative groups in research material and consultation responses received by the Department. Initially the majority of the issues identified have been gleaned from documentation such as press releases, research reports and a literature review commissioned by the Department of Health, Social Services and Public Safety.¹

It would be helpful for officials to consider these key issues as a starting point when undertaking Equality Impact Assessments.

The range of issues identified is not exhaustive and should be added to as consultation and feedback from representative groups and service users continues and as new research is published. The main issues identified are reproduced in the summary section. A more detailed description of issues is given in the following eleven sections. The first nine of these eleven sections deal with the issues identified in relation to: gender, age, marital status, disability, with/without dependants, religious belief, political opinion, racial group, and sexual orientation. A further two sections covering issues surrounding geographical access and deprivation have been included as these are interlinked with the equality issues. The issue of geographical access and in particular the difference in access between rural and urban areas has been raised consistently and will be included in this paper.

Summary

Age

The main issues identified can be sub-divided into issues affecting children and issues affecting the elderly.

In respect of **children** the key issues are protection of their rights (particularly if they belong to a vulnerable group i.e. in care, in deprived socio-economic groups (travellers etc.), in broken homes or are carers) and ensuring that they have equal access to services. The need to engage directly with children and to provide services appropriate to their age were also highlighted.

In respect of the **elderly** the main issues were ageism and the need to ensure that equal priority is given to the elderly in access to treatment and services. Additional funding for and increased provision of mental health services for the elderly was seen as important.

Gender

Gender issues arose under the headings of Male, Female and Transsexual.

The main issue identified in relation to **males** was the need to target publicity concerning mens' health (prostate cancer etc.) effectively to encourage men to make use of available primary care services and to seek help early.

Issues concerning **females** included a lack of choice in female only wards and choice of male/female doctor or worker. Access to services was also seen as a problem associated with the burden of care which tends to fall on women. Opening times and geographical access are important issues affecting women with children.

Violence against women was also seen as an important public health issue.

The issues raised regarding **transsexuals** were the quality of psychological counselling treatment available and the long waiting times for NHS treatment and the consequences of transsexualism on family life.

Marital Status

Issues raised around marital status concerned **lone parents** and their access to services. Problems highlighted were transport difficulties for single parents and lack of awareness and involvement of social services with lone parents.

Another issue is the availability of sub-fertility treatment – one of criteria is that service is only available to **couples**.

The children of **divorced** couples were seen as a vulnerable group whose receipt of services was limited and fragmented.

Religion

One of the main issues is to recognise that there are **more religions in Northern Ireland than the Catholic and Protestant** groups. These minority religions may have difficulties in accessing services that we do not know about due to the lack of information and data.

The **polarisation of Catholics and Protestants** in our society was seen as a problem that raised issues around access to services by religious groups. Again the lack of research in this area was highlighted.

The need to support young children through community relations work was suggested as a means of **alleviating the effects of sectarianism**.

Racial Group

Interpreters and communication gap.

Access to services- main problem language barrier e.g. post natal care

Risk factors and specific diseases and illnesses of ethnic groups are not addressed. Primary health services need to reach out to groups with a high risk of ill health.

Dearth of information on health of **ethnic minorities**.

Travellers – difficulties in GP registration, hospital appointments and continuity of care. Little known about overall health picture of traveller children.

Section 1: Age

AGE: CHILDREN & YOUNG PEOPLE

This section is divided into a two main categories dealing firstly with children & young people and secondly with equality of opportunity in relation to older people. These would appear to be the main groups that are differentiated in the literature review.

The Unborn Child

Consider the unborn child, equality of opportunity and health, from the perspective of **high-risk mother's who might not have equal access to antenatal care.**²

Young Children

With young children it is principally the mothers who decide whether or not to seek medical help and advice if the child is unwell. Therefore, **parental health education** must be a priority if all children are to have equal access to appropriate services.³

There is a need for greater attention to be given to exploring the outcomes of **interventions from the perspective of the child.** In particular, there should be specific measures taken to ensure that children are asked for their views and that these are taken on board when policies are being drawn up.²

Children born into poverty are more likely to die in the first year of life, be born small or early, or both, smoke or have a parent who smokes. These children may not have equal access to health care.⁴

Children of divorced couples are not seen as a vulnerable group. The services to these children are limited, fragmented and may vary from area to area.⁵

Little is known about the overall health picture of minority group children, particularly children from the Travelling community.³

More research is needed into how caring during childhood affects **young people** as they move into adulthood.⁶

Services need to focus on the whole family and be quick to respond to the needs of disabled ill parents, if **children** are to be prevented from taking on inappropriate caring roles and suffering problems as they move into adulthood. Young carers performing intimate care are no more likely than others to receive an assessment of their needs, nor are very young children who have caring roles. Age, gender, ethnicity and even caring tasks undertaken do not influence the likelihood of young carers being assessed by social services.⁷

There has been little recognition of the contribution that **children** make to family care. Attention needs to be given to assessing the needs of children within families, and services need to be provided which meet the needs of both children and parents. This has been shown to reduce the need for children to adopt caring roles. In the largest survey of young carers, it was found that the majority of young carers

interviewed were unaware that they had been assessed by social services, even after the event. Few had been actively involved in the process.⁷

NEXUS strongly recommend that information concerning **child protection** be implemented and processed quickly and that information regarding children and vulnerable people at risk, or data on known offenders and paedophiles, be shared with the appropriate statutory bodies.⁸

Children in Care

Investigations should be made regarding the extent to which children and young people in the care system are protected from infectious disease through **immunisations**.⁹

Measures should be taken to ensure that all **children in care have a care plan**, and that they know how to make an official complaint.¹⁰

The Joseph Rowntree Foundation states that **children's welfare is fragmented** amongst different people and different organisations. They highlight the need for a national strategy for residential care.¹

Care leavers need special support and advice.¹¹

Sexual Health

Attempts should be made to address **the sexual health needs of young people in care**, as the literature reveals that they are particularly vulnerable to poor sexual health and high levels of teenage pregnancy. In particular, it was noted that Care leavers need special support and advice.¹¹

Initiatives are needed that identify and intervene in health problems at an early stage; and involve **inter-agency alliances to address multiple health risks**.¹

Measures should be taken to ensure that all young people accessing sexual health clinics are convinced that the **service will be confidential**.¹²

There is a need to convince young men that the **services offered by sexual health clinics are for them**, and that they are legitimate users of the services.¹

Efforts should be made to consult with boys and use their feedback to shape both the content and the **delivery of sex education**.¹

Research has revealed that young people have problems in **obtaining sexual health services in the primary care setting**. There is a need to provide accurate up to date sexual health information to young people.¹³

Drugs

There is evidence to suggest that treatment and rehabilitation services for **young people who use drugs** are inappropriate for their age. It is recommended that the practice and guidelines in the SCODA Report, 1997 be taken on board when examining policies that relate to treatment and rehabilitation services for young people who use drugs.¹⁴

Mental Health/Suicide

There is a growing concern about the escalation of teenage and young adults committing **suicide** in Northern Ireland. Studies have shown that there is a need to address the emotional health of young men between the ages of 17 and 35, and to identify strategies which would encourage this group to seek help, and to identify the risk factors for this group.¹⁵

Specific Conditions

Awareness needs to be raised amongst teenage girls about **osteoporosis** (“brittle bones”) which is fast becoming a public health matter for younger women, many of which have no knowledge of the condition.¹⁶

AGE: OLDER PEOPLE:

There is a need to address **the lack of awareness about ageism** as a major problem within society as a whole and within health and social services in particular.

