Care Alliance Ireland

Guiding support for family carers

Discussion Paper 13

Diversity in Family Care

December 2025

Introduction

This is the thirteenth paper in the Care Alliance Ireland Discussion Paper Series, and an update of our previous paper 'Family Caring and Minority Populations', originally published in 2018[1]. The papers in this series are not intended to present a definitive account of a particular topic, but to introduce a less-discussed, sensitive or perhaps controversial topic for discussion within the wider community of practitioners, policy influencers, researchers and other interested parties. This often takes the form of a literature review (where possible), along with a discussion of views which have been shared with the Care Alliance team, either by our member organisations or by family carers themselves. In some cases, the topic will be one which has been raised and shared in the media or social spaces online.

There are in excess of 600,000 family carers caring for friends and family members in Ireland[2] with a particularly high concentration among women in their 40s and 50s[3]. Across the country, organisations supporting and advocating for family carers naturally focus on providing the best supports for the greatest number of family carers. However, the risk is that such an approach will be less successful in addressing the specific needs of minority group carers such as members of the Travelling Community, ethnic and religious minorities and members of the lesbian, gay, bisexual, transgender and/or queer (LGBTQ) community. In thinking about diversity within family care, attention must be brought to gender diversity, although this is not traditionally included in discussions around minority populations. We know from Census 2022 that male carers represent a significant (39%) minority of carers in the Republic of Ireland.

While there is evidence that they are less inclined to report providing intensive caring[4], they also are more than three times more likely than female carers to report never being able to cope with their caring responsibilities[5]. This is a stark difference that requires a significant response from family carer support agencies. Male carers also engage in relatively small numbers in the traditional carer support groups (both in person and online)[6]. We plan to publish a separate Discussion Paper on this very topic in the near future.

Family carers, in general, experience myriad challenges due to their status as family carers. These include social isolation and loneliness[7], with recent research in Ireland highlighting just how impactful this can be in the lives of family carers generally. Family Carers Ireland, in their most recent (2024) State of Caring research[8], found that 48% of family carers experience severe loneliness, with a further 28% experiencing moderate loneliness. Other mental health difficulties experienced by family carers include increased likelihood of depression[9] and anxiety.

> *Family Carers Ireland, in their most recent (2024) State of Caring research, found that 48% of family carers experience severe loneliness, with a further 28% experiencing moderate loneliness.*

Physically, family carers consistently report poorer general health, with recent Irish research indicating that only 40% of family carers in Ireland report their health as ‘Very Good or Good’, in contrast to 83% of the general population. 16% of family carers report their general health as ‘Bad or Very Bad’ – a stark contrast to the 2% of the general population who do so[10]. In contrast, however, the recent Healthy Ireland report[11], which includes a specific chapter on Women and Care, found similar levels of reported good physical health in women who care for a friend or family member as for the general population. It is not immediately clear why this apparent discrepancy in research exists – although it may be in part explained by the 2025 Healthy Ireland report being a population-based representative sample.

Family carers often prioritise the health and wellbeing of those they provide care for – UK-based research indicates that almost half (44%) of family carers put off accessing health treatments of their own because of their caring role[12]. Further research has shown that there is a likely possibility that existing health conditions will be exacerbated during caring[13], probably due to the increased physical demands, and the de-prioritisation of the carer’s own needs. Family carers are more likely than the general population to live in, or close to, poverty, with many family carers experiencing a sharp decrease in their earning ability – perhaps needing to give up work entirely – as well as bearing the costs of caring and disability[14;15;16].

For minority groups within family caring, these effects are likely to be compounded by other issues connected with their minority status which they may have been experiencing before the onset of caring responsibilities – these will be discussed later in the paper. Examples include social exclusion, poorer-than-average mental and physical health, lower educational attainment, poorer employment status and poor access to housing. In addition, since the first edition of this paper was published seven years ago, the rise in anti-immigrant, racist, homophobic and transphobic rhetoric has been significant[17].

> *… it's also important to understand that diversity often encompasses identities that are invisible, or that exist outside of the traditional understanding of 'minorities' – another example that relates particularly to family care is disability. Assumptions persist that disabled people are those 'needing care', while able-bodied and non-disabled people are the ones who provide it.*

When thinking about diversity in all its forms, it's also important to understand that diversity often encompasses identities that are invisible, or that exist outside of the traditional understanding of 'minorities' – another example that relates particularly to family care is disability. Assumptions persist that disabled people are those 'needing care', while able-bodied and non-disabled people are the ones who provide it.

Much of the understanding of the experiences, challenges and support needs of Irish family carers is based upon the assumption that the average family carer in Ireland is a white, Catholic, able-bodied, middle-aged, heterosexual woman. While this assumption does have statistical merit[18], this stereotypical portrayal of family carers does not take account of other caring situations.

