HOUSE OF COMMONS

Northern Ireland Affairs Committee

Oral evidence: The experience of minority ethnic and migrant people in Northern Ireland, HC 159

Wednesday 8 September 2021

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Watch the meeting

Members present: Simon Hoare (Chair); Scott Benton; Mr Gregory Campbell; Stephen Farry; Mary Kelly Foy; Mr Robert Goodwill; Claire Hanna; Fay Jones; Bob Stewart.

Questions 1 to 35

Witnesses

I: Kendall Bousquet, Migration Justice Advocacy Officer, Migrant Centre NI; Caroline Coleman, Manager, Craigavon Travellers Support Committee; Breidge McPherson, Regional Outreach Worker, Women's Centre Derry.

Written evidence from witnesses:

– Migrant Centre NI

- Craigavon Travellers Support Committee

- Women's Centre Derry

Examination of Witnesses

Witnesses: Kendall Bousquet, Caroline Coleman and Breidge McPherson.

Q1 **Chair:** Good morning, colleagues, and good morning to our witnesses for this, our first session in a very long time face to face here in Committee Room 15 of Westminster. It is nice to see you all here this morning, and a particularly warm welcome to our witnesses for this, our first session on our inquiry, which we are embarking upon this morning. We are grateful to you for that It is effectively the experience of migrant and ethnic groups in Northern Ireland. We are very grateful to you for joining us this morning.

We have two panels. I want to start the questioning, please, by asking Kendall, Breidge and Caroline in turn to briefly describe the experiences of living in Northern Ireland for the communities that each of you represent. I would be particularly keen to hear about direct experience as well as general anecdotal experience. Who is going to be our first victim? Shall we go to Kendall?

Kendall Bousquet: Good morning and thank you so much to the Committee for inviting us to be here today. I hope that we can share some information that will be helpful to you all.

My name is Kendall Bousquet, and I am the migration justice advocacy officer at Migrant Centre NI. We work across Northern Ireland with offices based in Belfast, Lurgan and Derry/Londonderry to support the migrant and ethnic minority communities in Northern Ireland. We offer a number of direct services and programming. If I talk a bit about these, it will shed some light on the needs of ethnic minority communities in Northern Ireland as we are providing services that are in very high demand at the moment.

We have three main branches of direct service provision. The first is immigration advice. Currently, we provide immigration advice and support for the EU settlement scheme. That provides us with some direct expertise on the experiences of those who have made applications to the settlement scheme: both EU nationals and non-EU nationals who are applying as family members. Currently, we are seeing the transitional period or growing pains post-Brexit of people making late applications and trying to communicate to employers what people's entitlements and rights to work are if they have pending status or are lodging late applications, both for employment and for their entitlements broadly.

We are also seeing a number of concerns in this post-Brexit period of EU nationals who are obviously not entitled to recourse to public funds because they would not fall under the purview of the EU settlement scheme. There is a lot that we could probably touch on there, but I know we are just giving an introduction at the moment.

We also provide hate crime victim support and advocacy services for victims of race hate crime in Northern Ireland. The scheme is tendered through the PSNI and there are a number of specialist organisations that support victims of disability, LGBT and race hate crime. We support victims of racially motivated hate crimes. Unfortunately, race hate crime is a big problem in Northern Ireland. In the past year with the lockdowns, et cetera, we would have hoped that our caseload would have gone down, but it has gone up.

Q2 **Chair:** How does it manifest itself? Is this verbal racial abuse on the street?

Kendall Bousquet: There are a few tiers of the ways that this manifests itself. The majority of the race hate crimes or race hate incidents that we would be called to support victims on would be the low-level, but still very distressing, street harassment and anti-social behaviour. This would come in day-to-day interactions in the street. It goes all the way up to very serious, very high-level, potentially life-threatening attacks.

For example, a very high-profile arson was committed against the Belfast Multi-Cultural Resource Association building this past summer. There have been attacks on occupied homes. We have also seen a lot of—and this falls in a grey area because the Housing Executive does not have a policy on this issue—pre-emptive attacks on, for example, Housing Executive property with racist slogans or intimidating messaging, breaking windows, et cetera, to deter ethnic minority families from moving into communities.

Q3 **Chair:** Just pause there. This is a slightly difficult question to answer, which I will ask with as much sensitivity as I can ever muster. Is there any picture to show that that sort of abuse and intimidation manifests itself in greater number in the nationalist or unionist community or community areas?

Kendall Bousquet: I want to be careful with how I answer this because I do not want to paint a false picture. The attacks primarily happen in the communities where there is available housing stock and where subsequently ethnic minority families, in particular new families, and refugee and asylum seeker families, tend to move into. Those are where the majority of the housing stock is. That is where we see the attacks happening.

Q4 **Chair:** For our information, where is that?

Kendall Bousquet: We might see the majority of attacks happening against, for example, eastern European communities in PUL neighbourhoods. The majority of attacks against Travellers are in predominantly Catholic, nationalist, Republican—or whatever you want to call them—areas, because the majority of Travellers are in or around those areas, as opposed to other communities where there might be a higher percentage of people from eastern European or African national backgrounds. The correlation is not based on community.

Q5 **Chair:** In essence, different types of abuse manifest themselves in both communities.

Kendall Bousquet: No. I would say that they are similar kinds of abuse and intimidation, but who they are levelled against is correlated to who is moving in. For example, I am based in Belfast, and no area of Belfast—north, south, east or west—is exempt from the issues we are seeing with hate crime. For example, south Belfast has the highest concentration of ethnic minority communities living in it, and the arson attack that took place was in south Belfast. Unfortunately, where newcomers are concentrated, there are race hate crime attacks.

Q6 **Chair:** Breidge, could you briefly describe the experiences of living in Northern Ireland for the community you represent?

Breidge McPherson: Yes. I am very happy to have the privilege of speaking to you all. My name is Breidge McPherson, and I work here at Women's Centre Derry with Syrian refugee families primarily. I sat with a group of women from nine countries yesterday: Egypt, Morocco, France, Spain, Israel and lots of different countries.