In particular attention should be given to changing the perceptions and attitudes of individuals about older people during Medical, Nursing and Social Work Training as well as in the **training of all other professionals and care workers who come into contact with older people.**¹

In a Survey carried out amongst people from the Travelling community in two areas in Northern Ireland, it was found that only 6% were over the age of 45.¹⁷

Less Priority Given to Older People

Measures should be taken to ensure that **age limits** do not operate in coronary care units and in relation to cancer treatments.¹⁸

Measures should be taken to ensure that appropriate **accident and emergency care is being provided irrespective of age.**¹⁹

Measures need to be taken to ensure that care and **treatment is not being rationed by age.**²⁰

The lives of **older people in rural areas** was highlighted by Age Concern as an issue that required a particular strategic focus.²¹

Older people may be being treated differently and **may have to wait longer** for services in general. It has been suggested that age discrimination is more often covert and subtle and is implicit in a general lack of priority for older people’s services.²¹

Research shows that one in 20 **people surveyed over the age of 65 have been refused treatment by the NHS** and one in ten say they have been treated differently since the age of 50.²²

Policy makers and service providers need to pay more attention to the **needs of lifelong older family carers**, as they have been overlooked and have had minimal statutory support during their life time. Older family carers differ from other groups. They are more likely to have small support networks. They are usually reluctant to seek help.²³

Specific Conditions

More funding is required for research and treatment in relation to the **mental health needs of older people**, which may be being neglected.²¹

Attention should be given to the deep concerns expressed by the Down Cardiac Support Group in relation to the **removal of cardiac acute services from the Downe Hospital**. In particular, the implications for older people living in the area should be investigated.²⁴

Mental health problems in older people may often be misdiagnosed or unrecognised. A survey by Age Concern found that 16% of **GPs had not referred older patients primarily because of their age.... Older people may not always be being offered the best treatment available** for their cancer.¹⁹

Communications

Health awareness campaigns should be targeted on older people. In particular material of interest to older people should be included, for example alcohol and medication. Older people are a low priority in health awareness campaigns.²¹

Research should be carried out to explore **the extent to which, and reasons why, older people may be viewed negatively by GPs**.¹⁹

Research in UK found that 97% of older people from the Chinese community found it difficult to use social services, due to language barrier, use of jargon & lack of information.²⁵

Investigations should be made into how successful the **complaints system** is working for older people. There is evidence to show that they battle against secrecy, intransigence, incompetence and time wasting.²⁶

Section 2: Gender

There is a need to evaluate the impact of gender awareness amongst doctors, nurses and other health workers, as a result of their initial training. There is a need to put in place programmes to **increase gender awareness amongst those working in the NHS** who were trained before such courses began.²⁷

Differences in health care use between women and men can be due to differences in the prevalence and severity of disease, differences in patient preferences, or due to clinical judgement. There is a need to examine these explanations thoroughly for gender inequalities.²⁸

Purchasers and planners need to ensure that **gender issues are built into routine monitoring** and evaluation exercises.¹

Male

More knowledge is needed to understand and measure both **effectiveness and efficiency of care services for men**. Men's health should be treated as a key concern. Pressures of masculinity may place unreasonable expectations about the ability of men to withstand pain.²⁹

Men tend to **use primary care health services less** than women. Men are more likely to **delay help seeking** when ill. Men are more likely to adopt health damaging or 'risky' behaviours like smoking, drinking, violence, fast driving, etc.³⁰

There is a need for increased knowledge about men's issues such as **prostate health**. The so called 'killer' diseases for men, such as heart disease and lung cancer have been given much greater attention and attract more resources than prostate health. Relatively little is known about conditions such as prostate health, compared to women's sex linked illnesses.³⁰

There is a need for good programmes for men in order to increase their interest in and use of **contraception**. The proportion of contraception attributed to men has fallen in recent years. Reproductive services for men tend to concentrate on treatment and control of STDs. Information on avoiding pregnancy and with regard to preventing infection is limited among married men.²⁹

Female

There are many gaps in the existing knowledge of maternity care. There is a reported absence of national data on **women only wards/choices of female/male worker**.²⁷

Significant gaps remain in the collection of statistics in the UK. There is a concentration on mortality rather than morbidity data. This is a particular problem in relation to **women as they tend to suffer more often than men from chronic less easily classifiable health problems**. Appropriate indicators are needed to monitor the health status of women and to assess their needs.²⁷

High technology **infertility** treatment such as IVF may be being offered at the expense of the under-research of the primary causes of infertility. **Doctors may be highly selective about the type of woman they treat.** There is concern that decisions may not be being made on purely clinical factors.³¹

Violence against women is a serious public health issue which needs to be monitored more closely.²⁷

Issues such as **geographical location; physical layout and opening times** can all pose problems, especially for **women with children.**²⁷

The burden of care has fallen largely on **women.** The impact of caring on employment is more severe for women than men.³²

Transsexual

Trans - the all-embracing term for those whose gender presentation or behaviour conflicts with the "norms" expected by the society they live in.³³

There was **no specific research uncovered in relation to the experiences of Trans people in Northern Ireland.** There is a need to address the dearth of definitive data with regard to Trans people in the UK and in particular in Northern Ireland. There is a need to address the gap in research in relation to the experiences of Trans people in Northern Ireland.¹

There is a need to address the concerns of Trans people in relation to the quality of **psychological counselling** treatment they receive. Transsexual (**Trans**) people reject the idea that their condition is a mental illness, rather they see it as an **anomaly of the brain/body.**³⁴

Trans people have expressed **concern about placing too much power into the hands of the medical profession** in terms of determining an individual's sexual identity.³⁵

'Queues are absurdly long for trans people seeking treatment through the National Health Service. It is not uncommon for some people to patiently attend a Gender Identity clinic in their own area, see the clinic closed by cuts, be referred to a distant centre such as the Charing Cross Hospital in London ... and then be told that their "evaluation" then has to start all over again, disregarding everything that has gone before. Finally, approved for surgery, the hapless trans person ... now halfway between the sexes after years of hormone administration ... can then find themselves at the tail end of a **surgery waiting list**, made long by a local health authority quota which arbitrarily dictates that only one or two procedures will be funded each year. With at least 100 trans people in every million of the population, it is little wonder that some reach this point seriously **contemplating suicide.** It isn't "gender dysphoria" (or whatever fancy name you give it) that drives people to such despair, however, but aggravated neglect.'³³

Most Trans people who cannot afford treatment are offered **grossly inadequate psychological counselling** at overcrowded and substandard centres.³⁴

Waiting lists of ten years for surgery for Trans people is not uncommon.³⁴

Privacy for Trans people is almost impossible to maintain because of the administrative systems that govern lives through sex and gender.³⁶

Increasing emphasis is being placed on measuring the **effectiveness of treatments** provided by an indubitably cash-strapped NHS - and quite rightly so. However gender reassignment surgery is one of the most successful forms of treatment offered, with clinical studies recording satisfaction rates of up to 97%. It is sought by only a small number of people each year: best estimates indicate **only about 5,000 transsexual people in the UK, of whom only a small number seek medical treatment** in any given year. It is also not expensive: treating transsexual people accounts for only a penny or two in every thousand pounds of the NHS budget.

Youth: and we should not forget the plight of young trans people in this account, for their status is often far more precarious than that of adults. Forced into gender stereotypes at school, with little chance of access to medical assistance unless they develop serious behavioural problems, many young trans people live their formative years in a silent nightmare, beginning the cycle of low self esteem leading to a mute acceptance of discrimination, which is the hallmark of a systemic, self-sustaining oppression. This is the cycle which Press for Change and the self help organisations needs to break in order to prevent another generation of trans children growing into damaged, desperately unhappy adults ... a goal which will be far easier to achieve when it is self evident that society respects and values its' trans people sufficiently to recognise the true nature of their identity.

