ADULTS AND HEALTH SELECT COMMITTEE

THURSDAY, 15 JUNE 2023

SURREY COUNTY COUNCIL

REPORT ON THE FINDINGS AND RECOMMENDATIONS OF THE HEALTH INEQUALITIES TASK GROUP

Purpose of report: To provide the Adults and Health Select Committee with a detailed report on the findings and recommendations of the Health Inequalities Task Group, which was set up to explore Health Inequalities/disadvantages amongst key priority population groups within Surrey.

Acknowledgements:

1. Task Group Members wish to offer great thanks and appreciation to all those who kindly participated with the Task Group and expressed their insights, expertise, and experiences with us. The witness sessions as well as the written submissions significantly contributed to both the findings as well as the recommendations of this project.

2. Any errors, factual inaccuracies, or inconsistencies within this report will be the sole responsibility of the Task Group alone, and not of those who provided their time, insights and experiences which were ultimately utilised to develop this report.

Introduction:

Context

3. During a private induction meeting on 14th July 2021, the Adults and Health Select Committee held a forward planning session, during which it was emphasised that reducing health inequalities should constitute an important focus area. Consequently, the committee agreed to form a task group to investigate health inequalities in Surrey and what is being done to tackle these issues.

4. The overarching objective of the task group was (and remains) not only to investigate some of the root causes and characteristics of Health Inequalities, but to utilise and harness these insights for the purposes of formulating sound, relevant, and timely recommendations that can contribute to policy by adding value. Achieving this involved a three-pronged process of the following:

    - Acquiring information/insights into Health Inequalities, including the causes of such inequalities and how they are manifested within Surrey.

- Investigating some of the existing measures in place to tackle such Inequalities.

- Discovering and proposing new ways in which such inequalities can be reduced (through producing recommendations).

5. The imperative to examine Health Inequalities has stemmed from three factors.

    - Firstly, the Covid-19 pandemic has exposed and deepened stark health inequalities across the nation. Those residing in deprived areas are more inclined to die from the virus amongst those diagnosed with Covid-19. This increasing susceptibility to death as a result of contracting the virus is an important indicator of inequalities that have existed for several years across all aspects of health, but have been increasingly exposed by the pandemic.

    - Secondly, tackling Health Inequalities is one of Surrey County Council's four priority objectives. This was also outlined in the Council's Organisation Strategy, and agreed by full Council on December 8th 2020.

    - Thirdly, the Health and Wellbeing Strategy for Surrey, initially published in May 2019, also emphasises the imperative to "reduce health inequalities so no one is left behind". The Health and Wellbeing Strategy's most recent update was published in 2022[1]. The strategy emphasises that by 2030, Surrey should constitute a County where residents have a "great start to life, people live healthy and fulfilling lives, are enabled to achieve their full potential and contribute to their community and no one is left behind. The strategy essentially encapsulates a refreshed and holistic understanding and overview of Health and Wellbeing, which revolves around encouraging policies, measures, and initiatives to improve the overall quality of life of residents. This marks a transition away from a reactive model of healthcare, toward a model that seeks to improve the lives of residents in a manner that could also potentially reduce susceptibility to illness.

6. The task group has conducted this investigation into Health Inequalities with a similar logic in mind; one that calls for a holistic model of Health and Wellbeing that seeks to reduce Health Inequalities by not merely reacting to Health conditions where and when they arise, but by emphasising a model that encompasses a wider contextual understanding of Health. The task group has adopted this as an overarching logic in its investigations of Health Inequalities as well as in the recommendations it has produced.

Objectives of Task Group:

7. The broad and overarching objectives of the Task Group are to:

    - Develop an understanding of the lived experiences of those residents experiencing health inequalities and the barriers they face.

[1] https://www.healthysurrey.org.uk/__data/assets/pdf_file/0008/299798/Surrey-Health-and-Wellbeing-Strategy-Update-2022.pdf

- Develop an understanding of the data, strategies in place and work being undertaken by the Council and its partners to help tackle health inequalities.

- Develop an understanding of good practice elsewhere and how this might be applied in Surrey.

- Develop a set of recommendations to help assist the Council and its partners in continuing to tackle health inequalities across Surrey.

- Communicate its findings to partners both locally and nationally.

8. The members of the Task Group were:

    - Angela Goodwin (Chair)
    - Bernie Muir
    - Trefor Hogg
    - Carla Morson
    - Riasat Khan

Task Group Methodology

Task Group themes:

9. In seeking to investigate Health Inequalities within Surrey and the associated impacts, the Task Group agreed to narrow the scope of its focus to ***three*** specific **themes/population groups**. These three populations groups are amongst several other "priority populations" as have been identified in Surrey's Health and Wellbeing Strategy. The task group sought to examine how specific groups tend to suffer from Health Inequalities and disadvantages which in many respects has impacted their capacity to live Healthy and fulfilling lives. The themes/priority groups that the task group investigated are threefold:

    - Individuals from BAME/GRT Communities.

    - Individuals experiencing Homelessness, Drug, and Alcohol abuse.

    - Individuals experiencing Domestic Abuse.

10. The reasoning and rationale behind selecting these three groups is fourfold. Firstly, these groups per se tend to suffer from Health Inequalities and disadvantages relative to other population groups. Secondly, these three groups are amongst the priority populations identified in Surrey's Health and Wellbeing Strategy, and so the timing and relevance of an investigation into these groups is pivotal so as to add value to policies that aim to reduce inequalities for these groups. Thirdly, selecting these groups in this way is constructive for any investigation into Health Inequalities within Surrey in that individuals who fall under these group categories may also fall into several other priority population categories identified by the Health and Wellbeing Strategy. Fourthly, more attention and focus on these groups is crucial at a time when System-Wide

efforts are underway within Surrey to help to identify and reduce Health Inequalities for residents within the County; and thus the timing of the selection of these population groups is vital.

11. Additionally, in terms of the nature of how information was gathered and received, the task group adopted an amalgam of a top-down and bottom-up approach, which involved conducting witness sessions and receiving evidence from key organisations responsible for conducting Health and Wellbeing Policies (such as Surrey County Council as well as the NHS), as well as third sector organisations involved in providing on-the-ground support to residents from the three groups mentioned above who may be suffering from health Inequalities.

Witness Sessions

12. Between December 2021 and April 2023, the Task Group conducted 17 separate evidence-gathering sessions with multiple witnesses from a wide range of organisations.

13. A list of the witness sessions conducted by the Task Group is attached as Annex 1.

14. There are two sets of Key lines of enquiry (attached as Annex 2) that were formulated and adopted by the Task Group. One was developed before the **first stage** of the Task Group which sought to brainstorm what "Health Inequalities" implies. The second set of KLOEs were adopted by the Task Group for the witness sessions undertaken in the context of the **second stage** of the project which conducted the deep-dive into the three aforementioned priority population groups. These were shared with all witnesses in advance of meetings and updated throughout the evidence-gathering process in response to findings from each witness session.