I was going to take the angle of access of healthcare today. That is what I was asked to focus on. The families I work with are here on the vulnerable persons resettlement scheme—VPRS—including women, children and fathers who have left their homeland, their country, their families, their jobs, and their education in Aleppo, Damascus and Idlib in Syria. They have had to travel to Lebanon and Egypt. They have had a long and winding road, and my oral evidence is called, "The road from Damascus to Derry". They have arrived here in Derry to be resettled, and have been placed in old, mid-terrace, low-level, poor housing stock managed by private landlords with huge rents. They are trapped within a system of poverty and trauma, and their access to healthcare is abysmal, to put it mildly.

I will give you a few examples to start with, and then hopefully you will be able to come back to me and I can elaborate. I had a session on Friday where I had to ring 999 for a family. As you will know, the ethnic minority groups are disproportionately affected by socioeconomic deprivation, which is a key determinant of health status. These people, who have been chosen because of their vulnerability, are women and children at risk, people in severe need of medical care, and survivors of torture and violence.

Those are the people who come here. They then try to access medical care, and their first language is not English. Therefore, some individuals are not registered at all with GPs. Some GP surgeries are not taking on new patients; nor are some dentists or ophthalmologists. These people have chronic health needs, have suffered horrendous trauma, are suffering from grief, and are brought here because they are chronically ill. They have a lack of confidence and are frustrated by the process of

accessing healthcare. The system is different to their own country, so they absolutely do not understand it.

The development of this telephone triage has been an absolute nightmare for the people I work with whose first language is not English. For instance, a woman speaking Arabic who has very little English will try to ring the GP receptionist, who gives little to no consideration that English is not her language. Therefore, the whole process breaks down before it even starts. Neither person understands the other, so they are not able to arrange a GP appointment for themselves. It is very difficult or impossible, and details get completely misinterpreted.

The telephone conversations between the GP and the patient are impossible. Even if they get a telephone interpreter, they often speak in a different dialect. They might be male, and a Muslim woman, or any woman, might not want to discuss her health problems with a male interpreter. Often, these interpreters are not specialised in health or health language. I hope I am making it clear that there is a myriad, a maze or a ball of problems there before you ever get to see a GP.

Q7 **Chair:** I know colleagues will have questions later on in the session on health. Let me just ask you for your observation on this. In that perpetual endeavour to balance public policy provision, commissioning, and evolution between "orange" and "green", are you persuaded that the policy formulators and commissioners take seriously and understand enough of, while it is a very small percentage of the population, a very important percentage of the population? Is that on their radar, or is that perpetual green/orange balance strike such a dominant thing that everything else is slightly set aside?

Breidge McPherson: I think it is dominant, and I think we in the north-west in Derry are doubly disadvantaged and marginalised because everything is Belfast-centric. These people who are brought here because of their chronic health needs are then doubly disadvantaged because they are sent down the road in a bus to Derry. They have one key worker among all the families. They are totally overwhelmed with the need, and they are forgotten about. They are ignored by the Department for Communities. Their housing is deplorable, and nobody will listen. The people who are dealing with all this are in Belfast, and the people who are suffering on a day-to-day basis from a lack of care and attention are not being heard at all.

Q8 **Chair:** Thank you for that. That is helpful. In the interests of time, Breidge, I am going to turn to Caroline Coleman now.

Caroline, good morning to you. It is the same question. Can you give a brief description, please, of the experiences that the people you are working on behalf of, representing, and advocating for, experience? Could you also address that broad cognisance point? Do the policymakers, setters and commissioners take into account seriously enough, and in enough detail, your community?

Caroline Coleman: Good morning. Thank you for the opportunity to speak here. It is not lost on us that this is probably the first time that any Traveller organisation has ever been invited to speak at this level, and it is very important to us.

Chair: You are very welcome, and we are glad to have you.

Caroline Coleman: Thank you. I am the policy officer in CTSC, and for the last 30 years we have been working with Traveller families in the Craigavon, Banbridge and Lurgan areas. We have extended beyond that in recent years just because of the lack of Traveller support organisations. The sector itself has fallen away. In the last decade, there were maybe 10 or 12 small organisations dotted right across Northern Ireland; they have all disappeared, largely because of funding, so we are probably the only independent one that is left.

We work with about 150 Traveller families in any one particular month, and we collate these statistics every month. About a quarter of them are nomadic, so their needs are very acute and different from many of the more settled families we work with. We provide a range of services, and the one that we spend the most time on is access to benefits and dealing with issues around accommodation and housing. That is both access and the very poor experiences that Travellers have had when they have accessed these services.

We also have two women's groups, which tend to be fairly well attended but then fall away. We have problems with consistency, and part of that is because of the nomadic lifestyle. We also have a homework club, which is really important because most of the parents do not have the literacy or IT skills to support children to do their homework.

We have male and female youth programmes, which have been segregated at the wishes of the families. Most of the children and young people we work with tend to be married by the time they are 17 and 18, so our youth programme would probably be classed as a children's programme with some other groups.

Our biggest issue, particularly in relation to my work, is, as you described, the policy deficit and the disconnect between policy and practice. I believe very strongly that part of that stems from the fact that we do not know the size of the population. The census figures were absolutely no reflection of the community that we work with, and that was partly because of the literacy issues, which extended into IT issues in this recent census. Most Travellers I know do not have access to the internet, and certainly do not have email addresses and all that, so they are automatically excluded from so many processes, particularly now that NI Direct is all online and you need an email address to access many of those services.

The other huge problem I have is the lack of ethnic monitoring. There have been many recommendations from the Equality Commission, the

UN, and your own Women and Equalities Committee, all of which have recommended that ethnic monitoring be implemented as mandatory; that has never happened. When it comes to tackling health inequalities in particular, no data exists to demonstrate that.

For example, 10 years ago, we knew that 1% of Travellers lived to be 65; I do not know if that has changed. I do not know if that has improved or got worse because we do not collate the data or specifically look at any of those areas. We send statistics on a quarterly basis to our local trust, for example, on the work that we have been doing, the types of work, the people at the age groups, and all of that, but it does not translate into policy. It is not collated or analysed at trust or departmental level.

Probably because we are one of the only Traveller support groups left, we deal with families who are living in Belfast and Ballymena. We do not do so much in Derry or the western trust, but we go right across the southern trust and Belfast trust. The two trusts operate very differently. There are support workers for Travellers in Belfast trust, for example, but there are none in the southern area. There are programmes working in the Belfast trust that do not work elsewhere.

