

# Half a million voices: Improving support for BAME carers



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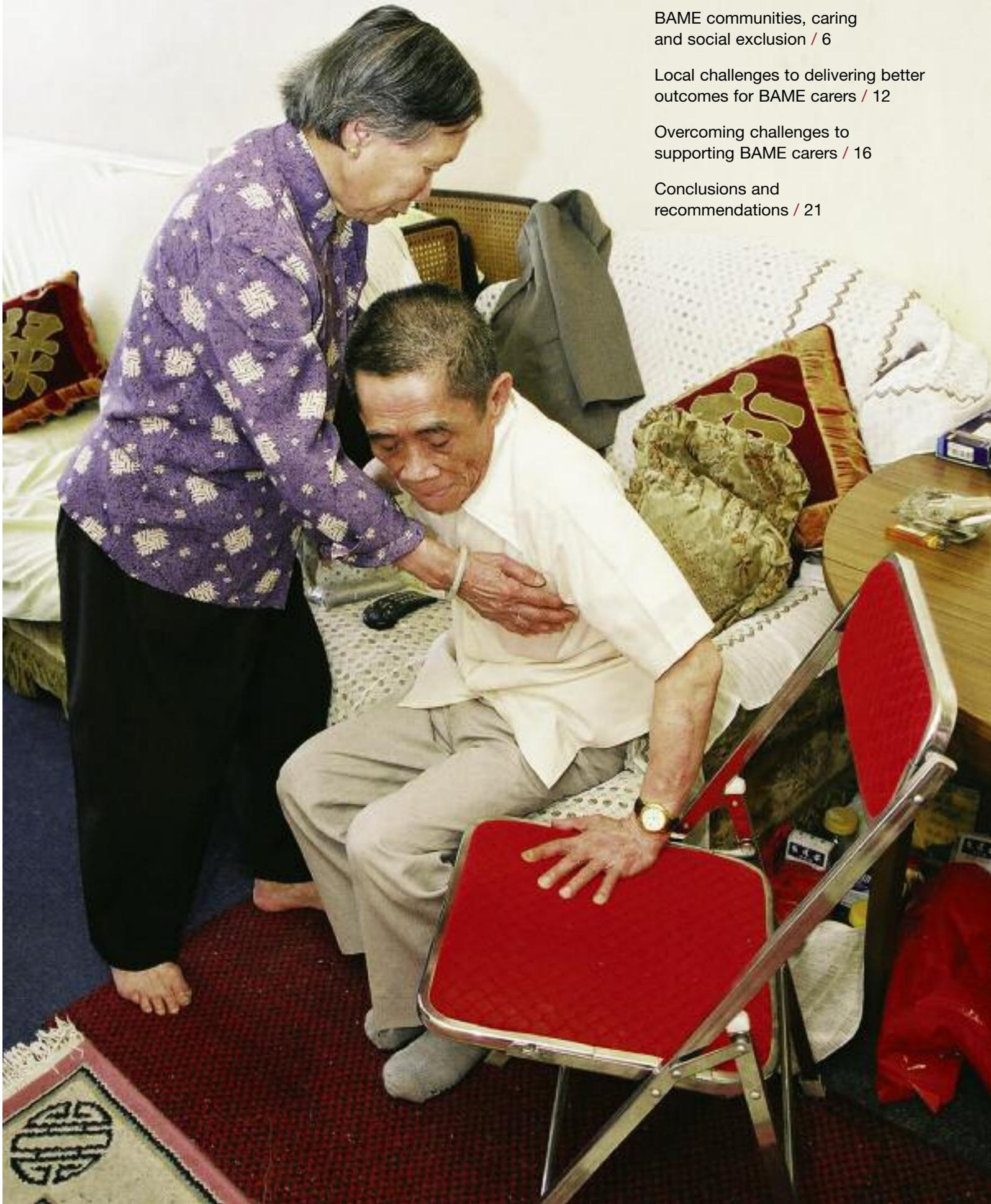
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# Executive summary

England's half a million Black Asian Minority Ethnic (BAME) carers save the state a staggering £7.9 billion a year which is 41% of local authority total spend on social care – in stark contrast to the investment that is there to support them. The research shows that BAME carers provide more care proportionately than White British carers, putting them at greater risk of ill-health, loss of paid employment and social exclusion. Certain groups also experience greater levels of isolation, namely Pakistani and Bangladeshi carers.

Britain's population is ageing and with it increasing pressure to fund social care. The BAME population is younger than the White British population but in the next few decades we will see a significant rise in the numbers of BAME older people needing care. It is vital

that creative funding and practical solutions are found to ensure that the right flexible and appropriate care is provided for BAME older people. If this does not happen then BAME families will have little choice to provide care, falling out of employment and risking ill-health and isolation.

It is important that a reformed NHS actively works to overcome the additional health challenges that are faced by BAME communities. There is an urgent need for the NHS to clearly understand and respond to the needs of carers and, within this, they need to understand BAME carers. Welfare reform, equally, needs to assess the impacts on BAME populations, including BAME carers and the people for whom they care.



# Key findings

## The value of BAME carers

- BAME carers save the state £7.9 billion a year.
- This was equivalent to 41% of local authority spending on social care.

## BAME carers in England

- There are 503, 224 BAME carers in England.
- 10% of carers are from a BAME background.
- Indian carers are the largest BAME group, as 2.2% of all carers.
- Black Caribbean carers represent 0.9% of all carers, or 44,402 carers.
- Every year, 180,000 BAME people become carers.

## How many hours are spent caring?

- 320,842 BAME carers (63%) provide 0-19 hours per week.
- 77,273 BAME carers (15%) provide 20-49 hours per week.
- 105,109 BAME carers (21%) provide over 50 hours per week.
- 10% of all carers providing round the clock care are from BAME communities.
- BAME carers are significantly more likely to provide 20-49 hours a week care.

## BAME carers and health

- 60,120 BAME carers in England are in poor health.
- This is slightly higher (by 0.6%) than White British carers.

## BAME carers and employment

- The majority of BAME carers are of working age.
- Nearly a quarter of a million BAME carers (241,320) juggle work and care.
- This is 9.74% of all carers in England.

## Key Findings in London

- London has the highest number of BAME carers nationally of any region.
- 216,277 BAME carers live in London.
- 43% of all BAME carers in England live in London.
- One in three carers (30%) in London is from a BAME community.
- Brent has the highest BAME carer population where 69% of all carers are from a BAME community.
- 47,034 of Indian carers are the largest number of BAME carers in London
- 16% of BAME carers cared for someone between 20-50 hours a week.
- Indian carers of working age had the highest number of BAME carers in work at 26,980.

## BAME carers and health

- 35% of all carers in London are BAME carers in poor health.
- BAME carers are more likely to be in poor health compared with White British carers
- Hackney and Wandsworth had by far the highest percentage of BAME carers in poor health (15%) followed by Islington (14%) and Hounslow(13%).
- Brent has the highest number of BAME carers in poor health(1860) followed by Ealing (1820), Lambeth (1460) and Newham (1420).
- The Indian community (7%) are the biggest BAME group of carers who are suffering from poor health. The Black Caribbean (6%) and White Other communities (6.4%) of carers also showing high levels of poor health

## BAME carers and employment

- 35% of all carers in London of working age are BAME carers in employment
- The 2001 Census data showed that the highest number of BAME carers were from Indian origin, with significantly high numbers of carers in employment also from Black Caribbean and White Other groups.

# Introduction

At some point in our lives every one of us will look after an elderly relative, sick partner or a disabled family member. 6 million people in the UK are caring right now and 2.3 million people become carers every year. Caring is part and parcel of life, but without the right support the personal costs of caring can be high. Caring can take its toll on your finances, your health, your social life, and on your other family and work commitments. Carers can fall out of paid work and many rely on benefits, forcing them into poverty.

Yet without unpaid carers, our NHS would collapse and the country would face an £87 billion care bill it cannot afford. Carers are contributing to society by looking after the people they love, yet in return many face ignorance, isolation and discrimination.

## **BAME carers**

Black, Asian and Minority Ethnic (BAME) carers face the same challenges as all carers, but also face additional barriers, for instance cultural barriers, stereotypes and language which can increase the chances of poorer health, poverty and social exclusion.

## **Impact of current reform on BAME carers**

78% of local groups interviewed felt that the reforms being planned would further marginalise BAME carers, putting them at greater risk of poverty and segregation. In this era of tight public spending, the cuts to public services and massive system reform across health, social care and welfare, there are significant risks that this social exclusion will be further exacerbated for BAME carers, and certain groups in particular, unless urgent and more creative action is taken. As well as being potentially catastrophic for families and individuals, this is also likely to work against social cohesion.