The aim of this paper is to discuss some of the particular issues which family carers who are members of minority populations face, and to act as a stimulus for discussion and debate. To date, relatively little work has been undertaken within these specific groups in an Irish context, and although more work has been undertaken in the UK and US, our knowledge of these issues remains low. We know that disability and illness, and consequently family caring, are cross-cutting issues which affect individuals across age, race, gender, sexuality and religion. There is evidence (discussed below) that certain groups are more likely to experience certain conditions that require care (for example, mental health difficulties) – and there is also evidence that certain groups experience proportionally much higher levels of disability and care, even if the actual numbers remain low in comparison to non-minority populations.

It is important to note that when the term ‘minority’ is used in this paper, it denotes that a population is in the minority compared to the majority white, Catholic, heterosexual population in Ireland.

Minority Groups in Ireland

Historically, Ireland has been an agrarian, Catholic country. However, following Irish accession to the European Economic Community (EEC) in the 1970s (subsequently the European Union), overseas investment began to develop, with Ireland positioning itself as an international hub of technology and communications, taking advantage of both a highly educated workforce (with free secondary education for all citizens and highly subsidised and continuously expanding third-level education) and an advantageous geographical location between mainland Europe and the United States. What followed, from the mid-90s until 2008, was an unprecedented economic boom. Unemployment fell to historically low levels, with some sectors unable to fill positions from the population. Ireland became an attractive place to live and work, with high levels of inward immigration. This dramatic reversal of the traditional Irish migratory pattern ensured that Ireland became a multicultural society, albeit still overwhelmingly white European; in 2006, for example, there were 420,000 non-Irish nationals living and working in Ireland – which equated to 10% of the population[19]. This compares to approximately 230,000 in 1991[20] and 137,000 in 1971[21], and represented a near doubling of the percentage of people living in Ireland with a nationality other than Irish, as found by Census 2002[22]. During this time, Ireland was named the 'most globalized country in the world' three years running[23]. By 2022, 23% of the population identified as other than 'white Irish'[24]. This is an increase from 18% in Census 2016[25]. This was in spite of the 2008–2012 economic crash, which severely impacted employment opportunities in many sectors, alongside the more recent effects of Covid-19 lockdowns. The increase also occurred despite the impacts of Covid-19 on migration patterns across the world. The inward arrival of large numbers of Ukrainians, estimated at over 119,000, from Spring 2022 onwards has yet to materially appear in Census data[26]. An estimated 85,000 remain living in the country currently.

The age profile of minority groups, in particular minority ethnic groups, skews younger than the white Irish population[27]. Just over 52% of people in ethnic groups other than white Irish were under 35 in Census 2022, compared to 42% of the white Irish population being in the same age range[28]. Just over 4% of people in these ethnic groups were 65 or older, compared to 18% of the white Irish group[29].

Ireland’s view and acceptance of individuals who identify as lesbian, gay, bisexual, transgender and/or queer (LGBTQ) has changed significantly in the last 25 years. Following campaigns throughout the 1970s and 1980s, homosexuality was decriminalised in 1993, with various pieces of legislation to equalise access to services and protect against discrimination following. In 2015, Ireland became the first country in the world to introduce equal marriage by popular vote. However, despite this legislative and policy progress, many members of the LGBTQ community are still a ‘vulnerable’ population, with increased likelihood of mental and physical health difficulties. Recent research[30] undertaken in Ireland indicates that

- 27% of LGBTQI+ people experience severe or extremely severe symptoms of depression
- 52% had self-harmed
- 64% reported suicidal thoughts
- 26% had made a suicide attempt.

LGBTQ individuals may be unable and/or unwilling to access appropriate health care for fear of discrimination[31], or because health care professionals are not appropriately educated on the particular health issues that are impacted by sexuality and/or gender identity.

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Minority Stress Theory

When we discuss minority groups and health and wellbeing, Minority Stress Theory is a useful lens through which to understand the additional stressors that minority groups face. The theory, first posited by Meyer in 2003[32], theorises that the disadvantageous social status that comes from being a member of a minority group in society results in worse health outcomes among those minority groups, compared to majority populations. First utilised with reference to sexual minorities, the theory has grown to have applications across minority groups.

Black and Minority Ethnic Carers

While it has been recognised by researchers that many of the issues facing carers from minority groups will be the same as, or similar to, those faced by carers from majority populations, those same issues can be compounded by carers' minority status[33].

The types of caring that minority groups may be doing is likely to differ in distinct ways. For example, research undertaken in the UK[34] suggests that compared to other carers, black and minority ethnic (BME) carers are:

- More likely to be caring for their children, particularly children aged 20–25
- Less likely to be caring for someone over the age of 85
- More likely to be caring for someone with a mental health problem.

In addition, they are more likely to report that they struggle to make ends meet.

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Further and more recent work, again in the UK, indicates that BME carers do indeed have poorer health, financial and mental health outcomes. A briefing from 2024[35], published by Carers UK, shows that BME carers are:

- More likely to be struggling financially, and to cut back on things like meeting friends and family or on essentials like food and heating
- More likely to feel lonely
- More likely to feel support services were not meeting their specific needs.