There is no one co-ordinated approach, and that has again translated into a lack of policy. We would really strongly advocate for what has happened in Wales, Scotland and the Republic of Ireland. They all have a Government-led, bottom-to-top strategy to deal with all the Traveller inequalities. We very firmly believe that, unless that happens, it is not going to change.

Chair: Thank you. That is helpful.

Q9 **Bob Stewart:** Thank you very much, ladies, for attending today. We very much appreciate that. Caroline, you mentioned that you wanted Government-led strategy; that is what you said. My question is this: which Government? Does the Government come from Stormont or London? It would be a bit difficult if it were direct from London. The nub of my question is this: fundamentally, what strategy do you expect from the Westminster Government?

Caroline Coleman: Obviously, the way forward is for the Northern Ireland Executive to release a Traveller strategy, primarily because the other devolved Governments have their own strategy, which is developed in relation to their own needs and experiences and the location. We have very particular issues. For example, we have a Housing Executive, which is not replicated in Scotland, Wales or England. From the point of view of a Traveller strategy, it must come from the Northern Ireland Assembly.

However, the Northern Ireland Assembly produced guidelines for developing ethnic monitoring over 10 years ago. It was just a guide; it never went anywhere. Most organisations did not implement it. I would like to see the Westminster Government make that compulsory. I am not

a legal expert and I do not know to what extent that can be legislated for, but without the evidence we will never tackle any of the inequalities.

I can tell you very clearly that Traveller issues are not a priority for our own Government. It is evidenced in many ways. We have a racial equality strategy that took almost five years to set up the Traveller subgroup that was supposed to be part of it. We have racial equality champions in each Government Department and, in their bios and blogs, only one mentions Travellers. They talk about newcomer communities. They see ethnic minorities as newcomers and people who have come to live and work in Northern Ireland from outside. They ignore the indigenous ethic minority community. We do not have representation at the race forum. There are no specific policies. With the exception of the Housing Executive, which recently released its Travellers accommodation strategy, we do not have specific policies and strategies to address the very specific inequalities that Travellers face, but also the wider ethnic minorities.

Look at the responses to this inquiry. There were quite a few responses, and I went through them. Only three mentioned Travellers. We have gone beyond the expectation that Stormont might do something about this. It is not a popular issue, unfortunately. I would like to see Westminster legislate for change.

Q10 **Bob Stewart:** I am not sure we can legislate for change. Perhaps we can ask Stormont to look at it. Like you, I am not a legal expert either, but it does seem that, as we are looking at this matter here in the Northern Ireland Affairs Committee in Westminster, we might say that someone should look at this matter when we report. Thank you very much for that. I do not know whether any other lady wishes to make a comment on that because we have that point hoisted aboard here.

Kendall Bousquet: I can echo the things that Caroline said about perhaps the lack of political will that see here from the Northern Ireland Assembly not only to produce strategies, but to make the strategies actionable. A big part of how strategies become actionable is that they are delivered with timelines as to what actions will be delivered, but even, perhaps most importantly, that the strategies come resourced with ringfenced funding for the organisations that support the most vulnerable populations. We have seen a real crisis of resourcing in the sector in recent years, and that translates directly to a lack of political will.

On the end of Westminster, I can say that we are in a unique devolved position where certain things are reserved, and certain things are not. What we run into a lot at the migrant centre is that, when we try to raise issues of the way that those with, for example, no recourse to public funds are affected at every level—be that housing, health, legal protections, et cetera—we are told, "This is a reserved matter. This has to go to Westminster".

We are trying to do the work of mitigating the damage that some of these policies are doing at the devolved, everyday level at which they are affecting the communities we are dealing with, while basically being told, "The buck stops here". Westminster can play a material role in delivering a higher standard of human rights and equality at the level of evaluating Home Office policies and listening to organisations that support the most vulnerable as a result of these policies.

Bob Stewart: I do not know whether Breidge wants to say anything, but I am conscious that I am stealing a lot of time.

Breidge McPherson: No worries—I will just quickly add to what my colleagues have said. We are currently the only region in the UK that does not have a refugee integration strategy to co-ordinate and monitor all interventions—a strategy to ensure that children have access to equal education, there is a coordinated response to hate crime, and refugees have access to a tailored pathway to economic and social inclusion. There is lots of other stuff: access to health, access to education, access to fair and equitable law advice, help with biometrics, isolations, pandemics, and children whose parents cannot speak English. They have no help with their homework and are totally isolated. Trauma and health needs are not addressed. Everything is abandoned.

Q11 **Chair:** A number of you have mentioned hate crime. My understanding is that the legislation is different in Northern Ireland with regards to hate crime rather than dealing with it on a UK basis. Could you just throw in a word or two about that? Kendall, you referenced it particularly.

Kendall Bousquet: The review was just undertaken by Judge Marrinan on the current hate crime legislation. The Justice Minister has spoken about the development of bringing Northern Ireland more up to speed with the rest of the UK, and in particular looking at the differences between, for example, Scottish legislation and our own, as to where Northern Ireland would fall short on certain protections. Yes, I would say that our hate crime legislation is probably the worst on the books for the UK at the moment, and so we are, within our sector, really pushing for the introduction of improved hate crime legislation that is being introduced or consulted on at the moment.

This would carry across sectors as well because there are these intersectional issues. For example, there is no case for gender-based hate crime. Obviously, we support victims of race-based hate crime, but people's identities do not stop with their race. Somebody might be attacked who had intersecting identities that are contributing factors in why they were vulnerable. We would be in favour of the most comprehensive hate crime legislation possible.

Chair: Thank you. We have taken that point.

Q12 **Mr Goodwill:** I would like to turn to Caroline first. You talked about the problem of poor health outcomes for the Traveller community, and that is generally shorthand for life expectancy. I would like to get a little more

understanding about what is going on here. Is it that the Traveller community cannot access the healthcare it needs? Is it because they will not access it, and people who would normally go to the doctor with a lump or something that they were worried about, or to get their blood pressure tested, are not coming forward? Is it down to some of the lifestyle issues that we have in other parts of the UK, such as alcohol, smoking, obesity, or all those things, that mean that often, sadly, some communities have poorer life expectancies than others? Also, is there a difference between the nomadic section and those who are more settled in terms of, for example, registering with a GP?