15. Members were very pleased with the wide range of witnesses that engaged with the Task Group.

Written Evidence

16. The task group's findings were also derived from written evidence, which stemmed from two avenues. First, the task group also received written evidence in the form of qualitative and quantitative data from the organisations that participated in the witness sessions. Such data was valuable in further substantiating as well as providing additional contributions to the verbal insights received during the witness sessions. Some of the insights extracted from these written evidences have been incorporated into the main text of this report; whilst other parts of this information have been incorporated as Annexes to this report. Details for each of the annexes are outlined immediately subsequent to the conclusion section of this report. Second, written evidence from other academic and policy/related research was also utilised, some of which has been referenced/footnoted within the main text of this report.

Task Group Recommendations

17. Below are the full list of recommendations that the task group believes will help reduce Health Inequalities within Surrey, particularly for the three aforementioned population groups that the task group focused on. These recommendations have been incrementally formulated throughout the course of this project, and have been informed by the research findings of the task group.

Recommendations for the BAME/GRT Community:

1. That mental health support services increase investment in Equality, Diversity and Inclusion leads, and that staff receive further training for cultural competence and unconscious bias.

2. To implement measures to help raise awareness of Mental Health Issues amongst the BAME Community, and to help overcome the negative stigma surrounding Mental Health within these communities.

3. To help reduce language barriers in healthcare in a manner that enables ethnic minorities who are not fluent in the English language to still receive appropriate and effective healthcare as and where it is needed.

4. That increasing efforts are made for mental health support to be provided in the first language of service users. This is particularly crucial for ethnic minorities to receive the best possible mental health support in the most explicit and transparent manner.

5. For exceptions to be made for individuals arriving from abroad with full medical history records to be directly referred to specialist services. This can help to bypass longer waiting times for a repeat diagnosis.

6. To ensure that cultural sensitivities are taken into account when providing healthcare services, including requests to be treated by health practitioners from the same sex.

7. That greater efforts are undertaken to improve the health and wellbeing of GRT communities through enhancing access to GP and other health services, reducing distrust of mainstream services amongst these individuals, tackling discrimination against these groups, and for targeted healthcare provision to those on GRT living sites.

Recommendations for Homelessness, Drug, and Alcohol Abuse:

8. That efforts are made to tackle negative and false labels against the homeless as part of initiating a new culture change that is more understanding and supportive of homeless individuals.

9. That work to support the homeless is conducted in a Trauma-informed manner across all services. It is believed that given that the homeless often come from a place of trauma, this will lead to better health outcomes both Mentally and Physically.

10. That efforts are undertaken to increase access to dental care for the homeless, including rough sleepers.

11. That homeless residents are able to access GP appointments and services as easily and as efficiently as possible, without any complexities in them being able to access frontline healthcare.

12. To continue to advance efforts to tackle rough sleeping by providing sheltered accommodation for the homeless, and for there to be greater coordination between all actors within the Surrey System, to ensure that this is achieved.

13. That efforts are made to increase access to mental health safe havens for homeless individuals who experience a mental health crisis.

14. For Surrey County Council to work more closely with District and Borough Councils, to provide more sustainable temporary accommodation facilities to help homeless individuals to remain in a stable environment through which they can access support for their mental health.

15. That homeless individuals suffering from poor mental health are provided with access to counselling and cognitive behaviour therapy to help them to cope with and to ultimately overcome their mental health challenges.

16. That there is joint commissioning for high quality mental health and drug and alcohol services that focuses on meeting individuals' core needs rather than the current presenting problem.

<u>Recommendations for Domestic Abuse victims:</u>

17. To undertake work to support not simply the victims of, but also perpetrators of domestic abuse in a manner that helps perpetrators understand the ill effects of abuse and how to avoid resorting to such abusive conduct.

18. That commissioning arrangements are such that long-term support and commissioning is provided to key organisations involved in providing support to domestic abuse victims.

19. To continue to ensure that domestic abuse victims are provided with an easy point of access for support, including for accommodation, in the event of victims seeking refuge.

20. That greater support is offered to tackle mental health as well as domestic abuse for Women during pregnancy, and that efforts are made to raise awareness of such support amongst pregnant Women.

21. To continue to undertake efforts to increase awareness of support for domestic abuse available to residents.

Key Findings for BAME/GRT Communities

18. The task group chose to examine some of the key Health Inequalities and disadvantages experienced by ethnic minority groups within Surrey. The overarching reason for this is that these ethnic groups do constitute priority populations as have been identified in the Health and Wellbeing Strategy, and the Task Group sought to investigate some of the key Health challenges these groups face, particularly given that these can often constitute hard-to-reach communities. The Task Group recognises that it is not a simple case of the BAME/GRT communities being side-lined by Health and Wellbeing services. Rather, in some cases, elements of these communities may actively choose to isolate and distance themselves from mainstream services. This could stem from a variety of reasons as will be outlined in some of the key findings below.

19. Demographically speaking, Surrey remains not as diverse as other areas nationwide. 83.5% of the population reported their ethnic group as being white British in comparison to 79.8% in England as a whole[2]. According to estimates from the 2011 census which were adjusted for 2020 demographic patterns, approximately 9.6% of Surrey residents have a non-white minority ethnic background[3]. That just under 10% of Surrey's residents are from minority backgrounds is a sufficient reason for the task group to examine the Health and Wellbeing prospects of these population groups, and to call for improvements in the Health and Wellbeing of these residents.

BAME Community Language Barriers:

20. A key finding from the task group's witness sessions, particularly with Healthwatch Surrey, was that some members of the BAME community suffer from language barriers which often reduce the quality of medical care and services that may already be available for them. The task group heard that language barriers can undermine the Health and Wellbeing of elements of the BAME communities who are not proficient in the English language in three ways as outlined below.

21. Firstly, in one project commissioned by the CQC to examine the barriers that BAME communities face when accessing care, it was found by Surrey Healthwatch that the lack of face-to-face appointments resulted in difficulties of those for whom English is not a first language to communicate effectively in their telephone appointments. It was found that such BAME community members lacked the confidence to communicate over the phone. This resulted in complications in the patient being understood, as well as in the patient's own understanding of what is being communicated to them by healthcare professionals. Or, in some cases, the patient may be able to inform doctors

[2] The Surrey Context: People and Place – Surrey-i (surreyi.gov.uk)
[3] The Surrey Context: People and Place – Surrey-i (surreyi.gov.uk)