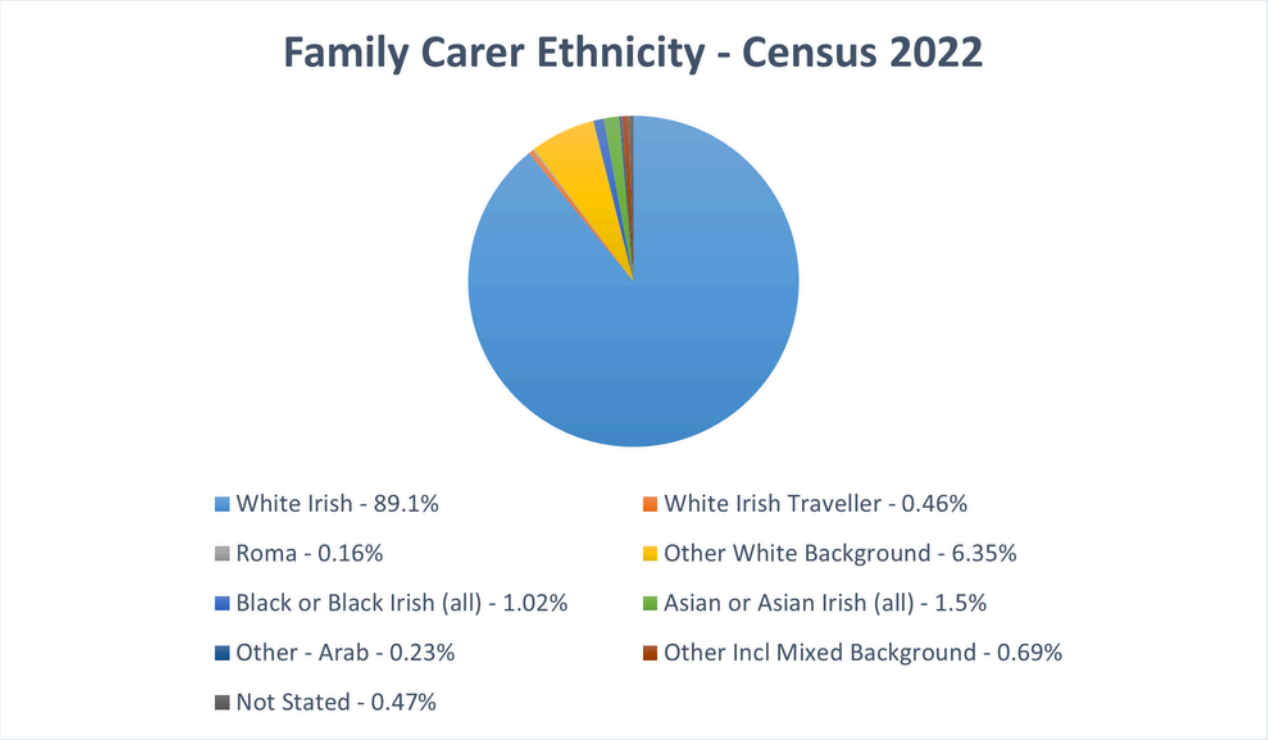
The UK, as a former colonial power, has a significantly different migratory pattern to Ireland – many Caribbean migrants arrived in the UK in the 'Windrush' era of the 1940s and 1950s, along with residents of other former British colonies such as India and Pakistan. However, it is possible that many of the same issues affect BME carers in Ireland, as the societal structure in the UK and Ireland is broadly similar in terms of both being Western welfare states with similar Western policy and legislative structures in place.

In some cultures, although the concept of caring for family members experiencing disability, illness, etc. does exist, there is no formal word or term equivalent to the term ‘family carer’, which is used with increasing frequency in Irish and UK society. Therefore, family carers in these communities are often undertaking caring responsibilities without formal acknowledgement of the role or identification as carers. We know from past research that the term ‘carer’ or ‘family carer’ is often a contested one for family carers regardless of ethnicity[36]; however, for Western family carers the choice is theirs as to whether or not they wish to accept the terminology. Family carers from other communities may not have that choice. As it is often necessary to know that you are a family carer to maximise your engagement with family carer supports, those who choose not to identify as carers or who are simply unaware of the terminology may be at a disadvantage in accessing support[37;38].

There is evidence that some of the traditional supports provided by family carer support groups are inappropriate for or unwanted by certain cultural and ethnic groups. For example, work in the UK with black and minority ethnic carers has highlighted that many BME carers

> *“emphasised how important it was for them to feel part of their ethnic community and consistently described their preference to spend their time participating in shared culturally relevant activities rather than pursuing ‘leisure’ activities such as clothes shopping, going to the gym or library, attending coffee mornings, meeting for lunch, going to pubs or clubs, walking, or even hobbies such as train spotting or bird watching”.*[39]

This is not to say that BME carers do not enjoy leisure activities, but that as so many of the social activities offered by family carer organisations across the country fall into such categories, it may be difficult for minority family carers to socialise with other carers and get information through those networks if the activities being offered are not experienced by them as relevant.