Caroline Coleman: It is a combination of all those factors, combined with very poor living conditions for some families. I am based in Craigavon, and I am looking out on to a site that is home to, at the minute, three large families. It is essentially a car park and nothing more. There are disused pods for washing facilities. They are in such poor repair. Those kinds of living conditions obviously have a detrimental effect on people's living standards.

Most families that we work with, well into the 90s, are registered with GPs, but follow-up is very difficult, particularly for those nomadic families. Nomadic families tend to travel seasonally. We know, for example, the season starts in and around Easter time. If nomadic families have been waiting on an appointment or a call to an appointment and it has come at Easter time, we have generally lost them. Those appointments are never picked up or followed up.

We do not tend to have huge problems from the more settled families. We have fewer problems with women accessing healthcare. There is definitely a very clear reluctance on the behalf of men to access healthcare. In some senses, it is a very superstitious community. We have found that a lot of people would turn to prayer rather than physical healthcare, and that has been a problem throughout the years.

The main problem when it comes to Traveller health, though, is the fact that there is a general reluctance to access healthcare for serious issues, and that a lot of services are not particularly targeted at Travellers. No one is targeting Traveller men on men's health issues. We do what we can in and around health issues, but we find that Traveller women in particular are very reluctant to talk about very personal health issues, even within our safe space.

We would need specialist health interventions to help them, which do not exist. They really do not exist. The trust in our area had two workers working on health issues for Travellers. One retired in March 2020 and one retired in March 2021, but she had already been redeployed because of Covid. There are no specialist programmes. There is no plan or strategy to address those health issues.

I genuinely do not know how we take this forward or where it goes from here, but the more worrying thing is that the data we do have in terms of

Traveller health is 10 years old. Those statistics are sitting there from 2010, and I do not know. I cannot stand over them. I genuinely cannot, and that is more worrying than anything else. I do not know.

Q13 **Mr Goodwill:** Can I just come in and ask if you have any understanding of the vaccine uptake, in terms of both the Covid vaccine for adults and childhood vaccination? We have seen some communities, in GB at least, in which they have not been vaccinating their children and putting their kids at risk from MMR diseases.

Caroline Coleman: Generally speaking, we have a very good vaccine uptake right across the board, even for the Covid vaccine. We have never had problems with young children and babies getting vaccinated. That is not an issue for us. Many Travellers are waiting on their opportunity to get the Covid vaccine.

Mr Goodwill: Turning to Kendall, in terms of particularly the VPRS families we have welcomed here to the UK, you mentioned the difficulty of getting past the GP receptionist.

Breidge McPherson: That was me.

Mr Goodwill: To be honest, a lot of my constituents have a problem when they speak the same language as the receptionist.

Breidge McPherson: I know.

Q14 **Mr Goodwill:** Do we have any strategy for trying to address that and getting better healthcare?

Breidge McPherson: I brought that up about the GP. There is no refugee strategy in Northern Ireland. We are the only part of the UK that does not have a refugee strategy.

If I could just give you an example of the seriousness of the outcomes of these difficulties, on Friday, I got a call from a woman who speaks Arabic. She had been trying to get through to the GP surgery, but firstly they would not answer the phone, or the phone was not answered. She called, and called, and called, over half an hour. Anyway, she eventually asked me whether I would go to the pharmacy—this was in broken English by text—and see if there was a prescription there. The pharmacist knew nothing about a prescription. I took it on myself to ring the GP, then was not answered for a long time. Eventually, they answered. There was no prescription, so there had been a breakdown in the communication there. The whole thing was broken down.

I eventually went to the house and found the man unresponsive on the floor. There were two small children in the house looking absolutely terrified. These are people who have left Aleppo and gone to Lebanon, and have been terribly treated there. The man was unresponsive, and the paramedics and the ambulance had to be called. It was a life-threatening situation.

He is still in hospital now. That happened on Friday; this is Wednesday. He has never seen an interpreter. The woman and family are not being kept updated. He has never been offered halal food. I think you could safely say that there was a total breakdown in the system there. It was found that his blood sugars were very high. His oxygen saturation was very low.

Chair: Sorry. Without getting into too much detail of this gentleman's case because that is his private healthcare, just picking up on what Mr Goodwill was asking, from memory, Northern Ireland accepted something like 1,815. It was something of that nature. I do not know why I am looking at Gregory, but it was something like that in terms of people coming from Syria.

Breidge McPherson: That is right, yes.

Q15 **Chair:** Put boldly, it has to be a failure, does it not, of public policy support and pre-thinking that there is no support strategy in place to deal with a very significant number of very traumatised, complex-needed people?

Breidge McPherson: That is right.

Q16 **Chair:** This is just a failure of politics, is it not?

Breidge McPherson: Yes, I believe so. Could I just give you an example of a family who were sent? When they came to a house, they had so many small children. She said the house was so small they had to go sideways into the bedroom, and that the blankets on the bed were grey with holes and they looked like prison blankets. For the first time since they left Aleppo, her heart fell.

Chair: Gosh. Robert, I interrupted you. Forgive me.

Q17 **Mr Goodwill:** I do not know if Kendall can give us a bit more background to some of the problems people have. Is there evidence that GPs are deliberately not signing some of these patients on to their books, because of the difficulties and possible cost of translation services, and trying to push the problem on to another practice somewhere?

Kendall Bousquet: We hear from the clients we are serving day to day that they are facing and having to deal with a number of healthcare needs. We commissioned a report in 2017 on barriers to healthcare for minority women in Northern Ireland, and a big issue that got brought up was this issue of interpreting. There should always be an interpreter provided whenever that is requested. Of our sample of 207 women who we interviewed across immigration statuses, nationalities, et cetera, over 11% reported that they had gone to a GP and requested an interpreter, and had not been given one. That is a substantial minority. We hear issues with interpreters reported by clients fairly often.