## **The role of service and policy organisations**

Public bodies and organisations need to work together to deliver on the race agenda for BAME carers, to

achieve fairness and to continue to invest in BAME support or measures that improve access to support for BAME carers. However, there are also strong economic imperatives to supporting BAME carers alongside important race and equality objectives. Public bodies should be focussing on preventing BAME ill-health and turning their attention to ensuring that BAME carers are more able to juggle work and care for longer.

This report is designed to build on previous work and provide a baseline for local authorities, health and well-being boards, Primary Care Trusts, and GP consortia, on which to improve services and support to improve the lives of BAME carers and their families. The report has examples of good practice that we can learn from and new opportunities for developing new services and forms of support which will work for different communities. The recommendations at the end of this report look to more creative and flexible future support for BAME carers.

# BAME communities, caring and social exclusion

## Caring and social exclusion

Caring can be a factor in starting or deepening social exclusion. We know that:

- One in five carers has given up work to care.
- Carers are twice as likely to suffer ill-health.
- 52% of carers providing round the clock care are struggling financially.
- Carers providing over 20 hours of care are less likely to be in full time work.
- Carers are less likely to be in managerial positions.
- Parents of disabled children are twice as likely to live in poor and unsuitable accommodation.<sup>1</sup>

## BAME social exclusion

Numerous reports over the years have shown that certain BAME communities are more at risk of poverty, ill-health, unemployment and social exclusion. For example:

- Many BAME groups experience higher rates of poverty than White British groups, in terms of income, benefits use, worklessness, lacking basic necessities and area deprivation".<sup>2</sup>
- Worklessness amongst working age people was highest amongst Black African Caribbean communities (21%) and South Asian communities (16%).
- The highest rates of poor health or disability in England and Wales were in Pakistani and Bangladeshi men; with higher rates for women in Asian and Black groups.<sup>3</sup>

## Current evidence on additional challenges faced by BAME carers

There are a limited number of surveys on the experiences of BAME carers, but what they tell us are:

- Non-white ethnic groups are considerably more likely to be struggling financially to make ends meet.<sup>4</sup>
- BAME groups are more likely to be caring for a sick or disabled child, especially for an adult disabled son or daughter aged 20 to 24 – which reflects long term and enduring caring responsibilities.<sup>5</sup>

- They are more likely to be caring for someone with a mental illness.<sup>6</sup>
- BAME carers found that caring was associated with extra costs and restricted opportunities for education, employment and promotion.<sup>7</sup>

## Data from the 2001 Census

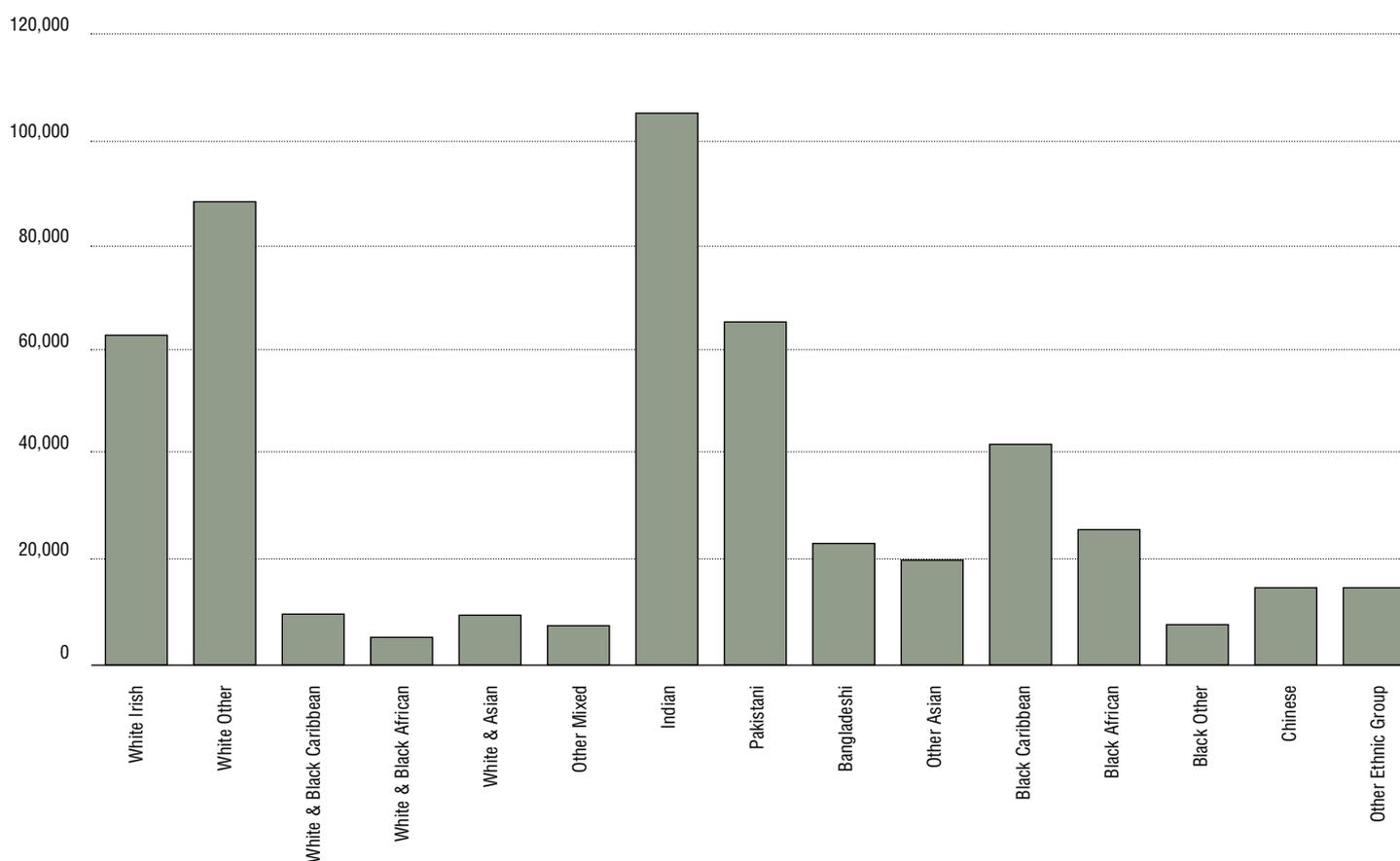
The inclusion of the question in the 2001 Census was a landmark victory for Carers UK having sought more robust data on which to understand some of the challenges facing carers, including BAME carers. The Census has enabled more sophisticated analysis to understand different populations of carers and compare these issues with White British carers to see where BAME carers face challenges above and beyond White British carers.

There are limitations, however, with the Census 2001 data. The Census will under-report people from some sections of BAME communities where there are language barriers, people's immigration status is not clear or where the "state" is viewed with fear or suspicion. Since the Census in 2001, many local populations will have changed considerably. However, the purpose of this work is to provide a baseline as major social, health and welfare reform is underway.

### KEY FACTS<sup>8</sup>

- There are 503,224 BAME carers in England.
- 10% of carers are from a BAME background.
- Indian carers are the largest BAME group, as 2.2% of all carers.
- Black Caribbean carers represent 0.9% of all carers, or 44,402 carers.
- Every year, 180,000 BAME people become carers.

**Table 1: All BAME carers in England** source 2001 Census<sup>9</sup>



More in-depth analysis of the 2001 Census statistics by the University of Leeds for Carers UK found that caring was a more common experience for some ethnic groups than others. They found that this variation is related to differences in the health, socio-economic circumstances, family and cultural preferences and age structure of each population group. They found that among men of working age, those of South Asian origin are the most likely (and those in Chinese and White Other groups are least likely to be carers. They also found that young men (aged 16-30) from the Bangladeshi and Pakistani communities in Britain are two and a half times more likely to be carers than young White British men.<sup>10</sup>

We know that one third of carers start caring every year, and one third stop. If we assume it is the same for the BAME population, nearly 180,000 BAME people in England start caring and will be new to caring and the same proportion will stop caring.

### How many hours are spent caring?

One key difference is the fact that BAME carers are far more likely to be providing 20-49 hours of care per week (15% of all BAME carers) compared with White British carers (10%). This is significant as caring for 20 hours per week has been shown to be the start at which carers are less likely to be in work than non-carers.<sup>11</sup> This has a critical bearing on all employment related

work and has implications for employers, service providers and key areas of health, social care and welfare reform.

#### KEY FACTS

- 320,842 BAME carers (63%) provide 0-19 hours per week.
- 77,273 BAME carers (15%) provide 20-49 hours per week.
- 105,109 BAME carers (21%) provide over 50 hours per week.
- 10% of all carers providing round the clock care are from BAME communities.
- BAME carers are significantly more likely to provide 20-49 hours a week care.