Anyone who has had the distressing experience of **registering the death** of a transsexual person will know that the Registrar is legally obliged to record the "original" gender of the deceased on the certificate. This is a grotesque and unnecessary cruelty to both the deceased and their surviving family.

Bad Practice : There have always been frustrations for people attending the "gender clinics" and other specialist services. Yet individuals very rarely **complain**, for understandable reasons. Problems seem to include: very **long waiting lists** and delays in starting **hormone therapy**, unrealistic demands for the "**real life test**", prescriptions of **inappropriate hormones** or inadequate doses of hormones, inadequate monitoring of hormones, requiring **sterilization** prior to initiating hormone therapy, **unnecessary hysterectomies** (men). Some of these problems may be the result of ignorance on the part of some medical professionals, others may reflect out of date policies. But unless someone complains, the professionals won't know their clients are not satisfied.

Press for change reproduced extracts from the Department of Health's policy paper on transsexualism. Given that NHS surgery is now available the Department indicate that the issues are now concerned with the consequences of transsexualism and in particular issues affecting the Family.

The Department also has responsibility for the Children Act, the law on adoption, and the Human Fertilisation and Embryology Act 1990. In all of these areas,

transsexualism raises potential issues. (eg what is the position of a female-to-male transsexual who is the partner of an artificially inseminated woman?)

Policy on transsexuals, particularly as regards marriage, divorce and legal parenthood, undoubtedly raises issues which must be examined from the perspective, amongst others, of the Family. Indeed, some of the most difficult problems arise in this area because the right to privacy sought by transsexuals would, if granted, in some sense be at the expense of others, namely spouses, children and other relatives.

Section 3: Marital Status

Equality of opportunity in relation to health care should exist for individuals irrespective of whether or not they are single, divorced, separated, cohabiting, or married.

Issues: Sub-Fertility Treatment – one of criteria is that service is only available to couples.

Male Lone Parents

There is a **need for greater publicity targeted at lone fathers** in relation to available services. Research indicates that lone fathers may not know how to contact social services, were found to have little contact with one parent family organisations and there was a reported lack of involvement between lone fathers and health visitors.⁵

Social Service Departments should be aware of issues pertinent to male carers. Social workers should be alerted to their own prejudices and stereotypes. Young single fathers face barriers to participating in their children's upbringing. Young single fathers felt that little effort was being made to encourage them to develop and maintain involvement with their child. Young single fathers felt that they were made to feel unimportant both during the pregnancy and after the birth.³⁷

Lone Parents - General

Gingerbread note that **day care is needed for the children of parents who are *not* working, as well as those who are.** Day care provides important benefits for the child and for the mother's psychological well being..... Whilst there is a lot of support given to lone parents when their child is a baby, Gingerbread report that there appeared to be a shortage of information when children reached "the terrible two" stage.³⁸

It should be highlighted that the **relationship between the social worker and lone parents** is a key element in determining the level of support required and help gained. Delegates of lone parents at a Gingerbread Conference stated that there is a need for improved availability and accessibility of welfare services for lone parents, as well as anti-discriminatory services and practice.³⁹

In research carried out with lone parents in the Upper Shankill in the early 1990s, it was found that lone parents felt ignorant about issues affecting their health and that **information was frequently passed by word of mouth.**⁵

Lone parents in Ardoyne and in Glencairn expressed similar concerns to those expressed by lone parents in Upper Shankill. They also expressed **difficulties in accessing health services due to lack of transport.**⁵

Research commissioned by the Western HSS Board in 1992, focusing upon pregnant teenagers, found that two thirds of respondents had not used contraceptive services, and **one in three stated that they were unaware of the existence of Family Planning Clinics.**⁵

The focus should be shifted to unintended conceptions, rather than teenage pregnancy... the aim of prevention must be to prevent conceptions which are genuinely unintended and unwanted, rather than those, which according to social definition occur too early.⁴⁰

Feelings engendered by **stigma** can have an adverse effect on help seeking behaviour and in relation to service providers.⁵

Gingerbread expressed the view that **pressure in relation to adoption** should not be exerted, in particular upon young lone mothers, as this might result in them being stigmatised, and also because it is a very serious decision.⁴¹

Research commissioned by the Health Education Authority found that **teenagers** in the UK **often find GPs to be distant and unapproachable.** They reported difficulties in obtaining appointments and expressed concern about confidentiality.⁴⁰

Divorced

Children of divorced couples are not seen as a vulnerable group. The services to these children are limited, fragmented and may vary from area to area.⁵

Section 4: Religion

Religious Belief: Other Religions

It should be noted that Catholic and Protestant are not the only two religious groups within Northern Ireland, and research is also needed to address the extent to which equality of opportunity issues in relation to health are relevant within other religious groups who may have particular needs which have not yet been uncovered, due to lack of research.¹

One of the key barriers to the mainstreaming of Equality is the lack of data, and this is particularly acute in relation to race and religions other than protestant/catholic. What should we do when there is no data to answer the question of whether there is disadvantage.... in the absence of data relating to those who face barriers to accessing services. The result of such a lack of data has too often been the assumption that there are no problems. This is clearly wrong.....A more appropriate approach would be make the assumption that there are problems there, based upon the broader knowledge that black and minority ethnic groups face difficulties in accessing services generally, and face disadvantage in society. Resources and efforts can then be focussed on identifying the details of those barriers and addressing the problems.⁴²

One specific issue is also that in many instances when it is stated that information on religious belief is excellent, this only applies to catholic/protestant, and not other religions. Where this is the case, this must be recognised and addressed.⁴²

A recent Report by The Sainsbury Centre for Mental Health, “Keeping Faith”, raises major questions about the failure of the mental health system in the UK to provide services that people from other cultures want to use. It suggests that services have no mechanism for dealing with the central importance of faith to other communities and instead choose to ignore it altogether. “Keeping Faith” states that professionals cannot expect people from minority ethnic communities to use services that do not meet their most fundamental needs.⁴³

Bond, writing in *Community Care*, May, 1999 cites a situation where a mother in England, who was under considerable stress, refused to engage with social workers, using her Muslim faith as the justification. In this case, her children were at risk, and were being denied their right to equal access to care as a result of their Mother’s views.⁴⁴

Catholic & Protestant

Whilst there is a range of religious groupings within Northern Ireland, it cannot be disputed that Northern Ireland is a very polarised society. O’Reilly & Stevenson, 1998 state that more than 60% of the population live in areas which have more than 80% of one religion. Whilst the focus of their study was upon deprivation and ill health within the two communities in Northern Ireland, they concluded that policy-makers should continue to periodically monitor for differences between the two communities, including any differences in service accessibility and uptake. No specific research was uncovered which focused upon service accessibility and uptake of religious groups in Northern Ireland. There is, therefore, an obvious gap in the literature that needs to be addressed.¹

Children and Young People

In 1999 Connolly & Maginn carried out a study for the Centre for the Study of Conflict, which is based at the University of Ulster. They state that it is reasonable to assume that children from the age of three are able to develop an understanding of the categories of Protestant and Catholic, and to apply negative characteristics to these. They assert that if children are not to become rooted in sectarianism, there needs to be some form of community relations work started with a focus upon children's needs. They note that the available research suggests that with the appropriate help and support, children of this age are capable of reflecting upon their own attitudes and behaviour.⁴⁵

Mental Health Services have no mechanism to deal with the central importance of faith to other communities.⁴³

Section 5: Racial Group

Ethnic Minorities - General

Ethnic health needs are not met because: Equality policies are not implemented for the benefit of ethnic minority groups; there is insufficient use of trained interpreters; there is a communication gap due to cultural insensitivity of care providers and individuals needing care; risk factors and specific diseases and illnesses of ethnic groups are not addressed by mainstream providers, and target population groups are not consulted in partnership to develop services to help address need.⁴⁶

There has been in existence for some time a vibrant and growing ethnic pluralism within Northern Ireland. However, because there has been a focus upon the long drawn out inter-group conflict between the two major communities, some would argue that the needs of people from within ethnic minorities have been overlooked.¹⁷

People from black and ethnic minority communities may not access Mental Health services unless in absolute crisis.⁴³

The Race Equality Audit, a response to all Draft Equality Schemes by the Black and Ethnic Minority Voluntary & Community Sectors, should be taken into account by DHSSPS in setting priorities for equality impact assessments.