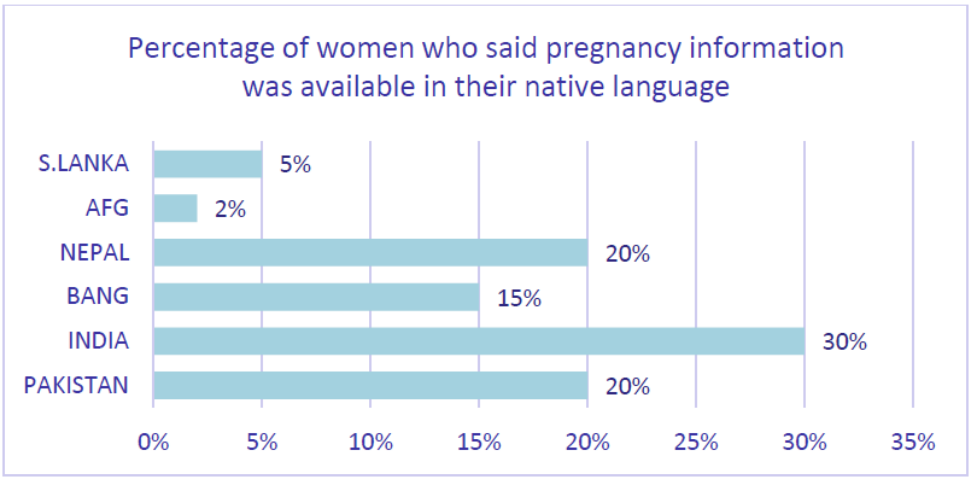
of their symptoms but would find it difficult to comprehend the advice or following steps that would be undertaken as part of their care. Added to this was the fact that this posed a privacy problem as it entailed that another close relative of theirs would have to assist them during such phone appointments.

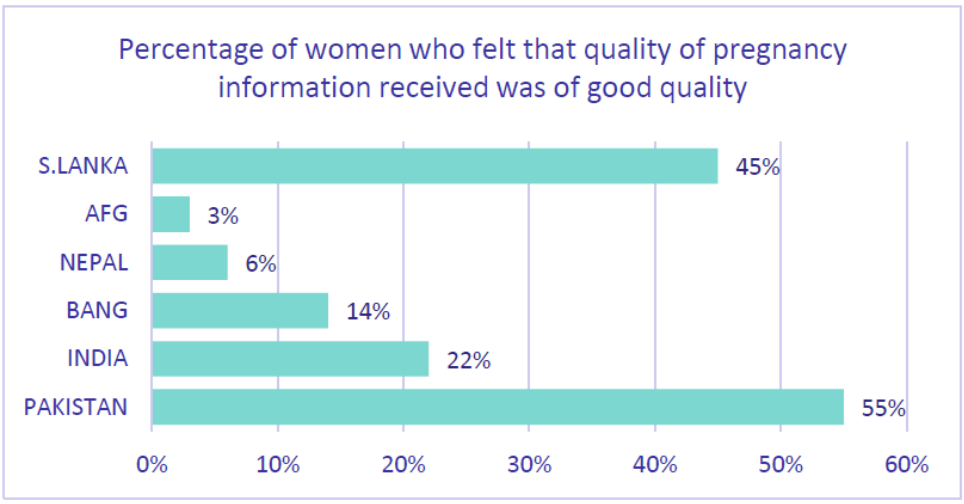
22. Secondly, the task group heard that it can often be difficult for less technology literate members of these communities to access, as well as to make effective use of technology and online services, which have also been increasingly utilised by GP practices. Some individuals have less access to the internet, or even a computer or a smart phone. Some even found online services or websites to be too complex to utilise. Again, such residents often have to rely on the support of relatives or friends who may be more technologically literate. However, the issue of privacy again also arises in this context.

23. Thirdly, the task group also heard that in some cases, translation services were not always readily available to patients in Primary Care. This means that in some instances, patients are having to attend appointments (whether virtually or in person) without fully comprehending what they are being informed by the healthcare professional; in which case crucial medical information or advice may not be fully processed by the patient. Additionally, in cases where such patients who cannot secure translation services resort to taking a relative along to an appointment for assistance in translation, often these relatives are not medically literate and hence crucial medical information is lost in the translation provided by them. It was also heard that this absence of consistently available translation services has also affected BAME community Women who utilise maternity services; where it can often be difficult for such Women to understand crucial antenatal advice and instructions being provided by Midwives.

24. In one recent study conducted by Surrey Minority Ethnic Forum, who also participated in a witness session for this task group, it was found that many Women from BAME backgrounds felt that information about pregnancy was not available in their native language; and that for those whom information in their own language was provided to, many felt that the information shared with them was not of good quality. The two-part figure below indicates this trend.

Figure A: Experience of women about information and attending appointments during pregnancy:





25. Hence, **the task group recommends that work is undertaken to help reduce language barriers in healthcare in a manner that enables ethnic minorities who are not fluent in the English language to still receive appropriate and effective healthcare as and where it is needed.**

Mental Health disadvantages for BAME Community:

26. In its witness session with "With You" (a national charity organisation providing support for Surrey residents with mental health, drug, or alcohol problems), it was reported that BAME community mental health clients can often feel uncomfortable about sharing their Mental Health experiences before an interpreter who may be from a similar ethnic background. This tendency particularly affects the South Asian Community, and partly stems from fears of being negatively judged by an interpreter. This is especially the case if such residents experience drug or alcohol addictions that are either a result of

or a cause of their mental health decline. This complicates these residents' ability to express their symptoms and to receive adequate mental health support. As such, the task group understands that it is not sufficient to simply advertise and provide mental health services and support for such communities, but to take adequate measures to increase these resident's confidence and comfortability in being able to utilise and maximise the benefits of these services.

27. Furthermore, With You also reported that through their experience of providing mental health support to Afghan refugees in hospitals and other settings, they learnt that it was pivotal to be able to provide mental health support by practitioners/support workers who communicate to patients in their own language. This enables one to understand a refugee's mental health symptoms and challenges, and to be able to provide adequate support through effective communication. That such refugees should receive support in their own language is imperative given that refugees may often not be proficient in the English language.

28. As such, based on the above, **the task group recommends that mental health support services increase investment in Equality, Diversity and Inclusion leads, and that staff receive further training for cultural competence and unconscious bias.** Additionally, **the task group recommends that increasing efforts are made for mental health support to be provided in the language that service users are proficient in**. This can ensure that such support is effective, and can help to establish a rapport between mental health practitioners and service users, which is pivotal for such service users to feel comfortable about expressing their feelings or symptoms in a confident manner.

29. The task group also heard that some members of the South-Asian community, particularly women, tend to suffer from Social Isolation. This entails not having a healthy network of friends or relatives that live nearby that they are able to socialise with. Such isolation can result in increases in Mental Health decline amongst such residents. That social isolation can elicit mental health decline is an issue that has been found in multiple studies. In one crucial study conducted jointly by the University of London and the World Health Organisation in 2017, it was concluded that Social Isolation can result in the development of mental health issues, including severe anxiety and depression[4]. Therefore, tackling isolation, including amongst ethnic minorities in this instance, can help to reduce incidences of mental health decline, thus reducing the strain on Surrey's mental health services.