Even in the instances where interpreters are provided, Breidge spoke a little bit to the issues that come along with that. Is the interpreter

qualified to specifically do health interpreting? Are there issues with regard to the gender of the interpreter? We saw in that survey that a significantly higher percentage of Arab women compared with the standard sample preferred a male GP, and so also male interpreters, in those instances.[1]

Q18 **Mr Goodwill:** If I might just interrupt, have you plans in place for the latest tranche of Afghans? I know we have about 250 temporarily in my constituency. The men often speak very good English, but the women pretty much do not. Do you have plans in place to make sure that we can extend the health support that they need to those families when they arrive in Ulster?

Kendall Bousquet: To my knowledge, there has been no support or policy planning communicated by the Government with regard to these specific healthcare needs. I think you are right that a lot of these issues are going to present with our incoming Afghan clients.

Another issue that we see with these interpreters is that these are brand new communities in Northern Ireland, and everybody knows each other. These are highly confidential issues that sometimes include disclosing abuse within the home and other very sensitive topics. In the interpreter pool that you have, everybody knows everybody, and so this presents another barrier to healthcare as well.

Within that, there are multiple ethnic groups within the likes of Afghanistan and the African countries that we have African nationals coming from. Just because someone might be from the same country, it does not mean that there is that same level of comfort if there are these ethnic or cultural differences. These are all things to consider as barriers to access to healthcare and other public services as it relates to interpreters.

Q19 **Scott Benton:** Good morning to all our witnesses. Breidge and Kendall, in your opening remarks and your recent answers to my colleague there, you spoke about difficulties many people who do not have English as a first language have in terms of accessing healthcare. Indeed, you have spoken about some of the translation services and difficulties having predominantly male interpreters and those who are not specialised. In many of your comments, you have pointed this back to the fact that there is no policy planning and we do not seem to have a refugee strategy across Northern Ireland as a whole.

Are there any other suggestions in terms of the health economy that you would point to if you had the Minister of Health from the NI Executive here? If there were two or three things you could highlight that would really improve the access to healthcare of ethnic minority and refugee

[1] Kendall Bousquet subsequently corrected this point, noting: "We saw in that survey that a significantly higher percentage of Arab women compared with the standard sample preferred a female GP, and so also female interpreters, in those instances."

people, what would those two or three points be, if you can focus on those?

Kendall Bousquet: We hear a number of issues, in addition to the interpreter issues of not being able to communicate healthcare needs, of also feeling that care is not culturally sensitive to the needs of the respective communities. Training on culturally competent healthcare within the different healthcare trusts would probably go a long way. Strategies need to be delivered at every level, with best practice for individually serving refugee communities, asylum seeker communities, migrant communities, et cetera, introduced not only within the NI Executive or the NI Assembly's broad remit of the Department of Health, but also within the trusts.

Also, those strategies have to be actionable and demonstrate steps that are going to be taken to make sure that this is in place. Again, resourcing would be an important part of this. Community organisations working with these communities can serve as important bridges for those who are most hard to reach or have the most unmet healthcare needs, but, if nobody is in post to work at those organisations, the strategies are dead in the water.

Breidge McPherson: I will just add a couple of points. Everything that Kendall has said is perfect. The people in the VPRS are traumatised and have complex needs. Access to counselling with counsellors who speak the same language is critical. A lot of people are experiencing day-to-day post-traumatic stress, and that includes small children. That would be my first thing because I see the people on a daily basis. I can see, of course, if you are suffering from PTSD, that that is going to prevent you from engaging in your English classes at the women's centre, bringing your children to the creche or going to the school. That is going to make you further isolated at home and further away from information and help that might help you to progress.

Secondly, I spoke to a woman yesterday, and she was trying to get an appointment at a family planning clinic. She said that she was told that the waiting list was five months long. That was too long for her because, in the meantime, she would be under pressure to produce a child. Five months' time is just too far away.

Caroline Coleman: I know the question was specifically in relation to refugees and asylum seekers, but, as Breidge has pointed out, the social determinants of health mean that it should not be the sole responsibility of the Minister of Health to deal with these issues. I am thinking particularly in relation to some of the very poor standards of Traveller site accommodation we have and the impact that that has on physical and mental health, but also on, for example, children's ability to do their homework, employment status and all that. I would very strongly advocate that it is looked at in the round across Departments, and that is why the need for a strategy is even more important for Travellers,

asylum seekers and migrant workers. You cannot look at those issues in isolation.

Q20 **Scott Benton:** Notwithstanding the obvious deficiencies in service provision, which you have highlighted, across Northern Ireland, is there any evidence of a two-speed system? For example, does Belfast have better services, with the rest of the Province lagging somewhat behind? I understand that the vast majority of the ethnic minority population is indeed concentrated in and around Belfast, but is there any evidence of specific communities outside Belfast in the Province having even greater difficulties accessing healthcare?

Breidge McPherson: Definitely; I can confirm that because I am here in the north-west. They are doubly disadvantaged because the consortium of groups that manage the VPRS, including the Red Cross, Barnardo's, Bryson Intercultural and South Belfast Roundtable, are all in Belfast. There was a key worker here, but he is gone. All the groups, from the consortium to the Law Centre NI, are based in Belfast, and there is nobody here.

Caroline Coleman: I can echo that. The southern area has the largest number of Travellers of any of the trust areas, and we are the ones with no trust support workers, whereas Belfast has numerous support workers and funds external projects to deliver work specifically to Travellers. It definitely is not an equal playing field.

Breidge McPherson: It definitely is not.

Q21 **Scott Benton:** Moving on to my next question, are you aware of any instances in which any individuals from minority ethnic and migrant backgrounds have been subject to questions surrounding their immigration status when seeking to access healthcare? Is this something that any of you have any experience of?

Kendall Bousquet: Yes, we can attest to that. None of our direct services bridges these healthcare gaps, but we hear anecdotally between our immigration advice, hate crime victim support and benefits advice services experiences of healthcare from our clients. We have been made aware of people having been asked about their immigration status, in particular around chargeable NHS services. These take a very gendered form because, for example, maternity services under the NHS are chargeable. We have had reports of people who are going in for care for anything related to maternity being asked about their immigration status.

Our stance, echoing statements issued by the British Medical Association, is that this immigration questioning, and indeed the practice of immigration reporting by the NHS, deters migrants from seeking necessary care from the health service. This includes things that play out in particularly gendered ways. For example, people avoid breast cancer screenings; getting smears or ovarian cancer screenings; and, really troublingly, reporting abuse that could be happening in the home. This

practice of immigration reporting and questioning by the NHS is making vulnerable people more vulnerable.