### Regional and local variations

Table 1 shows the largest BAME carer population regionally. As this shows, in the North East it is Pakistani carers (0.42% of all carers), in the West Midlands it is Indian carers (3.26% of all carers), in London it is Indian carers (7.71% of all carers) and in the South East it is White Other carers (1.98% of all carers).

**Table 2: 2001 Census data on carers by region and ethnicity<sup>12</sup>**

ALL CARERS

Region	White British	White Other	Asian	Black	Chinese	Mixed Ethnicity Group	Other Ethnic	BAME Total	Total
England	4,373,836	151,603	217,223	76,954	12,537	32,207	12,700	503,224	4,877,060
North East	269,928	2,472	2,699	252	358	695	196	6,672	276,600
North West	678,134	15,459	21,996	3,163	1,647	3,592	800	46,657	724,791
Yorkshire & The Humber	482,753	8,376	20,877	2,684	669	2,315	537	35,458	518,211
East Midlands	402,399	8,908	18,102	3,188	710	1,945	471	33,324	435,723
West Midlands	494,142	13,719	36,908	8,692	841	3,330	796	64,286	558,428
East	486,112	15,592	10,909	3,168	1,151	2,490	793	34,103	520,215
London	393,611	54,308	87,462	50,608	4,758	12,165	6,976	216,277	609,888
South West	477,825	10,222	2,743	1,644	651	1,788	557	17,605	495,430
South East	688,932	22,552	15,529	3,544	1,747	3,865	1,582	48,819	737,751

### BAME carers and health

According to the 2001 Census, all carers are twice as likely to suffer ill-health if they are providing round the clock care.<sup>13</sup> From surveys gathering their experiences, they put the reason down to stress, isolation, struggling to make ends meet, insufficient assistance, inability to attend to their own health needs because they are caring and, finally, insufficient training often leading to physical injuries whilst caring.

#### KEY FACTS

- 60,120 BAME carers in England are in poor health.
- This is slightly higher (by 0.6%) than White British carers.

England's BAME carer population is also likely to suffer greater ill-health proportionately than White British carers because it is a younger population. Although further research is needed, this is also an area that public health, health services and local authorities' services need to address.

One of the reasons behind this could be that "Many of the early migrants were employed in arduous and poorly paid or risky jobs, and a high proportion suffer from industrial illnesses, or diseases associated with poverty and poor housing ... there are high levels of diabetes and cardiovascular disease affecting those populations, which mean that they have high risks of developing disabling conditions."<sup>14</sup> As already mentioned, BAME communities are more likely to suffer from long term illness or disability which restricts daily activity, with over 25% of Pakistani and Bangladeshi communities most likely to be at risk.<sup>15</sup>

Although these present the overall figures in terms of BAME carers' poor health, it is also important to look at differences in poor health between different groups of BAME carers. We know, for example, that some BAME communities have a shorter life expectancy in comparison to White British communities. South Asians have a particularly short life expectancy.<sup>16</sup> The reasons for this are often key factors associated with ill-health – poverty, poor employment and poor housing.

### BAME carers and employment

The majority of all carers are of working age and, consultation with carers shows that the majority wish to work, but many are unable to because of caring. Successive governments have also placed an important emphasis on remaining in and returning to work. Not only is this critical for the economy, it is vital for the economic well-being of individuals and families, contributions towards pensions and other assets for later life.

#### KEY FACTS<sup>17</sup>

- The majority of BAME carers are of working age.
- Nearly a quarter of a million BAME carers (241,320) juggle work and care.
- This is 9.74% of all carers in England.

Comparing this profile to that of White British carers, it suggests that BAME carers face similar challenges to juggling work and care. However, this overview of statistics will mask differences faced by different communities and particular parts of those different communities.

Data from the Office for National Statistics shows that BAME communities, particularly Pakistani and Bangladeshi are most likely to work in manual labour jobs. Chinese and Indian were most likely to be employed in managerial or professional occupations. The same research found that “Indian, Pakistani and Black African women were around four times more likely than White British women to be working as packers, bottlers, canners and fillers. Pakistani and Indian women were respectively around six times and four times more likely than White British women to be working as sewing machinists.”<sup>18</sup>

Research has shown that BAME communities are most likely to encounter discrimination in the place of work. This hinders their chances of occupying senior posts and they may be overlooked in opportunities for promotion. For BAME carers this can result in limited opportunity to move out of poverty into work and hold positions where flexible working is more acceptable.

Statistics from the labour force survey in 2004 showed that Indian and Black Caribbean and Other had the highest employment rates and Pakistani and Bangladeshi had the lowest levels of employment.<sup>19</sup> A report undertaken by the Cabinet Office entitled ‘Ethnic Minorities and the Labour Market’ found that although Indian and Chinese were in employment and outperformed White British, Pakistani, Bangladeshi and Black Caribbean people experienced higher unemployment and lower earnings than White British people. Furthermore, the report shows that all ethnic minority groups are not achieving as well as they should be, given their education and other characteristics.<sup>20</sup>

## The value of BAME carers’ support

### KEY FACTS

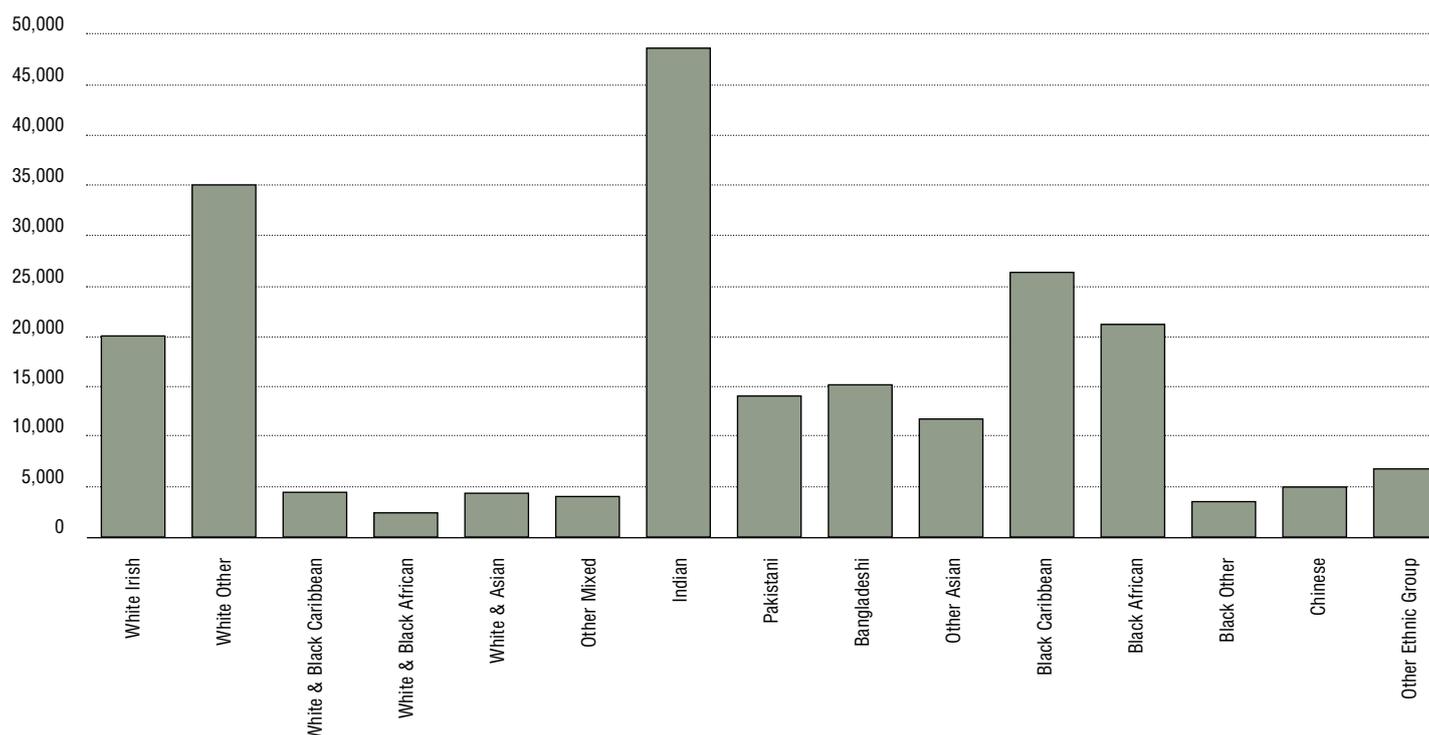
- BAME carers save the state £7.9 billion a year.
- This was equivalent to 41% of local authority spending on social care.

The value of carers’ support throughout the UK is a staggering £87 billion a year – equivalent to the value of the NHS at the time.<sup>21</sup> This figure is important as it quantifies the enormous contribution of carers to society, to family and to the state.