Equality policies are not implemented for the benefit of ethnic minority groups⁴⁷.

There is clear evidence that minority health issues and concerns have not become integrated into the commissioning process within Scottish Health Boards.⁴⁸ Arguably, this is something which could also be taken on board in Northern Ireland.

Minority health issues and concerns may not be integrated into the commissioning process.⁴⁷

Barnardo's and the Chinese Welfare Agency evaluated the Chinese Health Project (1998). This had helped to improve access to health and social services by members of the Chinese and Vietnamese communities in Craigavon and in Belfast. Perhaps lessons could be learned from the latter Project in terms of improving equality of opportunity for ethnic minorities.

Ethnic minorities have very little knowledge of Social Services and its functions..... Women from ethnic minorities in Northern Ireland are not aware that they can exercise choice in the gender of their GP.⁶⁰

Research in UK found a low awareness and uptake of Respite services among minority ethnic people.⁵⁸

Research in UK found that Asian carers had low awareness and usage of specialist services for people with learning difficulties. Existing services ignored cultural & religious needs.⁴⁹

An evaluation of the Chinese Health Project, 1998, found that this Project had helped to improve access to health and social services by members of the Chinese and Vietnamese communities. Lessons might be learned from the success of this project.

The Chinese Health Project had helped to improve access to health & social services.⁴⁷

The Kings Fund suggest that the Department of Health should invest in a National Service Framework for tackling inequalities with an emphasis on Black and minority ethnic health.⁵⁶

Evidence from child protection investigations in UK indicates that Black and minority ethnic families often do not have access to much needed services.⁵⁰

An article in Community Care by Tracey Race, August, 1999 states that Asian women emphasised their sense of isolation when seeking to address concerns about sexual abuse. The subject remained taboo in their communities, and at the same time they found it difficult to gain support from appropriate agencies. Many claimed that they did not know where to go to for help, and felt distrustful of white organisations.

Black African people living in Northern Ireland experience a sense of isolation.⁵¹

Racism

Connolly & Keenan, 2000(a) carried out a study into Racial Attitudes and Prejudice in Northern Ireland. They note that negative attitudes towards specific minority ethnic groups have become significantly worse over the last few years. Around twice as many respondents in the survey stated that they would be more unwilling to accept or mix with members of minority ethnic communities than they would members of the other main religious tradition to themselves (i.e. Catholic or Protestant). It could be argued that these attitudes might have adverse implications in terms of people from minority ethnic groups obtaining information about and access to health care.⁵¹

One of the problems highlighted was a sense of isolation. Again, this might have implications in terms of their ability to access appropriate health services, and further investigation is needed.⁵¹

Ward, 1998 highlighted the needs of Asian people with learning difficulties and their carers. Ward notes that Asian carers had low awareness and usage of specialist services for people with learning difficulties, and existing services were likely to ignore their cultural and religious needs and those of their relatives with learning difficulties.

The Charity "Mind" carried out a survey of black and minority ethnic service users, mental health professionals, statutory organisations and carers. Eighty-six percent (86%) of respondents indicated that they felt that the Mental Health system discriminates against Black and ethnic. When asked what was responsible for this discrimination, 71% indicated that it was due, in part, to inadequate policies⁵². The findings were launched at a Mental Health Conference in London in February, 2001, entitled "Diversity and Mental Health: Understanding the Margins".

Mentally ill patients from Black ethnic minorities are more often transferred to locked wards & compulsorily detained.⁴⁷

Survey of black and minority ethnic service users, mental health professionals, statutory organisations & carers, in the UK found 86% of respondents felt that Mental Health system discriminated against Black & ethnic minorities.⁵²

British findings indicate that black/ethnic minorities are more often transferred to locked wards, compulsorily detained under the Mental Health Act, admitted as offender patients and not referred for psychotherapy. There is a need for training within Mental Health Services to address the issue of cultural difference and racism.⁵³

The literature would suggest that there may be a need to address the extent to which Mental Health patients from ethnic minorities are treated equally to other patients.

Black and ethnic minority carers frequently received a stereotypical response from professionals - the false belief that their own communities would support them. Black carers were less likely to receive services sensitive to their specific ethnic needs.⁵⁴

Information

There is a **need to collect, record and analyse data by ethnic group**, in order to address the dearth of information on the health of ethnic minorities. In particular, risk factors and specific diseases and illnesses of ethnic groups should be addressed by mainstream providers.⁴⁷

Irwin & Dunn note that the problem in Northern Ireland has been the **absence of any scientific measure of the size of populations** of the main ethnic minorities.¹⁷

The literature suggests that, in particular, there is **little data available** on Black African people living in Northern Ireland. Routine demographic data collected on the general population not analysed by ethnic group, leading to a dearth of information on the health of ethnic minorities.⁴⁷

Little data available on Black African people living in Northern Ireland.

The **methods of collecting the data must be acceptable** to those who are asked to provide it. For instance, a monitoring form must ensure that it is sensitive to the identities of different groups, and must ensure that there is scope for self-definition.⁴²

The routine demographic data that is currently collected on the general population in Northern Ireland is not analysed by ethnic group; ethnicity is not routinely recorded in hospital admissions, community services, outpatients attendance or the cancer register. There is a **dearth of information** on the health of ethnic minorities. It is clear that this will have implications for people in relation equality of opportunity and health.⁵⁵

Language Barrier

The research indicates that all ethnic minority groups experience **problems with language and communication when accessing services**. There is, therefore, **a need for trained interpreters** for all ethnic minorities, across the full range of services.¹

Insufficient use of trained interpreters. Need for bilingual services..Communication gap due to cultural sensitivity of care providers & individuals needing care.⁴⁷

Greatest difficulty in accessing services, particularly in the Chinese community in Northern Ireland was **language barrier**.¹⁷

Research in UK found that families with a disabled child have been particularly poorly served, due to **poor interpreting support** and limited availability of translated materials.⁵⁷

There is a **need to increase the information** provided to people from ethnic minorities about the services available and to produce and disseminate this information **in a range of forms**.

There is a difference in the quality of post-natal care for ethnic minority patients, due mainly to **language barriers**.⁶⁰

Barnardo's in their document "Early Years" note that evidence from child protection investigations indicates that black and minority ethnic families often do not have access to much needed services. They also **suffer from cultural misunderstandings and language difficulties**.

The Kings Fund issued a Briefing in July, 2000 entitled "The health of minority ethnic communities". In it they state that access to health care is not simply achieved by providing facilities in a given locality. Rather for services to be accessible, they need to understand how, when and where people use them. Primary care services need to reach out to groups with a high risk of ill health, like refugees, young families and people isolated in their homes. Mental health care should be provided in a way that is relevant to the needs and preferences of each ethnic group. Moreover, **where people do not speak English, counselling services need to be provided in their own languages**. Finally, the Kings Fund suggests that the Department of Health should invest in a National Service Framework for tackling inequalities with an emphasis on black and minority ethnic health groups ⁵⁶.