30. Moreover, in its witness sessions (with Surrey Minority Ethnic Forum, Healthwatch Surrey, and with We Are With You), it was heard that there is a negative stigma around mental health amongst the BAME Community, particularly within the South Asian communities. It is often felt that mental health is not a phenomenon that genuinely represents a health issue. Consequently, some individuals actively choose to conceal the fact that they may be suffering from ill mental health due to feeling embarrassed to express this. Such individuals may choose to conceal this information not merely from

[4] Wang, J., Lloyd-Evans, B., Giacco, D. et al. Social isolation in mental health: a conceptual and methodological review. Soc Psychiatry Psychiatr Epidemiol 52, 1451–1461 (2017). https://doi.org/10.1007/s00127-017-1446-1

close relatives, loved ones or friends within their community, but also from health practitioners that may be from the same ethnic community as their own.

31. According to research conducted by the University of Glasgow in 2011, the negative stigma surrounding mental health within BAME communities can form a sense of shame. This sense of shame can render such individuals, particularly males, to endeavour to conceal their poor mental health for fears of appearing to be either too soft or lacking control of themselves[5].

32. Hence, the task group **recommends that measures are taken to help raise awareness of Mental Health Issues amongst the BAME Community, and to help overcome the negative stigma surrounding Mental Health within these communities.**

BAME Women and Male Health Practitioners:

33. A notable theme the task group encountered in its witness sessions and wider research revolved around the effects of having health practitioners from the opposite sex to patients, and how this contributed to health inequalities. In its witness sessions with Surrey Minority Ethnic Forum as well as Healthwatch Surrey, it was reported that in some instances, Women from ethnic minority backgrounds, particularly from Arab or South Asian ethnicity, prefer to be treated by health practitioners who are from the same sex. The reasoning for this is twofold:

    1. *Cultural reasons*: Some of these Women feel that it is not culturally appropriate to be in close proximity to a member of the opposite sex, particularly in enclosed settings.

    2. *Religious reasons*: Some of these Women feel that it is a religious obligation to do their utmost to avoid being treated by members of the opposite sex, particularly in contexts where their husband is not present also.

34. Indeed, some pregnant Women who have been admitted to hospital for childbirth may make special requests in their birth plans to be treated by members of the same sex. However, this may not always be taken on board in some situations, either due to a lack of a thorough review/analysis of birth plans, or due to unforeseen circumstances such as female practitioners or doctors not being available at a specific moment in time.

35. This has health inequalities implications in that such Women who have this aforementioned preference may deliberately choose to refrain from receiving healthcare or to attend appointments if their requests for being treated by female health practitioners are not met. In some instances, such Women also experience delays in being able to access GP appointments due to their requests for female doctors not being accommodated efficiently enough.

[5] https://www.tandfonline.com/doi/abs/10.5172/hesr.2012.21.3.287

36. As such, the task group recommends that **cultural sensitivities are taken into account when providing healthcare services, including requests to be treated by health practitioners from the same sex.**

Lack of Understanding of how the Health System operates:

37. The task group believes that an important aspect of reducing health inequalities and in ensuring effective healthcare provision is for residents to be aware of how the health system operates. Residents need to be aware of the services available to them, as well as how to embark on accessing these services, if they are to be able to equally benefit from healthcare as much as any other residents.

38. Part of this aforementioned challenge stems from language barriers, although this is not the only obstacle. In some instances, residents who have not lived in Surrey or the United Kingdom for substantial periods have a lack of understanding of how the health system operates. For example, they may not be aware of referral procedures for specialist treatment, or may not be aware of how to access a dentist appointment. The task group also heard that some ethnic minorities may embody a slight suspicion of Healthcare Services, or even feel that they are subjected to racial discrimination and not granted the appropriate level of care relative to majority ethnic groups.

39. Related to the above is also the fact that some ethnic minority residents are not aware of which transportation systems are available to help them reach appointments, or perhaps any support that might be available to help with transportation (or costs of transportation) to reach appointments.

40. Additionally, in its witness session with Surrey Minority Ethnic Forum, the task group learned that some BAME residents, particularly those who may have not lived in the United Kingdom for long, can often struggle with understanding how prescription systems operate. They may not understand where or how to order prescriptions from doctors, or in some cases not understand how to collect medications that have been prescribed. Hence, such BAME residents may not be able to sufficiently benefit from the very services that most residents may sometimes take for granted, simply due to a lack of understanding of how systems operate in Surrey and Nationwide. It is therefore vital that BAME residents are able to navigate through the healthcare system in order to fully and efficiently benefit from health services available to them. This could also be achieved through increasing the availability of guidance for patients on how to book appointments, how to collect prescriptions, or even how to access appointments through transportation routes.

Diagnosis/Medical records from abroad:

41. Another fundamental issue that was brought to the task group's attention related to patients from the BAME community who have arrived from abroad and wish to access and make use of healthcare services in Surrey. These may either be residents who have just arrived from abroad, or in some instances, may have lived in Surrey previously but have spent prolonged periods abroad. Such residents often experience issues with being able to utilise medical records which they brought from abroad to

enable them to access healthcare services in Surrey without the need to undergo initial diagnosis.

42. Such residents may often have detailed medical records which provide results from blood tests, scans, and other medical assessments which, if provided with the opportunity to do so, could easily be utilised to speed up treatment and referral processes without the need to experience long waiting lists as part of diagnostic stages. This is particularly crucial for BAME patients who have serious medical conditions and diseases such as Cancers, whereby any delays to treatments can result in the spread and proliferation of tumours, particularly in cases where the Cancer is malignant in nature.

43. Hence, the task group **recommends for exceptions to be made for individuals arriving from abroad with full medical history records to be directly referred to specialist services. This can help to bypass longer waiting times for a repeat diagnosis.**

Vaccine Hesitancy:

44. Another issue that was brought to the task group's attention through its witness sessions related to vaccine hesitancy. Specifically, it was reported that some elements of the BAME as well as the GRT Communities experienced a hesitancy toward vaccinations, and in particular Covid-19 vaccines. In one research study conducted from 2020—2021, which was published by the NHS Confederation, it was found that although there has been increased vaccination uptake amongst ethnic minority communities from 0.66 per cent in February 2021 to 38.35 per cent in May 2021, Covid vaccine hesitancy was still more prevalent amongst ethnic minority communities as a whole relative to majority ethnic group categories[6]. Indeed, the hesitancy toward vaccinations could result in increasing susceptibility to contracting viruses including Covid-19 as well as the Flu. Although some work has been undertaken through Surrey County Council as well as Surrey Heartlands and Frimley ICSs to increase confidence in Vaccines amongst ethnic minorities, the task group heard that such hesitancy still precludes elements of these communities from taking vaccines, particularly those from lower-income and refugee backgrounds, who may often base their perceptions of vaccines on rumours or conspiracy theories from their close networks. Indeed, that vaccine intake continues to be subject to hesitancy amongst elements of these communities is a cause of greater vulnerability and physical health disadvantages experienced by these groups relative to other communities in Surrey. According to research conducted by the University of Harvard in a 2021 study, the decision to avoid taking vaccines can result in greater susceptibility to viral infections which, in the long run, can result in longer-term side effects to one's overall Health and Wellbeing relative to those who do regularly vaccinate[7].