Using the same formula and unit costs for comparative purposes, BAME carers support in England is worth nearly a staggering £7.9 billion a year. At the time this was originally calculated, this was equivalent to 41% of local authority spending on social care.<sup>22</sup>

This puts the value of BAME carers support in context and in stark contrast to the amount of investment in support that is targeted at them to secure better support, access mainstream services, purchase their own services, look after their health and well-being and ensure that they are not left in poverty because they do not claim benefits at all or quickly enough when they are entitled.

**Table 3: Number of BAME Carers in London** source 2001 Census<sup>23</sup>



## BAME Carers in London

### KEY FACTS

- London has the highest number of BAME carers nationally of any region.
- 216,277 BAME carers live in London.
- 43% of all BAME carers in England live in London.
- One in three carers (35%) in London is from a BAME community.
- Brent has the highest BAME carer population where 69% of all carers are from a BAME community.

Other higher levels of BAME populations are in Newham this is 61% and in Tower Hamlets, 57%. Other boroughs with high levels of BAME carers are Hackney (55%), Ealing (54%) and Haringey (53%).

The Census data shows that the South Asian community is the largest percentage of BAME carers, with the Black African Caribbean community being the second largest and White Other group are the third largest.

### KEY FACTS

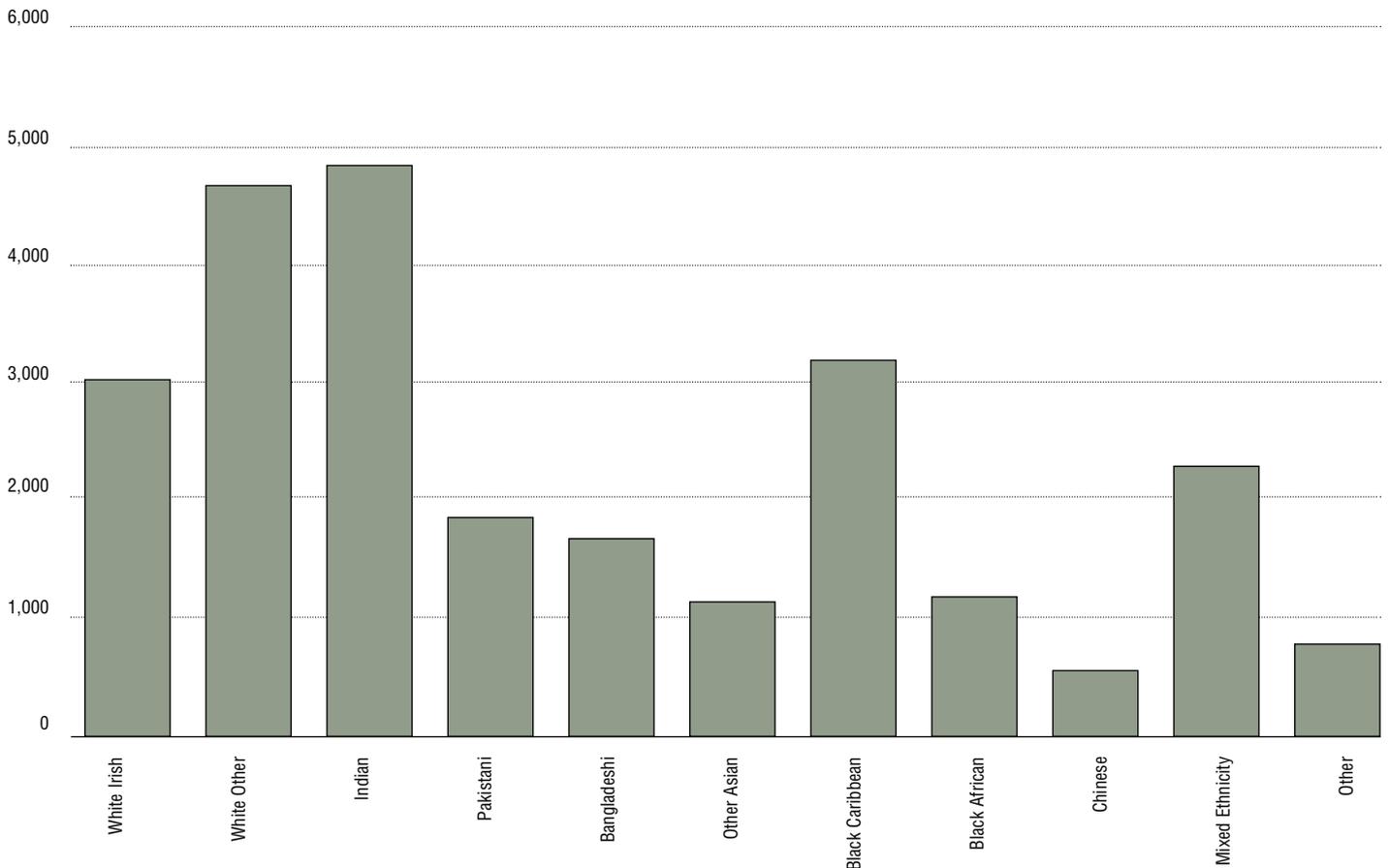
- 47,034 of Indian carers are the largest number of BAME carers in London
- 16% of BAME carers cared for someone between 20-50 hours a week.
- Indian carers of working age had the highest number of BAME carers in work at 26,980.

## London's BAME carers and health

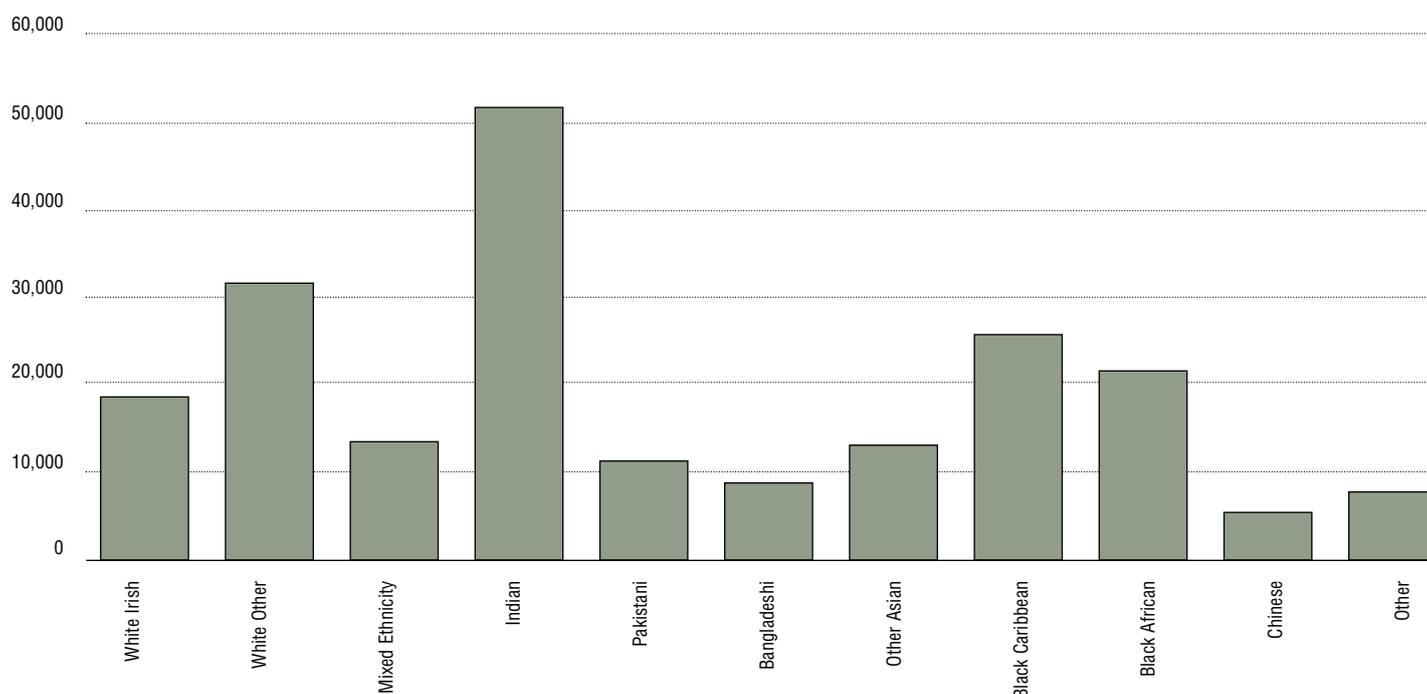
### KEY FACTS

- 35% of all carers in poor health in London are BAME carers in poor health.
- BAME carers are more likely to be in poor health compared with White British carers
- Hackney and Wandsworth had by far the highest percentage of BAME carers in poor health (15%) followed by Islington (14%) and Hounslow (13%).