Chamba, et. Al, 1999 carried out research at the Universities of Bradford and York Their Report entitled "On the edge: Minority ethnic families caring for a severely disabled child" states that it is widely recognised that minority ethnic groups experience social and material disadvantage and face barriers in their access to statutory support services. They add that families with a disabled child have been identified as being particularly poorly served. They found that parents wanted more information about their child's disability and, in particular, services for their child and themselves. However, they stated that **poor interpreting support and limited availability of translated materials** could make access to appropriate information difficult⁵⁷.

An article in the Journal of Public Health Medicine, (Netto, 1998) highlights that research into knowledge and use of community services among minority ethnic people has shown a low awareness and uptake of respite services. Because many of the individuals were house bound, they were isolated from information and services which could have eased the burden of caring. This isolation is exacerbated by the inability of many to speak English, combined with an overall lack of familiarity with the range of health and welfare services which are available.⁵⁸

Irwin & Dunn, 1997 in their study “Ethnic Minorities in Northern Ireland” looked at the needs of the four main ethnic minorities in the Province: the Chinese, Indian, Pakistani and indigenous travelling Communities. The study found that the greatest problem experienced by ethnic groups in accessing services, particularly the Chinese community, was language difficulties and the need for interpreter provision. Alongside this, the data highlighted that the dependency needs of all the ethnic groups are high, given the high proportions of young children. The researchers indicated that there was a particular need for research to increase general knowledge about ethnic minorities in Northern Ireland; to probe measure and record the opinions of minority groups on matters affecting them; and to identify specific problems and causes of disadvantage of ethnic minority groups.¹⁷

A Report entitled “Chinese older people: A need for social inclusion in two communities”, September, 2000, found that nearly all the respondents (97%) found it difficult to use social services. Difficulties included inability to speak English, and in particular, difficulty in understanding social services jargon. Lack of information about services and older people’s rights to these, and the costs of using the services were also cited.⁵⁹

The SHSSB and Child Care NI (1994) carried out an Assessment of Need for Services for Children and Families. They reported that ethnic minority communities faced barriers in accessing services. Moreover, “Out of the Shadows” highlighted that many problems of communication were experienced by all ethnic groups in dealing with HPSS personnel.

The report also highlights the differing quality of post-natal care received by ethnic minority patients, due mainly to language barriers. There also appears to be very little knowledge of social services and its functions. In addition, many women in the study were not aware that they could exercise choice in relation to the gender of their GP, and this had caused some difficulties.⁶⁰

Bi-lingual services are needed in order to implement equality of opportunity policies. They stated that this would improve access to and use of health services and reduce health inequalities.⁶¹

Research in UK found that 97% of older people from the Chinese community found it difficult to use social services, due to language barrier, use of jargon & lack of information.²⁵

Travellers

Little is known about the overall health picture of minority group children, particularly children from the Travelling community.³

Primary care services need to reach out to ethnic groups with a high risk of ill health. The needs of Travellers was one of the first issues to be identified by the Government in June, 1999 to be addressed within its Promoting Social Inclusion Initiative. This report details a range of recommendations in relation to Health and Social Services and Travellers. However, perhaps the key recommendation in terms of equality of opportunity is the recommendation in the Report that the DHSSPS carries out an equality impact assessment on the Sure-Start initiative as required by the Northern Ireland Act, 1998, Section 75. The Report states that the aim of this would be to determine whether Travellers, as a distinct community, are being disadvantaged by the initiative's current criteria and whether there is scope for widening that criteria to benefit Traveller parents and children.⁶²

Children and families face barriers in accessing services.⁶³

The EHSSB carried out a survey of Travellers in the 1980s, followed by a qualitative study of the health needs of Travellers in 1993. These studies highlighted difficulties in GP registration, poor communication with HPSS personnel, issues around hospital appointments, continuity of care and racism.⁶⁴

The NIHE undertook a needs assessment of Travellers Accommodation in Northern Ireland in 2002. Results from their survey concerning health indicated that 44% of respondents said that they or a member of their household considered themselves to have a disability. 30% of household members with a disability were under 16. The most common disability was depression, bad nerves or anxiety (25%). The majority (92%) of respondents were registered with a GP.⁶⁵

Irwin & Dunn, 1997 found that only 6% of Travellers in their study were over the age of 45.¹⁷ Perhaps this needs to be explored.

Section 6: Disability

There may be a need to address the extent to which **decision making** by people with learning difficulties about every day treatments is taking place. Decision making by people with learning difficulties about ordinary every day treatments has been given very little attention. Family and care-givers had a great influence on people with learning difficulties' decision making. This tended to encourage professionals to look automatically to care-givers to take decisions. This undermined any possible involvement by people with learning difficulties themselves. People with learning difficulties were often excluded from even very basic decisions like choosing spectacle frames.⁶⁶

The Joseph Rowntree Foundation reported on a study focusing upon people with learning difficulties and dementia. They note that few individuals had a **choice** about where they lived, what they did during the day or who supported them.⁶⁷

Consent

There may be a need to examine the extent to which the custom and practice surrounding '**consent**' is working for adults with learning difficulties. There was no evidence found of people with learning difficulties' consent to medical treatment being routinely assessed⁶⁶. A survey of 2,600 people conducted by the National Schizophrenia Fellowship, Manic Depressive Fellowship and Mind, found that psychiatrists routinely refuse patients any choice about drug treatments and frequently do not give them any written information about side effects.⁶⁸

Communication

Service providers and planners need to continue to work on **developing ways of listening** to the views of children and young people with disabilities⁶⁹. Mental Health service users and carers are commonly unaware of the range of treatment and support opportunities available, but they are eager to find out more.⁷⁰

Children with lower limb abnormalities don't have much of a voice. Therefore, their interests have to be represented through others. There appears to be a lot of inconsistency in prescribing shoes to disabled children - some hospitals do and some don't.⁷¹

People still have difficulty having their voices heard. Membership of a self-**advocacy** group helps people develop the self-confidence and skills required to talk and be listened to. The development of groups should be encouraged. Skilled self-advocates could provide feedback to service providers.⁷²

Advocacy and self-advocacy must be properly funded so that personal experience plays a key role in service provision.⁷³

Access

People living in community placements have regular individualised support but limited access to community learning disability services. The situation is reversed for people living with their families. **People living with their families receive very different levels of services.**⁶⁶

There may be a need to examine the opportunities being offered to older people with learning difficulties in terms of **access to community activities** and social networks. Older people with learning difficulties were offered fewer opportunities than younger people to develop personal skills, to take part in community activities and to develop social networks.⁶⁶

The Joseph Rowntree Foundation reported a study into **disparities in service provision** for people with learning difficulties living in the community. The issues uncovered have implications in relation to equality of opportunity⁷⁴. There was a wide lack of respect for the future of older people with learning difficulties with regard to their potential for greater independence.⁶⁶

“Open all Hours” a report by the Sainsbury Centre highlights that mentally ill service users often **end up in the local A&E department** as other provision is only available nine to five.⁷⁵

Access to support for mental health patients prior to them being compulsorily detained might need to be explored. A report by the SSI states that social services are failing people compulsorily detained under the Mental Health legislation.⁷⁶

A survey of all Family Planning Clinics in Northern Ireland uncovered a number of issues which have implications for equality of opportunity in relation to disabled people: **Physical access** to Family Planning Clinics in Northern Ireland was partial and access to information and services was extremely limited for disabled people. Family Planning Services in Northern Ireland in effect deny disabled people access to services and serve to produce cultural ideologies concerning disability and sexuality.⁷⁷

There is a need to ensure that provision of services to disabled children and young people recognise them as children first and that they have access to the same range of services as other children and younger people.¹

Lesbian women with a disability face a double oppression in terms of discrimination. Few if any of the lesbian social venues have disability access and there are no services provided by disability organisations for their lesbian and bisexual community.⁷⁸

Exclusion

“Keys to engagement” a report by the Sainsbury Centre for Mental Health, reports that there is a small but significant group of severely mentally ill people who have multiple, long term needs and who cannot or will not engage with services.⁷⁹

There appears to be confusion around who is **responsible for providing services for people with learning difficulties over 65**, and this might need to be clarified.