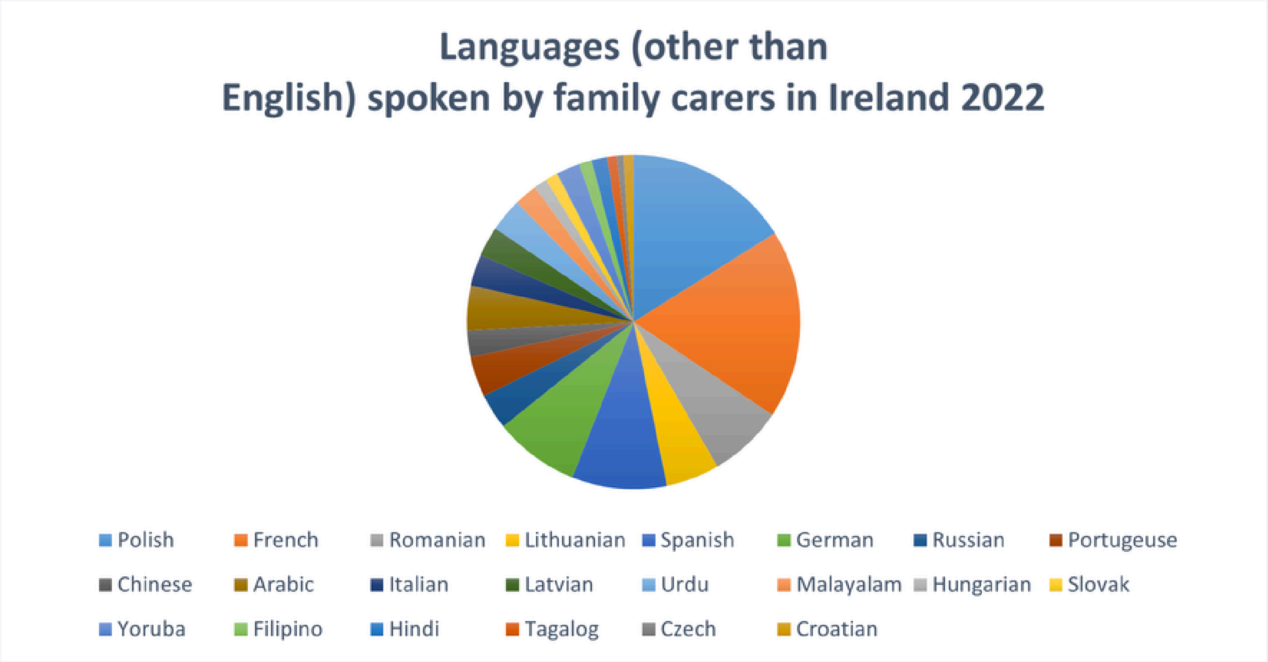
Data from Census 2022 show that 89.1% of family carers in Ireland identify as White Irish, with an additional 6.35% identifying as Other White Background. The remaining 4.55% of family carers in Ireland identify as some other ethnic group.

Minority Religions and Languages

With the abovementioned demographic changes in Ireland since the 1990s, traditional assumptions about family carers in Ireland (that they will invariably be white, Catholic and native English speakers) are invalid. Proportionally, of course, the largest demographic of family carers in Ireland is indeed white, native-English-speaking Catholics; however, that does not tell the whole story.

The following data from Census 2022 were shared with us by the Central Statistics Office, and paint an interesting picture of language and religions practised by family carers in Ireland, updated from the previous edition of this paper.

According to Census 2022, 29,654 family carers speak a language other than English at home. This represents 10% of all family carers – which is a considerable increase from 7% in 2016. The largest proportion of these speak French (4,065), followed by Polish (3,571) and Spanish (2,041). The Census identifies 22 named languages that family carers speak at home, including Czech (141 carers), Tagalog (213) and Yoruba (509). The latter, Yoruba, is an African Language with 30 million speakers worldwide – and this number indicates a doubling of family carer speakers of Yoruba in Ireland (increased from 244 in 2016).



While these absolute numbers and percentages for languages other than English spoken in Ireland are not large, they are not insignificant. Taken together, as outlined above, they equate to one in every ten family carers speaking a language other than English at home with family. Although many who speak a language other than English at home will understand and speak English to varying degrees, there will be a proportion who do not. Those carers are likely to be at increased risk of isolation. Being a family carer is often an isolating role, but add to that an inability or limited ability to speak the working language of the country well, and it is easy to see how isolated these family carers could become.