**Table 4: Number of BAME carers in poor health** source 2001 Census<sup>24</sup>



**Table 5: Number of working age BAME carers in London** source 2001 Census<sup>25</sup>



### The 2001 Census showed that:

- Brent has the highest number of BAME carers in poor health (1860) followed by Ealing (1820), Lambeth (1460) and Newham (1420).
- The Indian community (7%) are the biggest BAME group of carers who are suffering from poor health. The Black Caribbean (4.5%) and White Other communities (6.4%) of carers also showing high levels of poor health.

These findings were backed up by consultation sessions Carers UK held with a variety of different BAME community groups and BAME carers who reported that they had felt a decrease in physical and mental health since becoming a carer.

### London's BAME carers and employment

#### KEY FACTS

- 35% of all carers in employment in London of working age are BAME carers in employment
- The 2001 Census data showed that the highest number of BAME carers in employment were from Indian origin, with significantly high numbers of carers in employment also from Black Caribbean and White Other groups.

### Case study: The Catik Family



The Catik family came to the UK as refugees. Fikri Catik, 55, cares for his wife Gulshan Catik, 46, who had a stroke five years ago, since when she has been mostly paralysed. Neither Fikri or Gulshan speak English. Their daughter speaks little English and is attending English for speakers of other languages (ESOL) classes. They live in private rented accommodation.

Fikri helps Gulshan with bathing, changing, getting around and feeding. Their daughter helps with caring when she is home from college. Fikri said, "I feel depressed because I stay at home all day, I feel pressured and obliged to care and culturally it is not a man's role.... They (health care professionals) never come with translators so we don't know what they are saying and what forms we are asked we sign. They just tick boxes and go away." Frikri would like to return to work to provide for his family.

#### Solution

They should have a full community care and carer's assessment in the presence of a translator from their community. Adapted housing would make a big difference to Gulshan's independence as would other aids and adaptations. Offering a care assistant would allow for Fikri to take time to go to the job centre and actively look for work and attend ESOL classes.

# Local challenges to delivering better outcomes for BAME carers

With so much change currently underway in the statutory and voluntary sectors, Carers UK undertook a series of 28 interviews with local authorities and third sector organisations across boroughs of London. The purpose was to identify some of the challenges that local organisations faced, the key challenges they felt carers they represented faced and, finally, to identify areas of good practice.

Carers UK also attended eight BAME carers' groups to further seek their views on challenges. We interviewed 11 local authority contracted projects, 25 BAME community groups that were non-carer specific, 10% were mainstream carer organisations and two BAME carers' groups. A large variety of support was provided by the 28 organisations interviewed from simply providing referrals to more in-depth and practical support such as breaks. The range of services included signposting services, support with getting and completing a carer's assessment, support groups, interpretation, home visits, sitting services and trips. A few services offered BAME carers training and education workshops to educate them on the welfare system, mental health, stress reduction, health and coping skills. However, all organisations were struggling with demand and meeting the needs of their local BAME communities.

## Funding community inclusion

Funding for community inclusion work with BAME communities by local and national government and charities is often time limited. As communities evolve so do their needs, therefore community inclusion work with BAME communities needs to be long term and continuous. It is essential that the needs of BAME communities are integral to the long term policies and strategies for carers. Some community groups and local authorities are already doing ground breaking work with communities, have invested time and effort into working with communities and are recognising needs and providing culturally appropriate services where mainstream services have not been able to provide them.

However, with 27% cuts announced to local authority budgets, BAME specific services are at significant risk

and our interviews with 28 organisations suggested that the important diversity of services currently on offer to BAME carers would be under threat. Public authorities should not only look at the impact of service cuts to marginal communities and BAME carers in particular, but that they also look to more creative ways in which public services and local community organisations can help to provide an overall better offer for BAME carers. Failing this, there is a risk that relationships with BAME carers will breakdown and poor health amongst BAME carers may increase. As a result the cost of health care for public authorities will rise as they provide services for both carer and cared for person.

## System reform and risk to BAME carers

Worrying 78% of the organisations interviewed felt that BAME carers are at risk of being marginalised, and face increasing poverty and discrimination with the anticipated changes to the health and welfare system.

## Challenges faced by carers

Carers UK asked what they felt were the major challenges that BAME carers or BAME carers from their community faced. The following were raised, which have also been documented in more depth in, *Beyond We Care Too*.<sup>26</sup>

- Stigma of caring for particular conditions, eg HIV or mental illness.
- Language and literacy barriers combined with a lack of knowledge of entitlements.
- Cultural barriers which hinder access to services.
- A lack of culturally appropriate practical services.
- Fact that BAME communities are seen as homogenous and yet are extremely diverse.
- Particular barriers faced by refugees.
- Misconceptions about extended family support that may not exist.
- Faith is not always explored in relation to BAME issues.
- A stronger BAME carer voice.

## Case study: The Yilmaz Family



Necla Yilmaz is 57 years old and cares for over 50 hours a week for her son, Onur, who is 33 years old. Onur has had Duchene muscular dystrophy from birth, which has left him with little mobility and he needs 24 hour care because of his respiratory needs. Necla washes, clothes, feeds and moves Onur. Necla does not speak English, so Onur is her voice. She has started an English for speakers of other languages (ESOL) course many times but has had to stop because Onur's condition has become critical.

They use direct payments to pay for a care assistant to come in for five hours each day. During this time Necla cooks, cleans and does the shopping. All her time is spent caring for Onur. She has no social life and feels isolated and depressed. She also has high blood pressure and Onur is very worried about her. He says, "my mum is keeping me alive ... I told them (social services) she can't cope any more and they told me to go to a care home... And I should feel lucky that I am getting this."

The first time Necla had her needs considered through a carer's assessment was in 2009 when she came into contact with BME Carers Support Services, despite the fact her the GP, social workers and hospitals know that she is providing around the clock care for her son. She is still waiting to hear back from her local authority since 2009. Necla feels her needs are ignored because she doesn't speak English and visits from social workers are centered around the needs of the service user.

### Solution

Necla would like to learn English which would make her feel she could articulate her own needs better and feel less vulnerable. With a little more support and investment through direct payments, Necla would also be able to attend ESOL classes or have the option of learning from home. The local authority could also look creatively at a personal budget for Necla to ensure she had a break.

## Stigma of caring and of particular conditions

Although stigma around caring has been mentioned by some of the interviewees, others mentioned that caring itself is often seen as admirable in many BAME communities. Stigma is often attached to the medical condition, for instance, mental health, HIV or AIDS or learning disabilities. Like many carers, BAME carers can also be made to feel uncomfortable asking for help, whether it is financial or practical.

## Language and literacy barriers

Language continues to be a challenge for some BAME carers, especially for older and new immigrant communities of BAME carers. Some basic information sheets are translated and will work well for some communities. However, some communities cannot read their native tongue. Commonly the word "carer" does not exist in other languages, nor does the concept, although the concept of caring does. Many service providers save costs by using the array of languages that are available in-house or using community groups in the local area. 'Beyond We Care Too' highlighted the fact that BAME carers who faced language or communication difficulties often used family members for interpretation during assessments. Whilst this often led to a whole family assessment, there were occasions

when carers also felt this approach did not take account of their needs sufficiently.

"I have heard it suggested that professionals sometimes underestimate the skills and abilities of carers from ethnic minority communities, simply because their English language skills are weak."  
(quote from a care worker)<sup>27</sup>

A level of poor literacy amongst some BAME communities is an important issue in ensuring rights and entitlements are properly understood. For example, "Low levels of literacy amongst Gypsies and Travelers can prevent them from accessing support or managing their housing effectively. Failure by mainstream services to recognise poor literacy can undermine attempts at communicating and disseminating information, thus further increasing the risk of isolation."<sup>28</sup>

## Cultural barriers

Cultural barriers place huge restrictions on BAME carers coming forward to receive services and these are documented in depth in *Beyond We Care Too*.<sup>29</sup> There are many cultural barriers including:

- Notions of duty to care for relatives.
- Unacceptable to take outside help.
- Fear of disclosing personal information, eg mental illness, HIV, addiction or domestic violence.

## **Lack of culturally appropriate services**

One example raised by local BAME carers of people with mental illness was a lack of talking therapies in other languages. They felt that no alternative to medication was available, which was seen as the least preferred option. Holding carers support groups that were BAME specific would encourage BAME carers to access support and build a circle of friends. Furthermore, for those BAME carers for whom language was a barrier, access to staff and carers assistants that spoke the same language is vital. Also ensuring that all staff are trained in cultural and religious requirements would help overcome cultural barriers.