GRT Community demographics and trends:

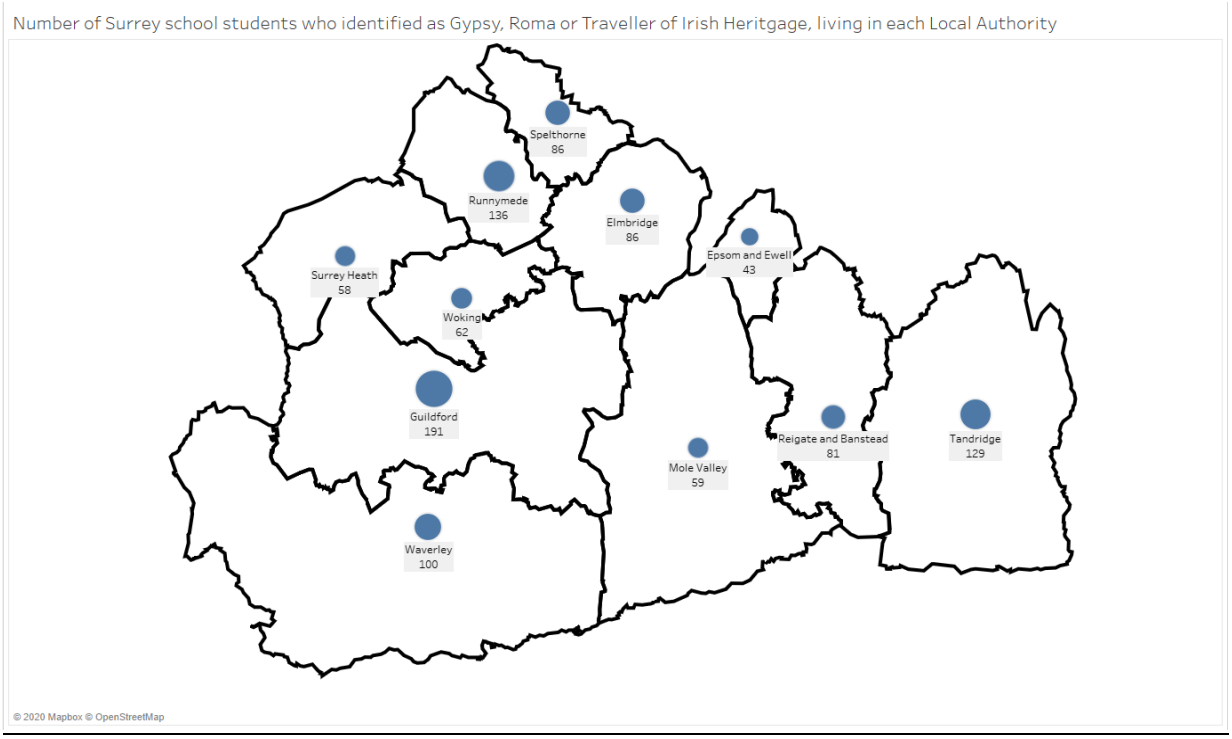
[6] Addressing vaccine hesitancy in different ethnic communities | NHS Confederation
[7] Vaccines | Free Full-Text | Antibody Focusing to Conserved Sites of Vulnerability: The Immunological Pathways for 'Universal' Influenza Vaccines (mdpi.com)

45. Given that the task group focused on the Health disadvantages faced by Ethnic Minorities as a whole, this included some insights into the GRT Community. Demographically speaking, the GRT community remains relatively small within Surrey. According to the 2011 census, this community constitutes less than 1% of Surrey's total population[8]. However, it is worth noting that there is a belief that the demographics of this group remain underreported within the census. The GRT community suffer from greater health disadvantages relative to any other ethnic group, both within Surrey as well as globally. According to the Office of National Statistics as of 2014, it was found that 14% of Gypsy/Travellers felt that they suffered "bad" or "very bad" health; and this community were over twice as likely to report this than White British ethnic groups[9].

46. According to the GRT Rapid Needs Assessment for Surrey, which was conducted during the height of the Covid-19 Pandemic, the GRT community share some common characteristics. These include: an emphasis on family bonds and networks, living a nomadic life, opting for self-employment over working for others, and experiences of poorer health outcomes. It is estimated that approximately 10-12,000 of Surrey's residents are from GRT backgrounds[10]. At present, there is limited data to indicate the geographical spread of GRT communities within Surrey, although proxy data on the ethnicity of students attending Surrey's schools indicates that most students from GRT backgrounds live in Guilford. The figure below indicates this geographical spread of GRT students, which can provide indications as to the areas with the greatest concentration of GRT residents:

Figure B: Numbers of school students across Surrey identified as GRT within every Local Authority:

[8] The Surrey Context: People and Place | Surrey-i (surreyi.gov.uk)
[9] Achieving better health outcomes for Gypsy, Roma and Traveller communities - Committees - UK Parliament
[10] Gypsy Roma Traveller RNA.pdf (surreyi.gov.uk)



GRT Health Challenges:

47. The task group learned that within the GRT Community lies a tendency to feel distrust and suspicion toward mainstream services. This distrust also manifests in a proclivity to avoid accessing or seeking healthcare services. In its witness session with Surrey and Borders Partnership, the task group heard that GRT communities may not always feel that mainstream services have their best interests at heart. It is this very distrust and suspicion of health services, including NHS services, that renders these communities more susceptible to developing poor physical and mental health. Below are some of the key tendencies and vulnerabilities experienced by GRT communities in Surrey. It is noteworthy that these tendencies and vulnerabilities significantly contribute to the poorer health outcomes and disadvantages experienced by these communities:

    1. *Lower Education/Literacy Outcomes:* According to a Needs Analysis that informed Surrey's Brighter Future's Strategy (2014-2017), GRT communities generally have lower educational outcomes as well as poorer literacy rates. This is partly shaped by preferences amongst many GRT families for self-employment. Whilst not directly impacting health outcomes for these communities, the task group understands that this has an indirect impact through reducing these communities' understanding of health and healthcare services, as well as their ability to access relevant medical information and advice.

    2. *Life Expectancy:* The life expectancy of GRT residents is ten years lower when compared to the national average[11]. Additionally, compared to the national population, GRT communities have infant mortality rates that can often be twenty

[11] Gypsy Roma Traveller RNA.pdf (surreyi.gov.uk)

times more. These lower life expectancies are elicited by a multitude of factors including; not being able to access health services, not being registered with a GP, displaying distrust toward mainstream health services as a whole, and living in poor conditions.