Q22 **Scott Benton:** Thank you, Kendall. That is very useful. My final question is in relation to asylum registration cards and HC2 certificates, which are obviously required to receive full access to healthcare services. Can you elaborate upon your experiences in terms of how timely those cards and certificates have been issued by the Home Office?

Breidge McPherson: They have not been timely. They have been delayed. Sometimes the process of applying for them is so fraught with difficulty that the families are unable to fill in the forms themselves. When they send them off, a mistake might be made. They are sent back and delayed tenfold, to the extent that it then just does not happen. People are without a GP, ophthalmology or a dentist. Rather than preventive healthcare and looking after children and vulnerable adults, it becomes chasing a serious healthcare matter.

Scott Benton: Thank you. That is very useful. I know this Committee has some correspondence with the Home Office, so that may be something we wish to say.

Q23 **Mr Campbell:** All our witnesses are very welcome. I fully understand what Breidge meant when she talked about the double disadvantage that we suffer in the north-west. Hopefully, the construction of the dual carriageway between Dungiven and Londonderry will help to get some staff relocated and they will find us not as far away as they think in Belfast.

I wanted to ask each of you a question regarding domestic abuse. Are there any issues that would specifically be attached, not exclusively, to female migrant individuals and people from ethnic minorities? It can apply to males as well, but, given that it is more predominantly aimed at females when there is domestic abuse, are there any issues there that have led to additional difficulties that people from ethnic minority and migrant backgrounds have that are not faced by people who have lived in Northern Ireland all their lives? They also face difficulties, but people from migrant communities face additional difficulties with language, et cetera.

Kendall Bousquet: There are certainly some facets of abuse that might particularly affect migrant victims of domestic abuse and some that exclusively affect migrant victims of domestic abuse. Some things that are particularly used as these patterns of coercive control within domestic abuse include the fact that, oftentimes, people from migrant communities who come and live in these domestic situations or marriages do not have the same support networks locally that a local person would, in terms of having family nearby to support them if they are in an abusive relationship.

In addition to that, they may face barriers as a result of, as we have talked about, having issues navigating the system; not knowing where to

go for help; or, even if they do know, not having the language skills to be able to navigate it. We have talked about issues with interpreters; the likes of even support charities for victims of domestic abuse do not tend to have interpreter budgets built within their services.

Women's Aid does not have interpreter budgets within its services. There are issues at every interface of every statutory service that you get passed around to, when you are a victim of domestic abuse, whether it is the benefits office, the Housing Executive, the police, et cetera. There are barriers every step of the way.

In addition to that, there are specific issues that affect migrant victims in addition to the issues that would affect anyone, in terms of needing financial independence, safe housing and benefits in their own name. People's immigration status can be leveraged against them by their abusers to keep them trapped in abusive situations. We unfortunately make a lot of referrals based on domestic abuse. In a lot of these instances, the abuser has used their immigration status against them as a form of coercive control, saying, "You only have your visa because you are married to me", or maybe, if she were an overstayer, saying, "I am going to call to get you deported", et cetera, making a climate of fear in which victims cannot come forward.

In addition to this, this is all set in a context in which Northern Ireland is the only part of the UK that does not have specialist services for ethnic minority victims of domestic abuse. The current Women's Aid, et cetera, support networks that exist do amazing work, but they do it under serious constraints. They do not provide specialist services that, as we have seen in England, Scotland and Wales, can provide an extra layer of support, are sensitive to the cultural facets of the abuse women are facing, and understand their specific constraints.

Q24 **Mr Campbell:** Just on the coercive control issue that you alluded to, do you have a word or two about that? If the cultural backgrounds in the countries of origin that some of the ethnic minority migrants have come from are ones where women are sometimes subject to greater coercive control, how does that then translate when they arrive in Northern Ireland and find it to be a completely different culture? If they suffer abuse in a different cultural outlook, how does that provide a difficulty for them trying to translate from their country of origin to their new country of residence?

Kendall Bousquet: Do you know what? We had a very powerful discussion a few months ago around the topic of spiritual abuse as a facet of coercive control. An abuser will say to the victim, "If you leave me, you are breaking our religious law" or "This is not what our faith wants", et cetera. It alienates the victim not only from their community, but also from their faith, and it is extremely psychologically damaging.

We had this conversation with women from ethnic minority backgrounds, and this conversation was started by Naomi Dickson of Jewish Women's

Aid, which is based in England. Some women from, for example, the Islamic centre here talked about how they saw that in their own communities. But women who had grown up locally from British or Irish backgrounds also said that they recognised this within the context that they had grown up in and within their own spiritual lives. Unfortunately, people had been subject to this.

It is not necessarily an issue that migrant women are more subject to coercive control, but rather that the coercive control they face can take specific forms, and that, when they are subject to it, it can be based on specific circumstances that they would face that local women would not face. But some local victims do face these. On this issue of the place of the woman in the home relating to culture, Northern Ireland is not without its own problems locally.

Breidge McPherson: There was a lockdown and, before that, Ramadan, and all the things that isolated people at home. When the people on the VPRS came to Northern Ireland, they were put into temporary emergency housing for one year. Some of the houses were in terrible condition. They were very small with no outdoor areas for the children and children with special needs. Those houses are and were like pressure cookers. I suppose that is not just for migrant families, but I am just saying that the housing scenarios of the people on the VPRS could not do anything to benefit what must already be a very pressurised situation.

Caroline Coleman: I very much echo what Breidge and Kendall have just said. We do not believe that coercive control is any more a problem in the Traveller community than the wider community, but the response when women do seek support is probably where the biggest challenge is. The vast majority of Traveller women do not work outside the home. They do not have access to finances or anything other than what their husbands earn.

We found that the hostel accommodation response tends to be miles and miles away, so that woman loses her immediate family network of support. She does not have access to any other money. Traveller families also tend to be quite large, and most hostels cannot accommodate large families, particularly male children over a certain age, which I think is 13. The family often gets broken up, and in that case, then, they are unlikely to seek any help.