## **Homogenous identity**

Often BAME communities have been put into one category; however each community has different experiences. For example, the cultural requirements for each Asian community is different: a Pakistani carer will have different religious barriers to an Indian carer, for instance; many Pakistanis do not eat meat unless it is Halal and some Indians are vegetarians; however, many of the elderly in both communities would prefer to keep their head covered. Furthermore, over time the BAME communities have evolved but old assumptions keep being used, some BAME communities are in their second or third generation, and although the cultural barriers may have become less prevalent, they still exist. Cultural stereotypes that they will want to care put them in a dilemma, as the stereotype will not only be carried by health services but also by some members of their community. As highlighted by our interviews, often those best placed to advise are community based organisations.

## **Refugees and asylum seekers**

There is little information on refugee and asylum seeking communities and their caring responsibilities. The Afiya Trust raised this issue in their recent publication stating, "There is evidence of significant levels of ill-health due to trauma, isolation, immunity related problems, sexual health, disability and undiagnosed issues among refugee and asylum seeker groups (Patel and Kelly 2006)".<sup>30</sup> Asylum seeker groups have difficulties in obtaining health care, registering with GPs and accessing health checks, screening or immunisation (Burnett & Peel 2001a, 2001b), and poorer health persist in those granted full refugee status."<sup>31</sup>

All of these health problems create a new generation of carers. One interview with a local organisation showed that the consumption of Khat and post traumatic stress disorder is a pressing issue for those boroughs where there are large refugee and asylum seeking communities from Somalia. The over consumption of Khat leads to psychotic episodes and long term mental health

problems predominantly amongst Somalian men, as a result Somalian women are taking on the role of a carer for their husband and children.

Many refugee and asylum seekers have a hard time understanding the health and social care systems, therefore they have little knowledge of what support is available. They may also have traumatic experiences of state having experienced war, persecution and conflict.

## **Non BAME carers groups**

Our interviews also showed that it is an unfair assumption that all BAME carers would like to have services that are from their own community. Therefore as with all carers it is important to present them with a range of options. This is particularly the case when there is stigma attached to their caring responsibility. Mainstream carers' groups and centres need to focus on outreach, providing culturally appropriate services and a self audit of their services and carers they are in contact with.

Carers' groups and centres need to meet needs for BAME carers, for instance providing appropriate food, accessing the right language, being religious aware and providing a friendly atmosphere. Outreach with faith and community organisations to identify BAME carers needs to be continuous because as we know, the number of people becoming carers and stopping caring each year is the same. It is also important to conduct an audit to evaluate whether they are meeting the needs of all their carers; in particular the needs of BAME carers in areas where there is a high percentage of BAME carers. A report by Crossroads Care and Princess Royal Trust, Caring for All carers, sets out how this can be done.<sup>32</sup>

## **Misconceptions about extended family support**

Our interviews with local groups and with BAME carers showed, in common with all carers, that extended family does not always help out with the care of a loved one. BAME carers have also suffered from the misconception – linked to the cultural duties around care – that they will want to "care for their own".

Several organisations interviewed raised their concerns that BAME carers were not being offered carer's assessments even when it was clear that they were the main carer and many local organisations were working to overcome this with BAME carers.

## **Faith**

There has been little discussion on the role faith plays in BAME communities. In delivering services for BAME carers, faith groups have played a key role in providing religious aware services. It is vital that mainstream services are knowledgeable about religious

## Good Practice: Jewish Care

Jewish Care is a well-known organisation which allows Jewish people to participate and live in their community, by delivering care and support that recognises and respects their Jewish values.

Jewish Care's centres, social clubs and support groups are enormously important to Jewish communities. They bring people together and give them many opportunities to learn new skills, improve their health and happiness and importantly, just have fun. They focus on preventative care and aim to rebuild confidence, self-esteem and independence. Their therapies and activities also help people cope with short or long-term mental health issues.

requirements. Not only does this involve dietary restrictions but also articles of faith, times of prayer and requirements not to remove hair or to keep the head covered. BAME carers said they often pay for private services because they need to ensure that the religious requirements of the service user are met.

Some boroughs have already begun working with faith groups to tackle the stigma associated with mental health and other conditions. Our interview research showed that this has produced positive relationships between boroughs and their communities. As a result, BAME carers with religious associations felt comfortable seeking help for the person they were caring for and themselves.

## A stronger voice for BAME carers

Several organisations felt that BAME carers' voices were not strong enough and, as a result, services were not commissioned in the right way, or their needs overlooked. A report published by the Department of Health in 2008 entitled 'No Patient Left Behind: how can we ensure world class primary care for black and minority ethnic people?' stated that people from BAME communities 'are afraid to complain about poor services and unable to exert real influence on improving local services. There is therefore an urgent need to build trust between BME communities and their local NHS.'<sup>33</sup>



# Overcoming challenges to supporting BAME carers

## More evidence on BAME populations and challenges for BAME carers

One of the major difficulties in evaluating the experience of BAME carers is the lack of data available. The 2001 Census statistics used in this report provide us with data that is almost a decade old, however it is the largest set of data available. Big cities like London, Manchester, Birmingham and Leeds change so rapidly that the data may not reflect the demographics of the city. Given language and cultural barriers, BAME communities are less likely to come forward and complete Census questionnaires. Particular attention needs to be given to people from BAME communities taking part in national and local data gathering exercises, using outreach where possible and working with local community groups. Carers UK will be publishing further work throughout the year on BAME carers using this model.

## Reaching BAME carers

Some BAME specific but not carer specific organisations were clearly very knowledgeable about their community, and had trust and strong links into that community. Each initiative was evidence that investing time in BAME communities produces a mutual relationship of trust and respect which resulted in positive outcomes. The research showed that many of the organisations had in-depth understanding of their local community and the changing demographics; they understood the needs of their community. In return, the communities felt encouraged to use their services and come to the support groups as safe spaces for them to meet other people and share experiences.

But many were also not experts in health and social care and the complex benefits system. Organisations with staff who were experts in these systems also felt that they were missing certain sectors of the community but were not necessarily funded to work with minority groups to ensure better access to services.

### Good Practice: BME Carers Support Services (BMECSS) [www.bmecarers.org](http://www.bmecarers.org)

Is a North London based organisation working with Black African and Caribbean, Turkish, Cyprian, Eastern European, Somali and Pakistani communities, funded by two local authorities. BMECSS has a clientele list over 1000 carers from the BAME community who they provide services to.

- BMECSS provides support to BAME carers through offering a range of services:
- A community income project which aims to increase household income by providing benefit information advice, help in form completion, and advocacy service.
- A BAME sitting service which is culturally appropriate and free of charge.
- A bereavement support project – providing culturally appropriate bereavement support,
- Help with completing carer's assessment forms.
- Support Groups for BAME Carers and BME Carers Assessment service in which they help BAME carers complete carers assessment forms.
- A consultative forum for Haringey to advise on new service development through the Haringey Strategic Partnership and
- A North London Carers Learning Network – helping carers to move towards their personal development and enhance learning.

WCEN was set up in 2002 concentrating particularly on bridging the gap between communities and public authorities. Their pilot project with its BAME carers group is taking a co-production approach and is aiming to ensure more carers receive a carer's assessment. The project brings together the Primary Care Trust, the Mental Health Trust, local BAME community groups and BAME carers from the borough. The project is training community groups to assist public bodies in conducting assessments and delivering services to BAME communities. It is seeking to overcome BAME carers "hard to reach" by working with different communities.

Outreach needs to be continuously funded by statutory organisations. They need to carefully balance support between those who can find the right information and support via the internet and other low cost, low intervention solutions, and others who need more support to understand how systems work. Authorities need to look at commissioning services across different local authority boundaries, for example. This will become increasingly important to ensure that smaller populations of BAME carers in some areas, or those with specific needs, are catered for. New creative solutions like this need to be found which use traditional and more modern ways of supporting carers.

## Early intervention and prevention

Early intervention or prevention has been identified as critical to targeting some of the issues that carers face. Good support through social, health and community services will reduce poor health and hospital readmission amongst carers. There is a clear public health remit for all health services, but this also needs to be specifically targeted at BAME communities, recognising the additional challenges that some members of these communities face.

Early identification of all carers must be a key target for GP practices, with specific attention to the needs of BAME communities. This needs to then link through to preventative strategies, ie health checks, advice and information and referrals to support groups.

In some BAME communities we know that there are certain conditions that are more prominent, like diabetes and stroke.<sup>34</sup> There are other medical conditions that carry significant stigma within certain communities, for instance mental health and HIV and AIDS. Public health and other health strategies need to tackle this directly. Primary Care Trusts and GP consortia need to ensure that their commissioning strategies clearly articulate the needs of BAME communities and carers within them.

## Personalisation in health and social care

Personalisation through social care is often seen as a way of improving support to BAME communities. Research has shown that many BAME carers need services that are tailored to fit the cultural or personal

needs of the service user to reduce anxiety of being in unfamiliar surroundings or company. For example, an older woman who had dementia became unable to speak English and could only then speak her first language, Gujarati. The carer found it difficult to find someone who could speak to her mother and understand her and, without this language, she felt it did not give her mother the dignity and support that she needed as she could not have her needs understood.