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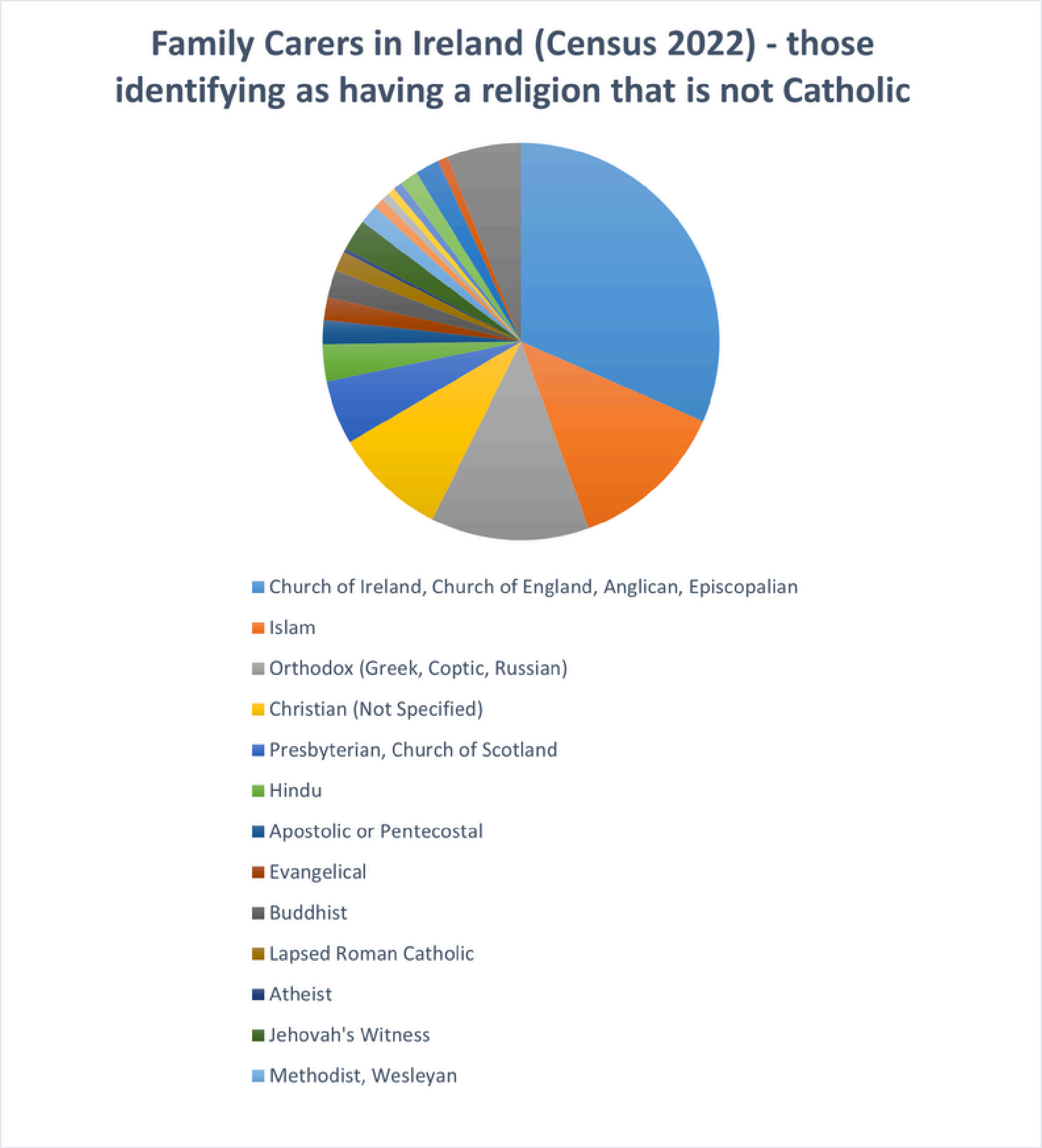
In addition to isolation, family carers who do not speak English will find it almost impossible to effectively navigate a complex health and social care system, such as the one we have here in Ireland. Research in the UK and elsewhere has highlighted the difficulties faced by those who cannot access information in the language that they speak. Depending on the situation, this can often mean that family carers and people with a disability are forced to find a translator – often a younger family member such as a child – which in turn may lead to a child hearing health details about their loved one which may be inappropriate for their age[40]. Access to official translators can be difficult, and in times of crisis or outside of office hours, access to translators for lesser-spoken languages may be non-existent.

With regard to religion, Catholicism is by far the dominant religion in Ireland, with 77% of family carers identifying as Catholic in Census

2022 – this, however, is down from 87% in Census 2011 and 82% in Census 2016. This rate of 77% is higher than the rate of Catholicism in the general population (which stands at 69%). 14% of all family carers specifically note having ‘no religion’, an almost tripling of the rate of 2016 (which stood at 5%). This now mirrors the general population, which in Census 2022 also recorded 14% of the population recording no religion.