3. *Poor Living Conditions:* These communities can often reside in sites that may be overcrowded or that may not be suitable for a healthy and fulfilling lifestyle in general. This results in poorer physical but also mental health outcomes for some GRT residents. Often, such individuals may experience immense uncertainty and instability with accommodation, which can also result in deteriorating their quality of life. In one national study conducted in 2016 by Bucks University as well as the Traveller Movement, it was found that over 60% of GRT residents residing within traveller sites felt that their physical and mental health was deteriorating, not merely due to the very fact of living on a traveller site, but due to existing societal arrangements and services not necessarily being conducive to their wellbeing as well as their chosen way of life.

4. *Poor Mental Health:* The task group learnt that GRT communities are also more likely to develop poor mental health outcomes. This is elicited by a variety of factors including; living in insecure accommodation arrangements, not accessing mental health services (for some of the reasons outlined above), and experiencing greater susceptibility to domestic abuse. It is also the case that mental health may often be underestimated, misunderstood, or even treated as a taboo. Individuals suffering from poor mental health outcomes within these communities may often feel too embarrassed at the thought of expressing their poor mental health to fellow community members or even loved ones.

5. *Domestic Abuse:* Individuals from GRT backgrounds, particularly Women, are more prone to suffering domestic abuse. This could either be direct physical abuse from their partners, or indirect abuse through cultural expectations that Females should, from early ages, adopt key domestic roles including motherhood and caring for Children and wider family networks.

48. Hence, on the basis of the above findings, **the task group recommends that greater efforts are undertaken to improve the health and wellbeing of GRT communities through enhancing access to GP and other health services, reducing distrust of mainstream services amongst these individuals, tackling discrimination against these groups, and for targeted healthcare provision to those on GRT living sites.**

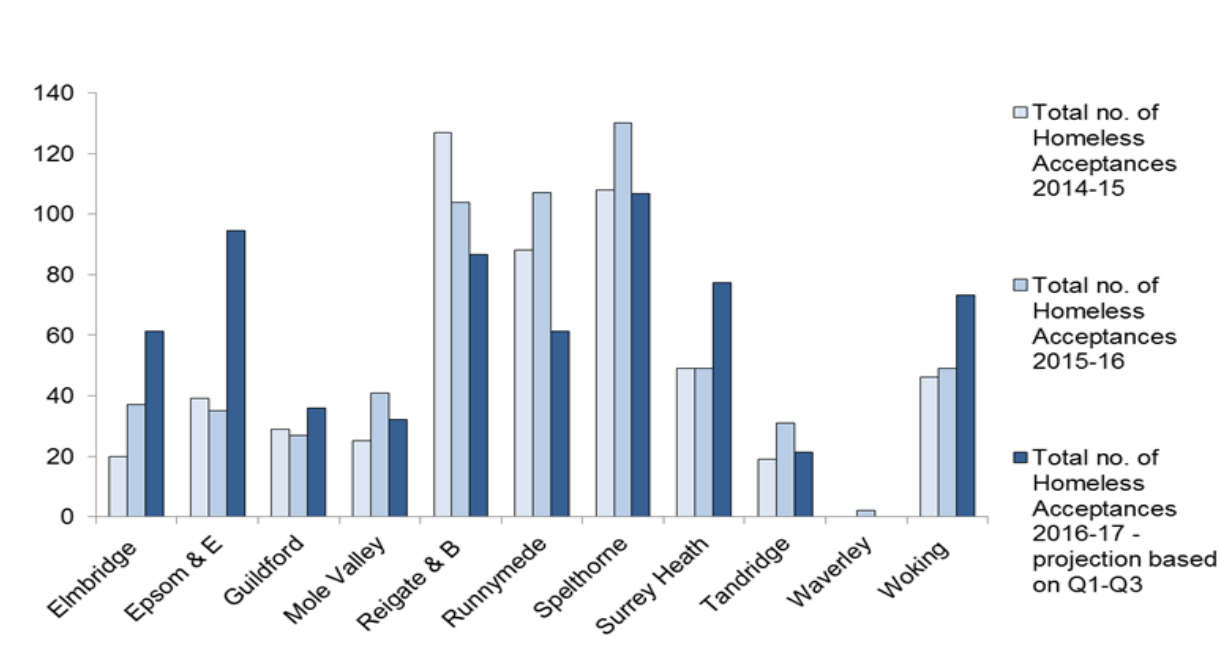
Key Findings for individuals experiencing Homelessness (including Associated Drug and Alcohol Abuse).

49. Being homeless can have significant impacts on an individual's Health and Wellbeing. According to the Royal Society of Medicine, being chronically homeless can have negative impacts on an individual's health and overall quality of life, and can often

result in premature death[12]. With this in mind, the task group has adopted a holistic approach to examining health inequalities and disadvantages experienced by those experiencing homelessness, drug, and alcohol abuse. This involved examining the effects of being homeless and suffering from drug and alcohol abuse on an individual's physical, mental and wider determinants of Health as outlined by all three priorities of the Health and Wellbeing Strategy.

50. Homelessness within Surrey has gradually increased since 2015. According to data identified by Surreyi, the number of homeless acceptances within Surrey has increased since 2015 in eight of the eleven borough and district Councils within the County. The graph below indicates this trend.

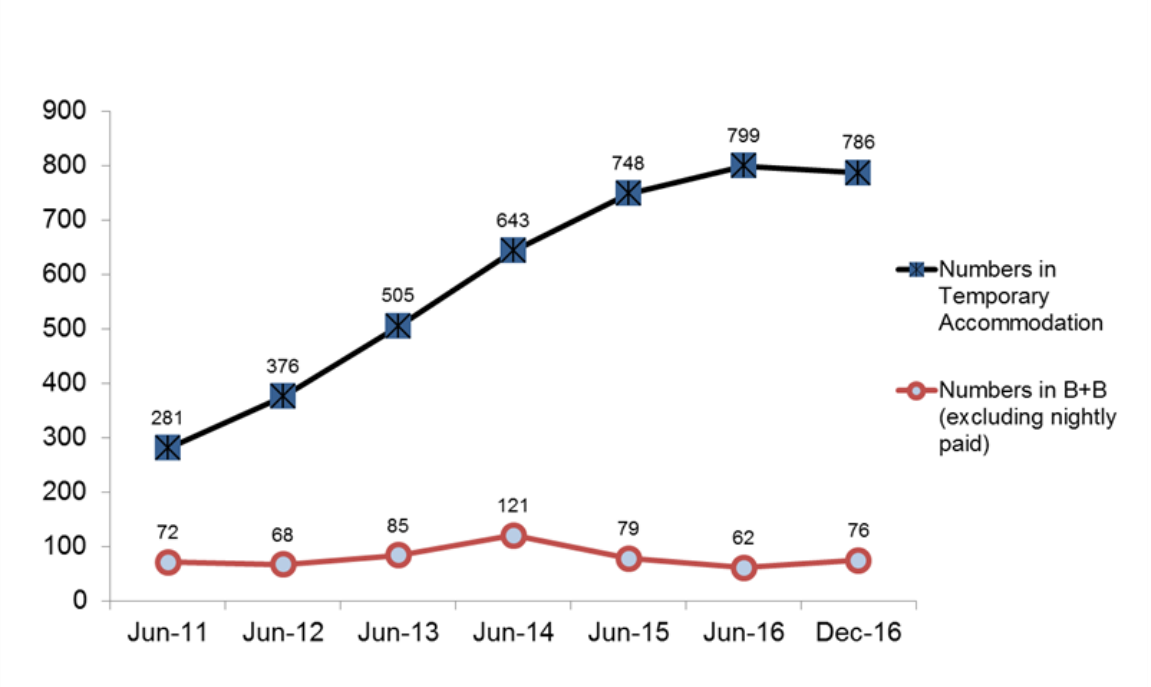
Figure B: Homeless Acceptances in Surrey 2015-16 and projections for 2016-2017