Research by Carers UK found that BAME carers were more likely to make use of direct payments than White British carers, because they were able to buy more culturally sensitive services.<sup>35</sup> The research by the Afiya Trust showed that 9% are in receipt of direct payments, 84% were not receiving any direct payment and 5% didn't know.<sup>36</sup> Whilst this shows that direct payments and social care personal budgets often much more potential to BAME carers, the majority of carers are outside of the social care system and will not receive social care support. The advent of personal health budgets however, may change the way that BAME carers are able to manage their own support.

Knowledge of personalisation amongst local groups ranged enormously from experts in health and social care locally who understood the systems and structures, to local BAME specific but not health and social care specific organisations who had not heard of the term before. If personalisation is to work across all communities then more efforts need to be made to bridge the gaps between community and faith organisations and experts who know about personalisation.

## Information and advice

The majority of organisations (68%) felt that there was not sufficient information provided for BAME carers in an appropriate and timely way to get the right support. And yet this is a key way to ensuring that carers, as with all citizens, are able to articulate their needs and get support.

Carers have more information than ever about their rights and entitlements provided by local and national organisations. However, the issue for all carers is how they first find out about the information and then they have the challenges of the complexity of support with different rules and regulations and different providers.

For some BAME carers, the challenge is even greater, with problems of language, ie not speaking or reading English, their language existing more in spoken rather than written form, different cultural understandings of what the state is there to do, and for some cultures, a deep suspicion of the state. This is well documented in a number of reports over the years, including *Beyond We Care Too*.<sup>37</sup> Interpreting rather than paper translations remains important. As already mentioned, creative solutions need to be found to ensure that BAME carers have equal access to information, whether that be face to face information sessions, delivering information in different languages or through community and religious organisations. It is important to continue to invest in outreach work and skills matching.

## **Empowering BAME carers and giving them a voice**

In responding to what would improve accessibility of services for BAME carers, almost all organisations felt that empowering BAME carers and giving them a strong voice whether individually, or collectively at a planning and strategic level would make a difference.

Carer strategies developed with a sound understanding of the local community will be pivotal to delivering successful action plans and good services. From point of diagnosis to transition to a stage when one is no longer a carer, cultural sensitivity should be weaved into the strategy. In an economic climate where cost saving is a key objective, it is vital that commissioners think creatively about how it is possible to still deliver culturally appropriate services and support for BAME carers by working with local community organisations and others to deliver a better deal for BAME carers.

## **Mainstreaming race equality**

Part of mainstream policy work is ensuring race equality is paramount to bridging the gaps in services and addressing inequalities. As this report highlights, there are many areas where the goal of race equality still has to be achieved. For example, despite health services being under a duty to address the disparities in service

access and delivery for BAME carers, 10 years later, BAME communities still have problems accessing these services.<sup>38</sup>

National health policies and strategies around carers must weave BAME needs throughout in a more robust and culturally competent way. Achieving Equality in Health and Social and Care, a framework for action by the Afiya Trust, sets out an important blueprint for mainstreaming race equality and needs to be implemented. Tight financial resources should not be an excuse for not delivering on race equality – rather there is a need to ensure that people from BAME communities are not disproportionately impacted on cuts and changes to services.

The Equality Act 2010 has introduced new opportunities which should help individuals as well as institutions tackle the challenges that are faced by carers. For BAME carers it has particular significance and should act as a piece of legislation that BAME carers can actively turn to for accountability and assurance that they will not be discriminated against. The Equality Act 2010 has set a landmark in outlawing discrimination against all carers because of their association with a disabled person. This means that an employer cannot discriminate against a carer in relation to caring for a disabled person, organisations that provide services and public bodies cannot discriminate either. Secondly, it recognised that many can be discriminated on multiple characteristics. The Act should act as a piece of legislation that BAME carers can actively turn to for accountability and assurance that their rights are safe guarded. The Act places a duty on all public bodies to produce anti discrimination policies as well as the conducting and publication of Equality Impact Assessments.

## **BAME Young Carers**

The documentation of experiences of young carers has shown that their caring responsibilities have left them isolated from their peers because they cannot enjoy a ‘normal’ childhood. Additionally, this has resulted in them underachieving in education and suffering from poor mental and physical health. Research has also shown that young carers are reluctant to come forward

### **Good Practice: Carers’ voices training**

Carers UK has developed a core set of training that has been commissioned by several local authorities to deliver with carers to ensure that their voice is heard and engagement is better. The training uses a mixture of techniques to empower carers with new skills, knowledge and an understanding of how systems work. It also aims to build improved and more constructive dialogue between local authorities, statutory organisations and carers.

BAME carers who have attended the training have said that they feel more confident, have a better understanding of the system and feel more in control of their of the care of the cared for person.

## Good Practice: National Black Carers & Carers Workers Network

### The Afiya Trust

National Black Carers & Carers Workers Network is hosted by The Afiya Trust and recognised by the Department of Health and BAME carers as the only national network addressing the issues around race equality. The Network was launched in 1998 and aims to develop and maintain an effective network of BME carers and care workers to facilitate the voice of BAME carers. This voice is implemented to improve services, policies and practice both locally and nationally to meet the evolving needs of BAME carers. In 2009 the network launched the UK's only national panel to give a voice to all BME carers who are often isolated without access to culturally sensitive services.

due to unwanted interventions, particularly the fear that they will be put into care or the family will be separated.

Amongst BAME young carers, research has shown that they take on caring roles that are beyond their age. Many are taking on the role of interpreters or translators in visits to the doctors or the hospital where they are privy to hard hitting information like long term or life ending illnesses, eg malaria, HIV or AIDS, cancer and psychosis.

## Good Practice: The Children's Society

### The Include Project

The Children's Society's Include Project offers information, training and support to both statutory and voluntary sectors who work with young carers and their families. More information and a range of resources, including a Good Practice Guide for Practitioners are available at [www.youngcarer.com](http://www.youngcarer.com).



## Further examples of good practice

### Carers UK

Carers UK has developed a toolkit for local authorities and other on improving outcomes for BAME carers. This has been developed jointly with Joint Improvement Partnership (London). This can be found at [www.carersuk.org](http://www.carersuk.org).

### Crossroads Care

The report Caring for all carers identifies six examples of good practice and signposts people to existing resources. It also provides recommendations for further action, including the development of new resources.

[www.crossroads.org.uk](http://www.crossroads.org.uk)

### Ethnicity Training Network (ETN)

The Ethnicity Training Network has been created to help change the way that people think and work in health and social care services. The Network was set up with funding from the Department of Health. The network aims to make it easier for health and support services to get training on ethnicity and health. Help to improve the quality of training courses. Help people find out about the needs and legal rights of minority ethnic and faith groups. Create links and share information between trainers, service providers and service users. <http://www.etn.leeds.ac.uk/>

### Equality and Human Rights Commission (EHRC)

EHRC have a statutory remit to promote and monitor human rights; and to protect, enforce and promote equality across the seven "protected" grounds – age, disability, gender, race, religion and belief, sexual orientation and gender reassignment. The EHRC helpline is can give information and guidance on discrimination and human rights issues.

0845 604 6610 – England main number

0845 604 6620 – England textphone

0845 604 6630 – England fax

Email: [englandhelpline@equalityhumanrights.com](mailto:englandhelpline@equalityhumanrights.com)

<http://www.equalityhumanrights.com/>

### HARP – Health for asylum seekers and refugees portal

HARP is a resource for working with asylum seekers and refugees. It also provides information on working with different cultures to facilitate a culturally sensitive practice. <http://www.harweb.org.uk>

### DipEx / Healh Talk Online

Healthtalkonline, an award-winning charity website, lets you share in other people's experiences of health and illness. This information is based on qualitative research into patient experiences led by experts at the University of Oxford. <http://www.healthtalkonline.org/carers/>

### The Afiya Trust

The Afiya Trust is a London based Black Minority Ethnic (BME) organisation that supports and maintains national and local networks concerned with the promotion of BME health and social care issues. As a second tier organisation with a national remit, and strong links to BME grassroots organisations, the involvement of service users and carers is central to Afiya's work as well as engaging voluntary and statutory organisations in the development and delivery of work programmes covering a broad range of health and social care issues. <http://www.afiya-trust.org/>

### The Race Equality Foundation

The Race Equality Foundation promotes race equality in social support and public services. They develop evidenced-based better practice to promote equality and disseminating better practice through educational activities, conferences, written material and websites. <http://www.raceequalityfoundation.org.uk/>

# Conclusions and recommendations

The Coalition Government has set out an ambitious programme for reform which covers several key areas that affect all carers. Welfare reform, health service reform, local authority budget reductions, a move to localism, education policy reform, housing reform and the concept of the Big Society. It is vital that race and caring are mainstreamed into all of these areas to ensure that carers and BAME carers in particular do not suffer from further social exclusion.