The chart above shows that there is a wide array of religions practised by family carers in Ireland. This is important because many of these religions – in particular many non-Christian religions – will have particular needs regarding health and social care which may seem ‘unusual’ to general family carer support organisations, and indeed to health and social care professionals in Ireland who are used to working with Catholics and the Christian religions we traditionally have seen more here in Ireland. This may include prayers, traditions regarding the treatment of sick and dying individuals, and indeed how bodies are prepared for burial. Many hospitals and hospice teams have a pastoral team in place; however, these will be predominately Catholic and/or Christian in nature.

During the writing of this paper, a review of the Pastoral Care webpages across multiple hospitals was undertaken and it became clear that while diversity is a well-intentioned consideration, the bulk of pastoral staff across these teams are white Irish. The majority of services provided specifically mention Catholic Mass, the traditional sacraments and to a lesser extent, other Christian/Protestant religions. Other religious traditions are described as being available ‘on request’.

While this is understandable, given the minority status of these religions within Ireland, and the need to provide greater access to the highest population levels, it is worth noting that in many hospitals that we researched, a Catholic priest is available on site 24/7. If a non-Catholic patient requests pastoral care, it may take several hours, if not more, for them to arrive.

Gender and Sexual Minority Family Carers

While a significant literature review is outside the scope of this paper, it is clear from work to date that specific challenges face LGBTQ family carers. Older LGBTQ adults were found to be serving as caregivers almost twice as often as the general population[41]. Yet organisations that support older people and their family carers appear to be ill-prepared to work specifically with older LGBTQ people, with some studies citing that up to 60% of older people's support groups did not feel the need to address LGBTQ issues specifically[42]. Many of these organisations describe their services as accessible to all – which is the case in practice, with minority groups, specifically LGBTQ carers, being welcomed into the support service. However, these 'sexuality blind' services, while well-intentioned, can leave LGBTQ family carers feeling at best misunderstood. Since the last edition of this paper, some really positive examples of organisations working to overcome this barrier in Ireland have been developed – most notably though LGBT Ireland's 'LGBT Champions' programme[43].

> *While many of these [faith-based] organisations have moved towards a more inclusive and secular governance and service model, the memory of the impact of the historical ethos of these organisations remains and makes older LGBTQ individuals – in particular – wary of accessing supports.*

Where there are faith-led support services, some LGBTQ family carers experience being overtly blocked from those supports due to a conflict in religious 'ethos'[44]. This is perhaps less likely in the Irish context given our equality legislation; however, in the context of the number of, for example, supports for people with disabilities still governed by or nominally under the patronage of Catholic faith-based organisations in Ireland, it is worth mentioning. While many of these organisations have moved towards a more inclusive and secular governance and service model, the memory of the impact of the historical ethos of these organisations remains and makes older LGBTQ individuals – in particular – wary of accessing supports. Some LGBTQ family carers provide care for individuals who now or in the past expressed hostility or displayed homo/transphobia towards them, such as unsupportive parents[45;46]. Often it is assumed that the last female in the family to remain single will take on the role of family carer[47]. The fact that many LGBTQ relationships are not recognised, or may only recently have been viewed as legitimised through the establishment of marriage equality (in an Irish context), may have an impact on how family care responsibilities are organised within families.

At a higher – policy – level, the ubiquity of heteronormative attitudes can create a reluctance on the part of LGBTQ family carers to engage with existing carer supports, because of how they are structured. If an LGBTQ person does not see their experience reflected in the promotional material or content of these support groups, they are less likely to engage, even when there is a lot of overlap in the support needs of LGBTQ family carers and their ‘straight’ peers[48].

There has been little research to date on the specific experiences of family carers who identify as a member of the LGBTQ community in Ireland. A scoping review, undertaken by researchers in the Open University in 2017, identified a mere 18 pieces of research concerning this cohort of carers in the UK and Ireland since 2000 – out of 3,434[49].

Current doctoral work taking place in an Irish setting[50] indicates that in comparison to other jurisdictions, attitudes of LGBTQ family carers in Ireland towards health and social care professionals are much more positive, with the majority citing no experience of homophobia or transphobia in that arena. This is a positive development and one that highlights the positive strides taken since the first edition of the paper in 2018.

Key Issues for the Travelling Community

The Irish Travelling Community was granted minority ethnic status in 2017, making history in the process. As of Census 2022, 1,368 members of the Travelling Community provide care to a friend or family member, up from 1,105 in Census 2011 and 1,273 in 2016. In addition, in 2022, 492 members of the Roma community reported providing care at home to a family member. The age profile of Travellers is much younger than the general population, with only 5% of the Traveller population being aged 65 or over. Children under the age of 15 make up 36% of Irish Travellers, compared to 20% for the general population[51].

The most recent large-scale quantitative research on Traveller health comes from the All-Ireland Traveller Health Study 2010[52]. This reports that Traveller women live on average 7 years less than women in the general population; Traveller men on average 15 years less. Traveller suicide rates are over six times the national average. Fatal respiratory diseases are 7.5 times higher in the Traveller population than in the general population, and heart and stroke rates are four times higher than the general population.