The Joseph Rowntree Foundation report on a study into services for older people with learning difficulties. The study highlights that little is known about how older people with learning difficulties view their changing needs or about how services respond to their increasing age. Older people with learning difficulties often fall between services for older people and services for people with learning difficulties. The ‘ordinary life’ model widely regarded as the appropriate model for young people with learning difficulties would appear not to apply to older people.⁶⁶

The NHS fails the health needs of people with a learning disability. They are often excluded from basic health services. Mencap want to see: annual health checks and equal access to healthcare for every person with a learning disability; Primary care structures and Trusts to take responsibility for people with a learning disability; better learning disability training for health service staff; commitment to resource and provide specialist healthcare and therapy services where and at times needed by children and adults with a learning disability; learning disability registers for children and adults so that services can be properly planned; commitment to resettlement from hospital accommodation on a timetabled programme, with the ultimate closure of long-stay hospitals.⁷⁷

Information

The quality of **mental health relevant information** collected might need to be examined. In particular attention might need to be given to information collected through needs assessment, in order to make it more useful to planners and thereby improve the outcome for users. The range of mental health relevant information collected varies considerably. Generally, it is not of good quality nor is it comprehensive. The way in which people with learning difficulties are given health information was highlighted as a problem.⁷⁰

Due to the fact that information collected through needs assessment has not been organised in a way that fits easily into a planning framework, services are not being designed to suit the needs of individual mental health patients.⁸⁰

There is a need to take into account both medical and social issues. Boards and Trusts need to consider how categorisation and recording of disability will take both these into account.⁶⁹

There is an urgent need for **better information** services regarding needs assessment data and service provision data on children and young people with disabilities. There was no register containing information about numbers of children with different types and severity of disability and social circumstances. **The development of a register is critical.**⁶⁹

A report by the British Society of Rehabilitation Medicine states that Orthotic services generally receive very low profile in the NHS. There is a lack of reliable information on the scope, nature and size of the Orthotic service.⁸¹

There is a **gap in information in respect of people with a mild/moderate learning disability**. This is a large group of people who may not qualify for help from Social Services, may not receive benefits may not be in contact with a specific voluntary organisation and, if of school age, may be attending special units in mainstream schools. This is a group of people who may be disadvantaged due to a lack of understanding from others, limited opportunity for employment, their difficulty in making and maintaining relationships, difficulties in accessing health care and social services, etc. Mencap are not aware of much written information or research about this group of people. Mencap has been providing training for several public sector bodies in respect of raising awareness of the issues which may effect these people in a bid to make staff aware of issues which effect those with hidden/non-overt disabilities.⁸²

RNIB concerned with lack of local prevalence data for visual impairment. Data is generally inadequate and quality data is the key to service provision, consumer involvement, social inclusion, targeting social need & EQIAs.⁸³

RNIB have argued that the number with (registerable) sight loss is four times greater than those known to social services. The equality agenda should be used to correct this situation by working to identify all those with a sight loss in the province not just those who have contact with Social services.⁸³

RNIB believe that for those with sight loss the following need to be urgently addressed:⁸³

- NI specific prevalence/incidence rates for sight loss must be established
- Data also needs established locally for dual/multiple disabilities
- Existing data sources need to be assessed and enhanced
- Links must be established between hospital and community systems
- Better disability data is required across all NI Assembly Departments
- All public bodies must “talk” to each other regarding data and data exchange
- Relevant voluntary sector organizations must be involved in agreeing the data to be collected and the method of doing so.

Disability Action recommends that the **definition of disability** should be the same on all information systems and should reflect the definition outlined in the Disability Discrimination Act.⁸⁴

In the field of health and personal social services there is the potential to fail to distinguish between health and disability issues. In terms of Section 75 duty, it is vital to ensure that **questions are asked relating to disability and not health....** although there is a positive correlation between disability and health, questions must relate specifically to disability, otherwise sub-groups could be omitted because they are not experiencing ill-health.⁸⁴

Primary Care

Understanding of mental health **problems by staff in the primary care setting** might need to be explored. Some professionals refused to treat people with learning difficulties.⁶⁶

People have good relationships with their **general practitioners**. They like to have explanations about diagnosis and treatment. They like to be involved, and are resentful when doctors ignore them and talk to others.⁷²

A report published by the Kings Fund states that many people with mental health problems get inadequate help from primary care services, due in part to a lack of

understanding of some staff. People felt that their physical needs were ignored and that their GP did not refer them to alternative sources for help.⁷⁶ A report by the Mental Health Foundation found that 44% of people with mental health problems experienced discrimination from their GP. This diminishes their chances of accessing good support.⁸⁵ Concerns were raised about the role of GPs in allocating assistive devices, due to their attitudes about disability. People with long term disabilities need access to certain services, but are not necessarily ill.⁸⁶ Disability Now report on a study carried out by the Department of Health. The DOH surveyed 500 people with learning difficulties about what they thought of the NHS. A number of issues which could have implications for equality of opportunity emerged: Many respondents reported problems in talking to doctors about their needs. They were often not told about services such as cervical smears and eye tests.⁸⁷

It has been recommended that Resource Centres, rather than GPs could be used by disabled people to access certain services. However, Resource Centres are not freely available to all.⁸⁶

“Acute Problems” a report by the Sainsbury Centre, reports that for many people their experience of acute in patient psychiatric care can only be described as a vacuum instead of a therapeutic environment.⁸⁸

Many people have had good experiences in **general hospitals**. They were appreciative when treated like others. There was the feeling that not all doctors were aware of disability issues, and that medical students would benefit from experiential visits to day centres.

Discussion on the **special hospitals** raised feelings of anger and fear. The threat of being sent to a special hospital was deeply resented. The special hospitals should not be used for respite-short term breaks. Many people felt that there was no longer a need for special hospitals and that they should be closed.⁷⁵

Dentists are skilled in putting people at ease and willing to explain procedures to them. The use of special hospital dental services are seen as inappropriate.⁷⁵

Waiting

There are excessive delays in carrying out assessments; **assessments were found to be inadequate**. Excessive waiting times for adaptations were reported.⁸⁹

There are long waiting lists with regard to wheelchair services and there are wide variations in assessments. There is a fundamental problem, namely, the shortage of expert therapists in the fields of wheelchair assessment and special seating.⁹⁰

Funding

There had been reductions in services despite increased need. The decision had led to family stress and breakdown and there was an ability to pay excessive charges.⁸⁹

Disablement services are the Cinderella of the NHS. For too many people with disabilities, the quality of service they receive varies according to their postcode.⁸¹

The decision to fund nursing care but not personal care to people living in residential and nursing homes reinforces the old oppressive message that the state will only help disabled people who can be 'made better'.⁹¹

No decision has yet been taken by the Northern Ireland Assembly with regard to the Royal Commission's recommendations about long term care. In particular, attention needs to be given as to what decision is reached by the Assembly about an individual's right to the provision of personal care, paid for out of general taxation, given that personal care is provided and paid for out of taxation in Scotland.¹