Taking NHS reform as just one area, the Government has announced its long-term vision for the future of the NHS. It has stated that the Health and Social Care Bill, “puts patients at the heart of everything the NHS does; focuses on continuously improving those things that really matter to patients – the outcome of their healthcare; on improving healthcare service.”<sup>39</sup>

The new NHS structure can be a positive opportunity to address inequalities in health. The role of the GP consortia and Health Watch will be pivotal in putting carers on the agenda. The GP consortia will be critical in delivering services to their communities, and more specifically commissioning services for carers. The local health watch will be an active voice for the community and therefore it is imperative that it is representative of the community. Through proper representation and awareness raising the GP consortia can ensure that carers services are commissioned and more particularly BAME carers are receiving culturally competent services. In order to deliver a ‘world class service’ it is important the repeated disadvantages of increased poverty and poor health amongst carers are targeted by addressing barriers including language, cultural barriers and discrimination. The role of the GP and surgery staff in identifying carers in their practice will be very important, especially in identifying hidden carers and signposting carers to services and ensuring they stay in good health – as part of early intervention and prevention.

## The Big Society

The Coalition Government has stated its commitment to ‘The Big Society’. The Big Society has been defined as a society in which individual citizens feel big: big in terms of being supported and enabled; having real and regular influence; and being capable of creating change in their neighbourhood.<sup>40</sup> For BAME communities, this concept has always played an integral part in empowering and supporting communities. The concept of the Big Society is an opportunity for community groups to empower individuals, to encourage social responsibility and to hold the state to account. However, the Big Society also relies heavily on a vibrant and active community sector. With services under threat, it is possible that some sectors of the BAME society could be marginalised.

## Conclusion

Our research showed that what BAME carers want is fairness and equality but there are certain disadvantages that will compound their experiences. BAME carers want a fair chance to access services that are appropriate for them, without feeling discriminated against or most importantly judged.

Carers’ needs are universal but services need to be tailored for BAME carers. Working in collaboration with local community organisations to provide culturally competent services through focusing on face to face information service and a sound understanding of your local communities will improve experiences for all.

Sustainable and ongoing outreach with BAME communities needs to continue because it will be paramount to mainstreaming race equality in health policies and strategies. Furthermore, it will help identify areas that still need to be targeted.

BAME carers in England already save the state a staggering £7.9 billion a year and, in providing care to their families, are the epitome of a strong society. However, the state has a duty, in return, to ensure that they are properly supported, free from poverty, ill-health and social exclusion.

## Recommendations

With so much systemic reform there is an urgent need to ensure that BAME carers are not further marginalised. Coupled with cuts to public funding locally and through welfare, it is vital that there is a re-examination of the ways that services are commissioned, policies created and services delivered. Nationally, Government needs to satisfy itself that race has been sufficiently mainstreamed and that BAME carers are not going to be increasingly marginalised.

Locally, there is a similar role for local government. For example, services need to be where people are and must work to build on strong and positive networks, for example, faith based, community or language based groups.

With diversity networks, there is a real opportunity for employers to consider linking race and caring together for the first time to build mutually positive policies.

### Central Government

- Government departments need to demonstrate in national policy and strategy development a serious commitment to meeting the needs of diverse Britain. National policy and strategy need to foster a cross government approach and consult equality experts to ensure equality is high on the agenda on race and caring grounds.
- Where Government departments are developing race policies, they also need to include the specific needs of BAME carers. For example, any policies looking at the challenges faced by BAME groups in securing employment, must also consider the additional needs faced by BAME carers.
- The Department for Business, Innovation and Skills (BIS) and the Department for Work and Pensions must ensure refugees and new immigrant communities are eligible for funding for English for Speakers of Other Languages (ESOL).
- BIS and the Department of Health must also look at how new and creative solutions like technology can be used to overcome some of the barriers faced by BAME carers. For example, telecare and telehealthcare has an equally important role, as could online support for some communities.
- Government must continue to fund capacity building measures and continue to invest in BAME communities who are disadvantaged by social inequalities.
- Government must ensure that policies which have particular cultural significance, such as end of life care, include a focus on BAME specific issues and the impact on carers.
- In looking at stimulating the care market as a means for supporting economic growth, Government should

use this to provide an environment where new businesses providing culturally appropriate support can flourish.

### Local Authorities

- The new public health agenda within local authorities offers a real opportunity to tackle some of the health inequalities faced by some sectors of the BAME communities. BAME carers need to be a specific part of local authority public health plans and the Joint Strategic Needs Assessment needs to be used as a vehicle for ensuring that this is followed through.
- Public organisations carrying out Equality Impact Assessments on the protected characteristics under the Equality Act 2010 need also to look at the combined impact of race and caring. Any plans arising from this need to set out clear courses of action.
- Local authorities need to work together to look at creative solutions to ensure that there is sufficient and appropriate language support, taking a combined approach using translations, simultaneous translation, working with community groups, etc. and access to Language Line. Local authorities could also look at utilising the assets of staff internally that speak different languages. Local authorities should also look at ESOL classes as a key tool in building resilience and confidence in individuals and families and need to ensure that there is sufficient social care to attend these.
- Personalisation offers an opportunity for BAME carers to receive the right support, but its success depends as with all carers, on the right brokerage and support mechanisms.
- Local authorities also need to ensure that there is sufficient advice, information and support for BAME carers who are not entitled to support as a result of tightening eligibility criteria.
- Local authorities need to explore more technological solutions to help BAME families build greater resilience.
- Local authorities should look at more commissioning across local authority boundaries, particularly where specialist services are needed.
- Local authorities also need to look at their commissioning strategies so that they have mainstream services to offer better support to BAME carers.
- Local authorities should use the new national carers survey and outcomes working to plan better support for BAME carers.

## GP Consortia

- GP commissioners must ensure that services are culturally sensitive. They need to ensure that services are appropriate for carers and need to understand some of the additional barriers that certain parts of BAME communities will face to ensure that health inequalities are reduced and ill-health prevented where possible.
- The new Health and Social Care Bill places a duty on both GP Commissioners and the NHS Commissioning Board to involve carers in informing them and, in dispensing this duty, and their duties on race, BAME carers must be an important part of this. It is also vital that consortia look at more creative ways of engaging with BAME carers and communities by looking at a range of the methods of engagement, not simply surveys or focus groups, but going to where communities are.
- Due to stigma of mental illness within certain BAME communities, it is vital that mental health trusts pay particular attention to engaging and involving BAME carers to ensure that they, and the person for whom they care, are better supported.
- The new mental health guidance strategy, 'No health without mental health', has promoted talking therapies and social inclusion. One of the most effective ways to action this amongst BAME communities will be to offer talking therapies in other languages.
- In order to prevent ill-health, GPs will need to ensure that they have early identification systems in place to identify carers. This also needs to include carers from BAME communities.
- The additional challenges faced by BAME carers must be part of the carers' awareness training for GP practices which will be work up to £6 million over four years.

## Local Groups

- Engage with local BAME and faith groups that are not carer specific as medium to outreach and deliver information to carers.
- Faith, BAME specific and mainstream local groups can work together to ensure that BAME carers are better supported.
- Local groups can work with BAME carers have a strong voice in shaping commissioning of health and social care and other services, working with HealthWatch.
- Local groups and carer centres need to ensure that their services are as accessible and culturally appropriate as possible for BAME carers. For instance, asking for feedback from BAME carers and conducting an equality impact assessment.

- When funded for ESOL or Information Technology courses, offer alternative methods to learning, eg home learning, weekend classes or with sitting services.
- Local groups need to keep up to date with the changes in health and welfare structure and procedures, as often they are the first point of contact for carers. To offer the best possible signposting service, it is important they attend training courses to bring themselves up to date with the changes, rights and procedures by becoming an affiliate of Carers UK.
- Outreach to BAME communities is important. Local groups need to do a self audit and review of carers using their services to ensure they go beyond the 'usual suspects'.
- Look at ways of encouraging BAME carers to cascade information to their communities.
- Continue to encourage carers and BAME carers to engage in the community action.
- Work jointly with job centres in your carers to encourage BAME carers to have the opportunity to return to work. For instance you arrange workshop with a job centre representative at BAME carers groups.
- BAME carers might benefit from basic training to assist them in their caring role; for instance many carers will value first aid training.

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- 24 Source: 2001 Small Area Microdata, Office for National Statistics. This work is based on the data provided through EDINA UKBORDERS with the support of the ESRC and JISC and uses boundary material which is Copyright of the Crown.
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## **Annex**

The figures for local authorities are published separately in an annex which is available from Carers UK's website [www.carersuk.org](http://www.carersuk.org)





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