> *Travellers, and in particular family carers within that community, are generally viewed as 'hard to reach', that is not necessarily the case – often it is simply that family carer support organisations are ill-equipped and occasionally unwilling to include this group as a specific target group for supports.*

While no research has been undertaken in Ireland to date with members of the Travelling Community about family caring, such studies have taken place in the UK, and it is worth noting some of the issues faced by Travellers in that jurisdiction, as they are likely to be broadly similar to those faced by Irish Travellers.

The main study of note in this sector is that undertaken and published by MECOPP (Minority Ethnic Carers of People Project) in Scotland, in 2012[53]. That project and subsequent study found that although Travellers, and in particular family carers within that community, are generally viewed as 'hard to reach', that is not necessarily the case – often it is simply that family carer support organisations are ill-equipped and occasionally unwilling to include this group as a specific target group for supports.

With regard to Travellers' ability to access supports for the people they care for, many of the Travellers in the study had experienced cultural insensitivity from health and social care workers. This includes feeling like they were being blamed for causing their own problems, as if it were their ethnicity that was the problem, rather than an inappropriate service or lack of flexibility. In common with non-English-speaking carers from other ethnic communities, the lack of information for those with literacy difficulties was a significant problem. This makes it even more difficult for people to navigate the often-complex health and social care system in an effort to obtain supports for both the person they care for and themselves.

Disability

Disability and care are often seen as interlinked; mostly through a unidirectional relationship which sees the 'disabled person' cared for by the 'nondisabled person'. This view leads to a paternalistic view that disabled people 'need care' and that care is provided by a friend or family member who is not disabled. The reality is, of course, very different. Many thousands of people who identify as disabled are providing care to another person.

This is clearly borne out in figures from the 2022 Census: 92,125 of those who stated they provide care for a friend or family member also stated they themselves have a disability. That equates to 31% of all family carers in the Census. This, of course, is considerably higher than the prevalence of disability in the general population, which for Census 2022 stood at 21.5%.

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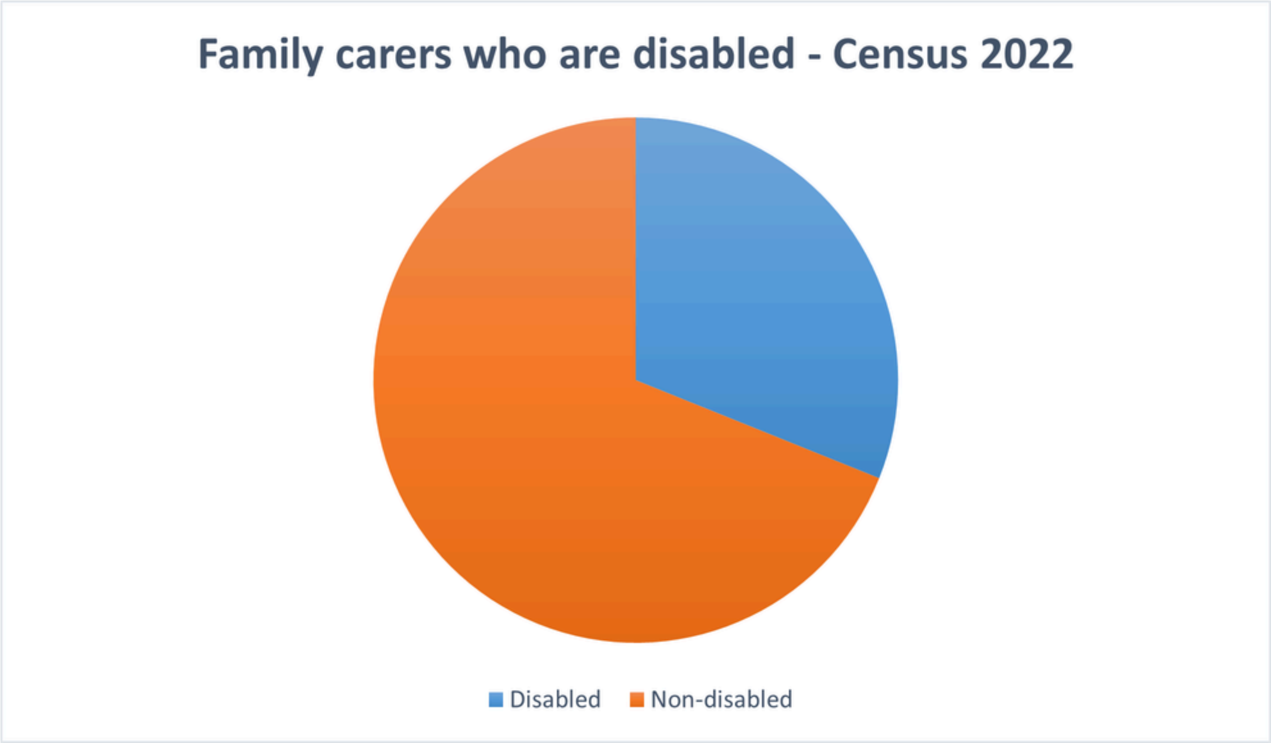

By continuing to see care as something provided only by non-disabled people to disabled people, opportunities for appropriate supports, accessibility and education are lost. Ableism can be perpetuated by organisations and health and social care professionals.