NEXUS urge that the lack of services and accommodation for disabled women suffering from sexual abuse be addressed and ask that it be noted that the NEXUS Institute has facilities for physically disabled men and women and have offered counselling to visually and hearing impaired clients.⁹

Funding shortages are leading to people in need being denied services. Service provision is a growing postcode lottery. Mencap want increased funding and provision of learning disability services, increase in number of housing places for people in the community and a legal right to short-term breaks.⁷⁷

Disabled - General Issues

Arguably, one of the biggest problems for people who are disabled is being labelled 'disabled'. The total number of people in Northern Ireland who have disabilities may be unknown. What is clear, however, is that we all experience disability to some extent at some point in our lifetime. The difficulty lies in where to draw the line from 'normality' to 'abnormality'.¹

People are seeking more variety in the activities offered by **day centres** and they want to see community-based activities as an extension of the day centre programme. People would like to be consulted about day centre programmes. Many stressed that small centres were preferable to large ones. Some people do not have the opportunity to go to a day centre and others would like their attendance to be increased.⁷²

Day services for people with a learning disability are limited. They need modernisation and expansion. Mencap wants: increase in number of day places; Day services available five days a week; extra funding to modernise day services; local resource centres that offer a range of activities; independent regulation and inspection of day services; appropriate training for staff.⁷³

A Joseph Rowntree Foundation Report on the first ever Disabled Women's Project: Disabled women feel they suffer from a broad range of discrimination. Disabled women feel their needs were not being taken into account by service providers. They were offered little choice on the form of services they might receive. They reported difficulties in accessing information and having to face patronising attitudes.

Services for women suffering sexual abuse, such as women's refuges and rape counselling services were rarely able to accommodate the needs of disabled women.

Disabled lesbian women felt the effects of multiple discrimination, including being discriminated against by service providers. Disabled black women expressed similar concerns.

Disabled women in residential care and in long term units in hospital seemed to be the most isolated and to experience extremely low quality of life.⁹²

Mental health problems in older people may often be misdiagnosed or unrecognised. A survey by Age Concern found that 16% of GPs had not referred older patients primarily because of their age.¹⁹

The literature would suggest that there may be a need to address the extent to which Mental Health patients from ethnic minorities are treated equally to other patients.

Mentally ill patients from Black ethnic minorities are more often transferred to locked wards & compulsorily detained.⁴⁷

Survey of black and minority ethnic service users, mental health professionals, statutory organisations & carers, in the UK found 86% of respondents felt that Mental Health system discriminated against Black & ethnic minorities.⁵²

Bullying is widespread. People with a learning disability need to be encouraged to report incidents of bullying and given strategies for counteracting bullies. There is a need for greater disability awareness in schools, in the workplace and in society in general. Segregation does not help in the reduction of bullying. Self-advocates are very willing to be involved in disability awareness training for schools and community groups.⁷²

Section 7: Dependants

Issues such as geographical location; physical layout and opening times can all pose problems, especially for women with children.²⁷

The research shows that the number of carers who get an **assessment** is low. Those at the 'heavier end' of caring are not informed of their right to an assessment under the Carers (Recognition and Services) Act, 1995.⁷

Carers do not appear to be **informed of their rights**, nor about the services that may be available to them. All Carers should be made aware of these.⁷

Carers have expressed **concern that their views are not being treated equally to those whom they care for**. In particular in relation to discharge arrangements where patients' views tended to be given higher priority than their own views, and that the hospital discharge was mainly patient centred. Many carers complained that they are not treated with respect by professional staff.⁷

Carers stated that carer's **assessments** were conducted on an 'informal' basis. This resulted in failure to identify areas where carers and patients had conflicting views and needs. Carers should be recognised and addressed as active participants in their own right throughout. Systematic monitoring should be put in place to ensure this.⁷

Quality and variety of support to carers remains a matter of chance. Both carers and staff were unclear about **what carers were actually entitled to**.⁹³

Carers of people with mental illness have been less visible, and perceived not to perform personal care to the same degree as those caring for people with physical disabilities.⁹⁴

A need for **more information** was identified by carers.⁷

Research shows that **Carers are underrepresented** in advisory groups responsible for future service developments.⁹³

Attention should be drawn to the need for sensitivity of social services staff when discussing caring. The use of **jargon should be avoided**, and help should be given with the filling in of forms.⁹⁵

Consideration should be given to the fact that 80% of carers surveyed by St. John Ambulance indicated that they had no **training** for their caring role, yet most felt that they needed some. BT and St. John Ambulance provide a three-hour introductory care training course across the UK.⁹⁶

All individuals who provide regular and substantial care for a person with mental ill health on the care programme approach are entitled to have an **assessment** for their own caring, physical and mental health needs, and for this to be repeated at least on an annual basis. Fewer than one in five people caring for someone with a mental illness knows that they have a legal right to an assessment of their own needs.⁹⁷

Carers of people with mental illness need to know how to gain **access** to services, particularly out of normal office hours. Others need a regular break by arranging respite care.⁹⁷

The **respite** care needs of carers of people with mental health problems need to be identified in the same way as they are for carers looking after people with consistent and ongoing care needs.⁵⁴

Families caring for two or more children with severe impairments are likely to need both more support and more flexible support than families with one disabled child. Particular needs and circumstances of the 7,500 families in the UK who have two or more children with severe impairments, have generally been overlooked by research and social services.⁹⁸

Policy makers and service providers need to pay more attention to the **needs of lifelong older family carers**, as they have been overlooked and have had minimal statutory support during their life time. Older family carers differ from other groups. They are more likely to have small support networks. They are usually reluctant to seek help.²³

More research is needed into how caring during childhood affects **young people** as they move into adulthood.⁶

Services need to focus on the whole family and be quick to respond to the needs of disabled ill parents, if **children** are to be prevented from taking on inappropriate caring roles and suffering problems as they move into adulthood. Young carers performing intimate care are no more likely than others to receive an assessment of their needs, nor are very young children who have caring roles. Age, gender, ethnicity and even caring tasks undertaken do not influence the likelihood of young carers being assessed by social services.⁷

There has been little recognition of the contribution that **children** make to family care. Attention needs to be given to assessing the needs of children within families, and services need to be provided which meet the needs of both children and parents. This has been shown to reduce the need for children to adopt caring roles. In the largest survey of young carers, it was found that the majority of young carers interviewed were unaware that they had been assessed by social services, even after the event. Few had been actively involved in the process.⁷

Age, gender ethnicity and caring tasks should all be taken into account when deciding if **young carers** should be assessed by social services. At present this is not the case. 40% of young carers felt their own mental health had suffered and 70% said their education had been affected. Many felt isolated.⁹⁹

Black and ethnic minority carers frequently received a stereotypical response from professionals - the false belief that their own communities would support them. Black carers were less likely to receive services sensitive to their specific ethnic needs.⁵⁴

The burden of care has fallen largely on **women**. The impact of caring on employment is more severe for women than men.³²

Section 8: Political Opinion

This category is difficult to comment on in terms of equality of opportunity, primarily because the researcher found it particularly difficult to locate literature with a specific focus upon political opinion, equality of opportunity, and health.

There is a need for specific research focusing upon equality of opportunity, health and political opinion.

In particular more research is required focusing upon participation and accessibility in relation to the two main traditions in Northern Ireland.

There is also a need to address the lack of research from a multi-agency perspective, as there would appear to be suspicion and mistrust of statutory services by some victims.

Training, organisational development and specific organisational policies are required to address the needs of all victims of the 'Troubles'.

The DHSSPS should take into account the findings of the Social Services Inspectorate Report "Living with the Trauma of the Troubles", 1998, and the findings of The Cost of the Troubles Final Report, April, 1999, when considering how their policies might impact upon equality of opportunity in respect of this category.