Q25 **Claire Hanna:** Thanks to all the witnesses. This has been really informative, and I wanted to pick up on some of the questions that colleagues have had about the policy and legislation needed. I am aware that this is potentially a very big question.

I am hearing strongly from all of you, and certainly it reflects the experiences of my constituents, about the inadequacy of Home Office processes and support, and the fact that they are deteriorating and set to get worse in terms of the policy framework. Just in the terms of the impact that our report will be able to have, I wanted to focus on Northern

Ireland-level interventions, and I suppose to ask about Northern Ireland Executive-level co-ordination of policies and strategies to support the communities you are working with. Do you have the sense of an overarching strategy or policy, or do you find yourselves having to join the dots and navigate through? Do you find yourself having to draw together those strategies, and is there a particular framework that would be helpful?

Kendall Bousquet: Unfortunately, there really is not much, in terms of taking an intersectional approach, between the different strategies that do exist. They have their own problems of even how much they are acted on. Our current racial equality strategy, for example, makes no mention in the entire document of gender. It is taking identities in a vacuum without bridging the dots between different issues that affect people. For example, this would be enormously influential on this topic of domestic abuse that we are talking about.

It certainly feels like the ethnic minority community is included in the likes of consultations, strategies, et cetera, as more of a tick-box exercise a lot of the time, rather than as groups that genuinely want to be engaged with and deliver on the needs of these communities. It feels like a matter of just getting into the room in as many places as possible to voice these needs, but it is hard to feel, at times, like you are being taken seriously or they are considered important within the wider context.

Say, for example, we are talking about good relations. It is just a green and orange issue. There is no concept of good relations involving ethnic minority communities, and you can apply that across that board. I am sure my colleagues on the panel will have other things to say about this as well.

Q26 **Claire Hanna:** We are going to hear a lot over the next few weeks about how these issues are subservient to the traditional divides and those divides are soaking up all the resources. Breidge, you have mentioned your work under the Syrian vulnerable persons resettlement scheme. In some ways, there were a lot of successes because of the supports that were in place. I found that some of the navigation was available, where it is not for other refugees and asylum seekers. Is there a clear refugee pathway, do you find, for the people you are supporting? Is each person having to reinvent the wheel in terms of trying to find what services they are entitled to? Is there a one-stop shop or recourse for them?

Breidge McPherson: No, there is no one-stop shop. There are families in Belfast, but then some families come to Derry. There are families in Omagh. There are a couple of families in Cookstown and some families in Lisburn. I find myself still supporting some women in Lisburn and Armagh.

There are pockets of women, families and children who came here on the VPRS, and they do not feel supported at all. They do not know about this consortium. They have never heard, except maybe during their initial 10

days in Belfast when they came from Lebanon, of Bryson Intercultural. Who is the person to contact at Bryson Intercultural? There is no Red Cross or Barnardo's here. There was an Extern, but it has gone. The people are left to the four winds.

I would put this forward as a model for going forward. The women and children find a very safe space in women's centres. These are places that empower women. They can have their English classes. Another very important issue in all this is childcare and being able to access English classes while your child is being minded free of charge. Remember that the people are living in poverty.

Those are the sorts of things that are springing to mind for me. In terms of a pathway, it is not working down this way, anyway. In terms of Covid information, trying to stay safe, and trying to keep your children healthy, there is no cohesive information being passed to the families in their own language. They completely do not understand what is going on. They do not understand. Some of the PHA information is translated, but most of it is not.

Claire Hanna: That is very concerning. I represent South Belfast, where a lot of the organisations that you mentioned that are doing really good work are based, but it is very concerning if that is not reaching in or being replicated outside the city. I take your point entirely about childcare, and I know one of my colleagues is going to pick up on that.

Chair: In the interests of time, can we have quick questions and nice, quick answers as well? I want to cover this ground, because it is so important.

Q27 **Claire Hanna:** I just had a quick question about hate crime in particular. Are there improvements that the PSNI can make? Are there ways that we can improve reporting, or is it a legislative gap? I suppose I specifically wanted to ask about the PSNI relationship and what more it could be doing.

Breidge McPherson: If I can just chip in very quickly, I will say that we engaged the local community bobby. He came up and he spoke. He had no interpreter or anything, but we managed between us to get to know what he was saying. It was a revelation to the women to be able to speak to somebody from a police force because, where they come from, you are often frightened of the police force, and you might have to pay them backhanders and stuff like that. It was a great model to bring the community police officer to the women's centre and the women appreciated that.

Claire Hanna: That is really encouraging. Thank you.

Q28 **Stephen Farry:** Good morning to all of our witnesses. I just want to ask a couple of questions around the mental health issue. Breidge, you made some initial references to that, but let me just ask all three of you about, first of all, the range of mental health issues that occur within your own

bases that you work with. Within that, are there particular gender issues? Are there problems with people coming forward? Secondly, in terms of issues with ability to access services, is that even more problematic to access than other aspects of the healthcare system?

As a subset of that, to what extent, Caroline, is the prejudice and stereotyping that people often engage in against the Irish Traveller community feeding into the difficulties that people may be experiencing, in terms of dealing with wider healthcare issues and other aspects as a focal point of hate crimes, given how people have wrongly perceived the Irish Traveller community?

Caroline Coleman: We do know that Traveller men are seven times more likely to die from suicide than the non-Traveller population, so that in itself is alarming. It is anecdotal because these statistics are not recorded and suicide rates are not desegregated by ethnicity, so it is very difficult to put an actual figure on it. Most of the Traveller women we work with suffer from low-level, consistent depression and poor mental health, and some of that is because of the living conditions on sites, overcrowding, and all of that.

A lot of it is because of the isolation that so many Travellers face in society. The vast majority of them do not access local women's groups, local community centres, the leisure centre or local services. They live very much isolated within their own family unit, and that has obvious consequences for their mental health. There are no targeted services. Even though we know that Traveller men are seven times more likely to attempt or commit suicide, there are no specific services.

Stephen Farry: You have just said a hugely shocking thing, which has to be a huge wake-up call for us.

Caroline Coleman: In the Republic of Ireland, more research and intervention has been put into place. There are examples of good practice, but it has not been picked up by the Department of Health or the local trusts here. That is just another example of how Traveller health inequalities have slipped down the agenda. They are not recorded. There is no intervention, but it is a shockingly alarming rate. We hear of suicides quite regularly within the community.