In writing this paper, it became clear there is relatively little research or work being undertaken in this area – the majority of both grey literature and academic outputs is based on the assumption that the disabled person is the focus of care rather than also the provider. It is possible that a proportion of those identifying both as a family carer and disabled are older parents providing care for an ageing disabled child; however, given the increase in adults seeking neurodiversity diagnoses, for example, it is likely that the community of disabled carers themselves is diverse.

Responses

As always in these Discussion Documents, a range of responses to the issues raised can be identified – both at policy level and at direct-support level.

Policy Level

The current National Carers Strategy (NCS) (2012) does not directly acknowledge minority carers in any way, in particular those groups discussed in this paper. The closest that the NCS comes is to acknowledge the existence of caring ‘sub groups’ such as young carers, male carers and rural carers. Of course, supports directed at these particular groups are important; however, none of these supports will adequately address the specific issues experienced by family carers from cultural and ethnic minorities. Any new or refreshed National Carers Strategy should include direct actions which address the specific issues faced by family carers from minority groups. Health and social services must operate with the values of understanding of diversity and cultural competency.

We understand that a new or updated National Carers Strategy is not high on the agenda of the State at this time. However, looking to the 2025 Programme for Government, we also see no acknowledgement that caring is a diverse activity across gender, sexuality, ethnicity, religion and disability. Care, it seems, is continually assumed to be undertaken by white, Irish, settled, heterosexual and able-bodied individuals, with little consideration given at policy level to the intersection of these identities, and how that impacts family carers’ experience of providing care.

Therefore, in future policies that directly impact family carers, there must be a true acknowledgment of this diversity, and thought given as to how best support family carers who have specific cultural needs that may not be being addressed.

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Likewise it is important that health-related literature be available in as many languages as possible, or at least that steps be taken to ensure key messages are available in the languages spoken by family carers and those they care for. Information must be made available in order for family carers to make informed decisions on care.

It is vital that the Irish health and social care systems recognise that Ireland is very much a multicultural society, and that although many of the problems facing minority ethnic and LGBTQ carers are the same as those facing the mainstream family caring community, the solutions will be different[54].

Services Delivered by Support Organisations

Given the pressure on services for people with disabilities and services for family carers to support the largest number of people in the most financially efficient way, it is not surprising that specialist support for minority family carers has not been at the forefront of service provision. However, in light of the increasing number and visibility of family carers who are members of ethnic, cultural, religious or sexual minorities, it is clear that thought must now be given to how to most appropriately support family carers who do not fit the traditional picture of an 'Irish family carer'.

This could be as simple as ensuring that carer groups celebrate non-Christian religious holidays such as Eid or Passover, or that gender-inclusive language is used when discussing how to support partners. Many activities and resources for family carers are provided along gender-specific lines (for example, groups for women which involve makeovers, and activities for men based around sports or DIY), which for many in the LGBTQ community may not make sense or be comfortable, or fit with their experiences and preferences. Again, we reference the work being done by the LGBT Champions programme as an example of how organisations can collaborate to create inclusive care and education environments for all.

Conclusion

As discussed above, it is to be expected that as the actual number of family carers who are members of minority groups is low, carer organisations and health and social care professionals, both in terms of policy and support, have been slow to address them directly.

However, Ireland is increasingly multicultural and diverse, with changing family structures likely to impact on how family care is provided now and in the future. It is important that we understand and acknowledge that what works as a support for a white Catholic Irish carer may not work for a Chinese Buddhist carer, nor for an LGBTQ family carer. The challenge moving forward for those of us who support family carers is to begin to understand the assumptions we make about carers in Ireland – which are not always correct – and how we as a sector can ensure that all family carers in Ireland are supported in the way that works best for them, no matter what their race, religion or sexual identity.

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[3] **Central Statistics Office. 2023.** Census of Population 2022 Profile 4 - Disability, Health and Carers', Central Statistics Office.

[4] **Family Carers Ireland. 2022.** Gender Dimensions of Care - An Irish Perspective.

[5] **Healthy Ireland. 2025.** Healthy Ireland Survey 2025. Summary Report.

[6] *For example, in a recent (late 2025) survey of members of the Online Family Carer Support Group facilitated by Care Alliance Ireland, only 5% of respondents were male family carers.*

[7] **Grycuk, E. et al., 2022.** Care Burden, Loneliness, and Social Isolation in Caregivers of People with Physical and Brain Health Conditions in English-speaking Regions: Before and during the COVID-19 Pandemic. International Journal of Geriatric Psychiatry 37, no. 6. https://doi.org/10.1002/gps.5734.

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Guiding support for family carers

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