Some services are not accessible to people living in sectarian areas.¹⁰⁰

Fears about confidentiality makes people reluctant to accept help. Lack of trust in social services reported by voluntary & community groups.¹⁰⁰

There is a lack of a joined up approach to community violence... and suspicion and **mistrust of statutory authorities by victims.**¹⁰¹

People bereaved and injured by security forces might be **reluctant to use services** because of their mistrust of state provision.¹⁰²

Attention needs to be given to **participation and accessibility to services** of the two main traditions in Northern Ireland.¹⁰²

Section 9: Sexual Orientation

Information

The literature review indicated that there was a lack of information and research material into lesbian, gay or bisexual people

The Coalition on Sexual Orientation fear that this lack of information could be used as an excuse for ignoring sexual orientation issues – **‘Little evidence has been accumulated about sexual orientation** and there is concern that this might be used as an **excuse for excluding it from impact assessments...**There is concern that differential impact will be used to screen/scope out sexual orientation issues.¹⁰³

This is echoed by NHSSB **‘There is currently no data on the exact numbers of people living in the NHSSB area who identify as lesbian, gay or bisexual.’**¹⁰⁴

There is a **need for necessary funds to research** the impact of each public authority’s policies on the LGB Community.... **Research** conducted through and with the support of the LGB Community will provide that most **accurate evidence** upon which impact assessments can be conducted.¹⁰³

It is essential that each public authority **develops indications of sexual orientation in close consultation with LGB Groups...**Public Authorities should **through discussion and information gathering with groups make efforts to increase their knowledge** of equality of opportunity issues.¹⁰³

Sensitivity

The need for sensitivity was also highlighted in the literature review. It might be preferable, in some instances, if **meetings were publicised only in the LGB Press.**¹⁰³

Gay men often **feel vulnerable if they have to disclose their sexuality to the GP.** This is especially true for Gay men in small communities who may suffer malicious or accidental disclosure resulting in discrimination from third parties.¹⁰⁵

Low visibility research shows that **most gay men do not confide in their GPs** about sexual health matters. As a result, the sexual health needs of Gay men may be underestimated.¹⁰⁸

There is concern that the **most sensitive issues** such as sexual orientation are being **placed at the end of the 5 year programme,** rather than at the beginning.¹⁰³

Exclusion

The Coalition on Sexual Orientation (CoSO) states that members of the Lesbian, Gay and Bisexual community (LGB) have been largely invisible in society due to prejudice, ignorance and misinformation. This has led to the marginalisation and social exclusion of LGB people.¹⁰³

CoSO maintain that access to services is particular to specific sectors. **LGB people have, until now, been largely invisible. As a result, their interests may not have been taken into account in access to services.**¹⁰³

The sexual health promotion needs of gay people are complex. **Gay, lesbian and bisexual people living in rural areas may have particular sexual health promotion needs....** Innovative approaches are required in promoting sexual health with LGB people living in rural areas.¹⁰⁴

Gay Men **fear that if they disclose that they are gay, they will receive poorer treatment** than if they don't. They fear that they will be denied care, and they will be made to feel judged or unwelcome in the consultation.¹⁰⁸

The BMA has made a number of recommendations which, if these were communicated practice policy, would allay the fears of LGB patients, as well as promote equality of opportunity....**GPs need to know that there is a very wide range of information and support available for LGB people.** They should be aware that updated referral lists are available regularly within minimum cost or effort, and that the local health promotion unit will usually be able to help.¹⁰⁸

Inequality exists on the grounds of sexual orientation, driven by dominant negative social attitudes and an unwillingness to address the differing needs of LGB people. This impacts upon the emotional, mental and physical health of LGB people.¹⁰³

Lots of young people have really serious problems with their sexual orientation, there is a high suicide rate because people can't come out. A 1983 study of 416 gays and lesbians aged 15-20 years and living in London discovered that 19% of them had attempted to take their own lives. Interviewees felt that General Practitioners were largely ignorant and unsympathetic to the health needs of lesbian and bisexual women.⁷⁸

A recent study by Glasgow Women's Library found that Lesbians and Gay men in Glasgow are being **denied basic good health because of the pervasive homophobia that they face.**¹⁰⁶

Access to services must embrace the increasing diversity in society through the lives of LGB people.¹⁰³

Voluntary Organisations might be in a better position to **have easier access** to prostitutes, gay, lesbian and bisexual people.¹⁰⁷

Lesbian women with a disability face a double oppression in terms of discrimination. Few if any of the lesbian social venues have disability access and there are no services provided by disability organisations for their lesbian and bisexual community.⁷⁸

Primary Care Commissioning Groups should continue to commission services to meet the needs of vulnerable groups such as prostitutes, gay, lesbian and bisexual people.¹⁰⁷

Training of staff within public authorities is necessary. However, in light of the different needs, experiences, issues and priorities of LGB people, in-house training would be very difficult for any public authority to do. CoSO recommend that effective training will be developed if the expertise of representatives from the relevant constituencies is utilised. They recommend that **public authorities should enter into detailed discussions with them on the provision of training.**¹⁰³

HIV

Questions about positive HIV status: Doctors should answer factually based on records; ensure your patient knows what his record contains. - Questions about prior negative HIV tests: Doctors should answer in accordance with current Association of British Insurers (ABI) policy, "I do not disclose details of past negative tests".¹⁰⁵

Whilst there is a wealth of specialised information and support available in relation to HIV AIDS, not everyone knows how to access this. Some people may not even know it exists. Alternatively, some patients may not know where to start to look because so much has been written.¹⁰⁸

The 'Lesbian Advocacy Services Initiative' reports that the needs of lesbians and bisexual women in Northern Ireland are largely invisible and their experience remains undocumented. As a result of the impact of HIV and AIDS on the male community, the health needs of lesbian and bisexual women have been largely overlooked. The women interviewed felt that homophobia has had an impact on their health. Problems relating to alcohol and drugs abuse, domestic violence and emotional problems remain undocumented and ignored by mainstream health services.⁷⁸

Section 10: Geographical Access

In their response to the collection of equality information the Lifestart organisation (Lifestart's interest is with parents of children Birth to 5 years) raised the issue of possible exclusion of rural families from services.

“We greatly value the Sure Start programme and its inclusive approach within a school catchment area. Those who do not have access to one of the Sure Start programmes in Northern Ireland regard themselves as disadvantaged or excluded, especially rural families. This is so, especially as it is the one programme that is inclusive of children Birth to Five, the role of parents and the home.“

The lives of older people in rural areas was highlighted by Age Concern as an issue that required a particular strategic focus.²¹

Issues such as geographical location; physical layout and opening times can all pose problems, especially for women with children.²⁷

Rural lone parents face particular difficulties, according to the Joseph Rowntree Foundation. These include social isolation and hostile social attitudes. There is also a difficulty due to lack of access to transport.¹⁰⁹

Issues such as geographical location; physical layout and opening times can all pose problems, especially for women with children.²⁷

The sexual health promotion needs of gay people are complex. Gay, lesbian and bisexual people living in rural areas may have particular sexual health promotion needs.¹⁰⁴

The sexual health promotion needs of gay people are complex. Gay, lesbian and bisexual people living in rural areas may have particular sexual health promotion needs.¹⁰⁴

Innovative approaches are required in promoting sexual health with LGB people living in rural areas.¹⁰⁷

Section 11: Deprivation

GP fund holding has taken hold most effectively in more affluent districts. Some families with children living in deprived areas may be at a disadvantage in terms of access to health care.³

Children born into poverty are more likely to die in the first year of life, be born small or early, or both, smoke or have a parent who smokes. These children may not have equal access to health care.⁴

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