[12] Hewett N, Halligan A. Homelessness is a healthcare issue. Journal of the Royal Society of Medicine. 2010;103(8):306-307. doi:10.1258/jrsm.2010.10k028

51. In addition to the above, according to data released by Surrey Districts from Government (P1E) returns, between 2011 to 2016, the number of households residing in temporary accommodation has also increased. The figure below indicates this trend.

Figure C: Temporary Accommodation/B&B All Surrey authorities – up to Dec 2016



52. As such, given that Homelessness has increased within Surrey, the task group has conducted witness sessions with a vast array of organisations which have expertise on, or which in some cases directly provide support for, those experiencing homelessness and the drug and alcohol abuse associated with this. These insights are outlined below.

53. In its witness session with Guildford Action, an organisation which supports homeless individuals in Guildford and which receives support from Guilford Borough Council for doing so, the task group heard that the homeless often experience needs that are highly complex. The complexity of their needs often presents challenges for their ability to access mainstream health and wellbeing services. It was explained to the task group that homeless people often come from a place of trauma, which has been aggravated by remaining in rough living conditions for prolonged periods of time. Additionally, such homeless individuals are often subjected to negative and unhelpful labelling; entailing accusations or false impressions that the homeless are partially responsible for being homeless, and that they are somehow not taking adequate steps to resolve their homelessness. It is labels such as the above which lead to assumptions that it is homeless individuals themselves that do not wish to seek medical treatment. **Thus, the task group recommends that efforts are made to tackle negative and false labels against the homeless as part of initiating a new culture change that is more understanding and supportive of homeless individuals.**

Homelessness and Physical Health:

54. Through its witness sessions, the task group learned that homeless residents within Surrey are experiencing various challenges to their overall physical health. Details of some of the physical health complications induced by homelessness are outlined below.

55. In its witness session with Guilford Action, the task group heard that rough sleepers often suffer from poor foot health, which is caused by their feet becoming infected as a result of inadequate footwear. Such infections can result in the need for hospital treatment. However, as is often the case when those with infected feet often go to A & E, they are patched up and released back onto the streets. Rather, the dressing for such infections/wounds requires regular changing; which is a service that rough sleepers often cannot receive. According to the Surrey Homelessness Needs Audit of 2016, almost 10% of homeless individuals reported as having problems with their feet.

56. Another issue that rough sleepers often experience is hypothermia, which includes severe physical symptoms such as cold skin and shivering, as well as cognitive symptoms such as confusion and slurred speech. This is caused by a lack of adequate clothing and warm shelter. According to research conducted by the National Centre for Biotechnology Information, rough sleepers who suffer from hypothermia are more than twice as likely to develop further health complications from those who are not homeless[13].

57. Moreover, the task group heard that rough sleepers have greater proclivities to experience infected nails. Part of this stems from the lack of adequate protection and sanitation for their hands and being consistently exposed to unhygienic environments. The inability to access shelter entails a lack of access to taps, sinks, and soaping facilities which raises this susceptibility to nail infections. These nail infections can result in swelling and excruciating pain, particularly for those who cannot access treatment swiftly.

58. Furthermore, the task group learned that rough sleepers are becoming more prone to developing diabetes. This is partly due to poor dietary choices stemming from an inability to purchase or access healthy and balanced dietary meals. Upon developing diabetes, rough sleepers are unable to access appropriate medication and treatment such as metformin tablets or insulin injections. The absence of regular treatment and medication further deteriorates the overall health and wellbeing of diabetic rough sleepers.

59. As such, on the basis of the aforementioned physical health challenges that rough sleepers are facing within Surrey, the **task group recommends that homeless residents are able to access GP appointments and services as easily and as efficiently as possible, without any complexities in them being able to access frontline healthcare.** Additionally, given that rough sleeping per se can raise susceptibility to physical health problems, **the task group recommends for the**

[13] Singer J. Taking it to the streets: homelessness, health, and health care in the United States. J Gen Intern Med. 2003 Nov;18(11):964-5. doi: 10.1046/j.1525-1497.2003.30903.x. PMID: 14687285; PMCID: PMC1494948.

continuing advancement of efforts to tackle rough sleeping by providing sheltered accommodation for the homeless, and for greater coordination between all actors within the Surrey System, to ensure that this is achieved.

60. Another key concern that the task group heard related to poor dental health amongst the homeless, most notably amongst rough sleepers. Rough sleepers face rapidly deteriorating dental issues such as tooth decay and tooth/gum infections. These are caused by a consistent lack of access to dental appointments, where even basic check-ups would have been able to identify such early signs of dental decline. The 2016 Homelessness Health Needs Audit reported that over 20% of homeless males and nearly 13% of homeless females experienced dental problems. This Audit also found that over 42% of those who participated in the study were not registered with a dentist in the local area. In some cases, the homeless struggle to gain access to toothbrushes and sink facilities to routinely maintain their dental hygiene. Indeed, as the NHS has also concluded, the absence of regular check-ups and dental hygiene results in long-term exposure to more serious conditions such as Oral Cancer[14]. **As such, the task group recommends that efforts are undertaken to increase access to dental care for the homeless, including rough sleepers.**

Homelessness and Mental Health:

61. During its witness sessions with Surrey and Borders Partnership, the King's Fund and Guilford Action, the task group heard that homeless individuals, particularly those experiencing rough sleeping, are significantly more prone to developing mental health issues. Given that mental health needs can stem from a place of trauma, being homeless can increase one's susceptibility to mental ill health. According to research conducted by King's Fund, over 80% of individuals experiencing homelessness report having mental health difficulties[15].

62. Homeless individuals are more prone to developing a stronger sense of paranoia, which is partly elicited by consistent and negative labelling and stigmatisation of the homeless. This paranoia often results in a deeper disconnect between the homeless, particularly rough sleepers, and wider society. According to a 2017 study by the University of Southampton, being homeless is more likely to cause paranoia, but being in a prolonged state of paranoia can actually prolong one's homeless condition due to greater isolation from society and a suspicion of mainstream services[16].