Breidge McPherson: I can say it is not just the trauma from the warzone. It goes without saying that, for people who have witnessed atrocities, it does not disappear just because you leave the warzone. There is then the trauma of travel, Lebanon, Egypt, the way the children were treated, the schools, the camps, the years of waiting for travel and not knowing, being apart from your family, and the worry about the family still in Aleppo or Damascus. There is the trauma of coming here and the idea of culture shock. There is the absolute paralysation of knowing that you wished for travel, but you now find yourself in a place where they do not speak the language and the culture is different. You have to access health, education and the benefits system. Everything

about the journey of the life of the women, men and children on the VPRS is psychologically damaging and has not been addressed at all.

I can speak safely about this because I speak to Syrian women about this. Every single day of their lives, they are sad. They grieve. They have trauma. Their children are impacted by their mother's grief, and they are still trying to support the family left behind. Among that, they are living in matchbox-size accommodation five years later when they were promised that they would be moved to permanent, decent housing within a year.

Q29 **Stephen Farry:** In terms of accessing services, Breidge, how is that going? I know it is difficult enough at the best of times.

Breidge McPherson: Even for ourselves, we all know that the waiting list for mental health services is extraordinary. You are not talking about weeks and months here; you are talking about years. In terms of accessing services at the moment, you cannot get to see a GP.

The other thing is about the literature or letters coming from hospitals. The people do not understand. They would not understand that the appointment was urgent, and then it might get ignored until I would have time to go to the house. By that time, the appointment would be lost, and the person would be struck off the list because they were considered DNA. There would be no recognition by the system that these people have extra-special needs, and maybe we should just take a little care and attention with them.

Kendall Bousquet: A lot of important information has been shared here by the other panel members. I just want to reiterate that mental ill health does not happen in a vacuum. It needs to be contextualised against all of the other issues that ethnic minority communities are facing in Northern Ireland, whether they are poor working conditions with precarious hours; difficulty accessing the necessary benefits that they would require with a culture of disbelief, honestly, oftentimes, at the universal credit office; insecure access to safe housing; and the impact and psychological toll that hate crime takes on people.

I really want to drive this home. The psychological toll that the precarity of an unsure immigration status awaiting an asylum decision or an immigration decision has on people cannot be overstated. If it is not something that you have experienced, you will never really be able to understand it. Unfortunately, we do not have this kind of disaggregated data in Northern Ireland with this level of specificity of research, but Women for Refugee Women in England, which did a very comprehensive report on asylum-seeking women who were made destitute as a result of NRPF, found that over three-quarters of the women who claimed asylum and then became destitute had experienced sexual violence in their country of origin. Shockingly, of those women, almost a third who had been raped in their country of origin were then raped or subject to further sexual violence upon being in the UK.

The toll that the confluence of gender-based violence has with the economic material suffering inflicted on people as a result of no recourse to public funds and insecure immigration statuses, again, cannot be overstated. Obviously, services are important. We are in dire need of them, and specifically specialist services, but people do not fall into depression and PTSD for no reason.

Stephen Farry: Thank you, Kendall. Those are very important points that you just made.

Chair: I know that Mary Kelly Foy has an important question, which we want to hear evidence on.

Q30 **Mary Kelly Foy:** Thanks to the panel. It has been really useful to hear about the wider determinants of health that have affected the health outcomes for the people you represent. They really do need to be addressed by political will and they are avoidable issues.

I want to ask a specific question to Breidge. Can you see a comparison between the levels of support and care provided to the refugees living in Belfast and those living in the more rural areas in Northern Ireland?

Breidge McPherson: The comparison is that it is unequal and imbalanced. Once people come away from the Belfast-centric Belfast thinking, the people are at the will of very little interest, really, in terms of their health, wellbeing, access to services and everything else, especially the people I deal with in Derry, Omagh and Cookstown. The comparison is that it is total inequality.

Q31 **Mary Kelly Foy:** For instance, you mentioned that there is no data collection for those groups. How can you see and influence policy development?

Breidge McPherson: We are hoping to influence policy development by speaking to you and raising awareness. We are hoping today to be the voice of the people we work with. These are day-to-day lives here, their wellbeing, their children's wellbeing and their futures. We are hoping that, by us speaking passionately about the people we work with, you will take up a mantle and be able to forge forward some sort of change on the behalf of these people. They have been brought here because of their complex needs through the United Nations and the UK Government in an agreement to offer protection, healthcare and wellbeing, and it is not happening at the moment.

Mary Kelly Foy: Thank you. We will certainly try our best.

Breidge McPherson: Thank you very much indeed.

Q32 **Chair:** I am going to guess both of our other witnesses would replicate the differential and the imbalance between rural and urban.

Kendall Bousquet: Yes.

Chair: I have two very quick final questions for you, witnesses. In a good quiz show host way, I am going to say that they will require a yes or no answer.

Caroline Coleman: No prizes.

Q33 **Chair:** There is no prize. First, do you have concerns that there is sufficient support and awareness of the need for support among the communities you are representing to deal with the post-Covid environment and building back—yes or no?

Breidge McPherson: There is no support.

Kendall Bousquet: Yes.

Q34 **Chair:** Do you think there is or not? I think you meant to say no.

Kendall Bousquet: I am sorry. I have concerns.

Chair: You have concerns. Fine, thank you.

Caroline Coleman: No.

Q35 **Chair:** My last question is another yes or no question. When taken in the round, do you think Northern Ireland politicians, the MLAs, policy-makers, commissioners, et cetera, realise there is an ethnic and migrant community in Northern Ireland that has very specific needs outwith those usually defined by the traditions—yes or no? Are they aware that there is a community out there that needs bespoke policy?

Breidge McPherson: I think they are aware, but some are doing absolutely nothing about it.

Caroline Coleman: They are aware, but with neither the experience nor the will to do anything about it.

Kendall Bousquet: I agree with the other two panellists.

Chair: I was lenient there. Those were not quite yes or no, but we got to it in the end. Can I thank the three of you very much indeed for your evidence? You have given us a lot of food for thought and some very startling statistics, as Stephen Farry noted in his questions. We are very grateful to you.