63. Furthermore, the task group heard that homeless residents, including rough sleepers in Surrey, are more inclined to develop psychosis. This often manifests with symptoms such as delusions or visual and audio hallucinations. According to the Homelessness Health Needs Audit of 2016, nearly 12% of males and 8% of females experienced psychosis. This psychosis is often induced by a multitude of factors experienced by the

[14] https://www.nhs.uk/conditions/mouth-cancer/causes/
[15] https://www.kingsfund.org.uk/publications/what-are-health-inequalities
[16] Powell K, Maguire N. Paranoia and maladaptive behaviours in homelessness: The mediating role of emotion regulation. Psychology and Psychotherapy: Theory, Research and Practice. 2018 Sep;91(3):363-79.

homeless; particularly a sense of helplessness, isolation, and prolonged physical symptoms of pain and discomfort. Such mental health issues often go undiagnosed or even untreated as a result of a prolonged lack of access to GP services, let alone to mental health services. Therefore, as stated in the recommendation outlined in the previous section, the task group strongly recommends that GP access is enhanced for homeless individuals, as this can help to identify and tackle not merely the physical, but also the mental health challenges that these individuals experience.

64. It is not only rough sleepers who are more prone to mental health issues, but also homeless residents who are having to "squat" and constantly move around the homes of friends or relatives. Such "squatters" often feel a sense hopelessness and a loss of control over their housing situation or their overall lives. This sense of loss of control results in an increase in anxiety and depression, which leads to a constant and negative cycle of remaining in a consistent state of poor mental health which further debilitates their wellbeing and capacity to overcome their homelessness.

65. The task group found that the lack of availability of mental health services for the homeless has impeded their exposure to treatment. For instance, Community Foundation for Surrey reported to the task group that there is a lack of availability of mental health practitioners as well as qualified counselling staff within Surrey; and that this has resulted in the homeless being left far behind in the list of those requiring mental health support.

66. The task group also heard that homeless individuals who experience a mental health crisis, particularly rough sleepers, often do not receive the urgent and immediate support required. For instance, they struggle to gain access to Mental Health Safe Havens, and in some cases when they attend A & E departments, they are not provided with the adequate and appropriate support required for an individual undergoing a mental health crisis.

67. Hence, the **task group recommends that efforts are made to increase access to mental health safe havens for homeless individuals who experience a mental health crisis**. In addition, the task group also importantly **recommends that homeless individuals suffering from poor mental health are provided access to counselling and cognitive behaviour therapy to help them cope with and to overcome their mental health challenges.**

68. Furthermore, in its witness session with Surrey and Borders Partnership, the task group heard that there are complex barriers which increase difficulties for rough sleepers or homeless individuals to receive mental health support. Such barriers include:

    1. Homeless individuals often struggle to prove that they are Surrey residents in the very first instance, which can create complications for seeking support or being referred to services.

    2. Homeless individuals often struggle to fill in forms to register with GP surgeries or to simply apply for GP appointments.

3. Homeless individuals are often subjected to being “bounced” between different services. Whilst the tendency to be bounced around services is not unique to homeless individuals, these individuals are more inclined to suffer from this, particularly if they are rough sleepers.

4. Homeless individuals that are granted temporary accommodation are sometimes relocated outside of Surrey, which makes it difficult for them to continue to access Surrey-based mental health services.

5. Homeless individuals need to be in environments where they are in a position to be able to start thinking about improving their overall health and wellbeing and accessing mental health services. This includes the need to have more sustainable temporary accommodation arrangements for the homeless; particularly those who are suffering from poor mental health.

69. As such, **the task group recommends for Surrey County Council to work more closely with District and Borough Councils, to provide more sustainable temporary accommodation facilities to help homeless individuals to remain in a stable environment through which they can access support for their mental health.**

Drug and Alcohol Abuse:

70. The task group learned that homeless individuals in Surrey have a greater proclivity to resort to drug and alcohol use and even misuse. This tendency to resort to alcohol and drug abuse is fuelled by the physical and mental distresses of remaining homeless for prolonged periods. Thus, remaining in a state of addiction and misuse often precludes homeless individuals in Surrey from being able to access housing. The 2016 Homelessness needs audit found that almost 20% of homeless individuals within Surrey consume Alcohol on a daily basis.

71. In its witness sessions with both Guilford Action as well as with “We You”(the aforementioned national mental health charity which is also a member of the Adult’s Mental Health Alliance in Surrey), the task group heard that local councils within Surrey are highly reluctant to provide housing support to the homeless until they overcome their drug or alcohol addiction. However, the drug and alcohol abuse experienced by the homeless could not be resolved or overcome whilst they were still in a state of homelessness or rough sleeping on the streets. Rather, it is the consistent rough sleeping on the streets which raises susceptibility to drug and alcohol abuse in the very first instance.

72. It was reported to the task group that an Alcohol-harm paradox exists in Surrey, whereby, in some instances, although residents in deprived areas may not drink as much as those in afflue nt areas, the impact of the alcohol on their overall health is greater given the other factors surrounding their living conditions and socio-economic situation. People from less deprived areas may consume more alcohol due to being able to afford it, although this does not translate into direct physical or mental harm as a result inasmuch as it does for those in more deprived areas.

73. It was also heard that residents with an Alcohol addiction, including those who are homeless, may often be refused assistance with their mental health. This may be due to negative and misleading stigmatisations that those who are suffering from Alcohol or Drug addictions are consciously eliciting harm onto themselves. As such, there is a need for greater sensitivity with how Alcohol or drug addiction are referred to, and terminologies such as "drunk" or "drug dependent" should be avoided when referring to such individuals in health and wellbeing settings where these individuals may be receiving support. Indeed, any indication of the use of the aforementioned terminologies can lead victims of Alcohol or Drug abuse to abstain from seeking support due to feeling uncomfortable with such labels.

74. Thus, the task group **recommends that there is joint commissioning for high quality mental health and drug and alcohol services that focus on meeting individuals' core needs rather than the current presenting problem**. Hence, if homelessness is a root cause of an individual's drug or alcohol addiction, then this should also be taken into account and support should be provided to help tackle this.

Key Findings for individuals suffering Domestic Abuse

75. Domestic abuse is a phenomenon that affects residents nationwide. According to the Office for National Statistics (ONS), 5.0% of adults (6.9% women and 3.0% men) aged 16 years and over experienced domestic abuse in the year ending March 2022; equating to an approximately 2.4 million adults (1.7 million women and 699,000 men)[17].The task group took a keen interest in this category of individuals for three reasons:

    1. Individuals suffering Domestic Abuse constitute one of the priority population groups within Surrey's Health and Wellbeing Strategy.

    2. Domestic Abuse victims may also fall under some of the other priority population categories found within Surrey's Health and Wellbeing Strategy.

    3. Domestic Abuse victims are more prone to experience physical and mental health challenges, and the task group believes that a more holistic approach needs to be adopted towards not merely understanding the complex and comprehensive nature of domestic abuse, but to reduce some of the Health challenges that these victims face.

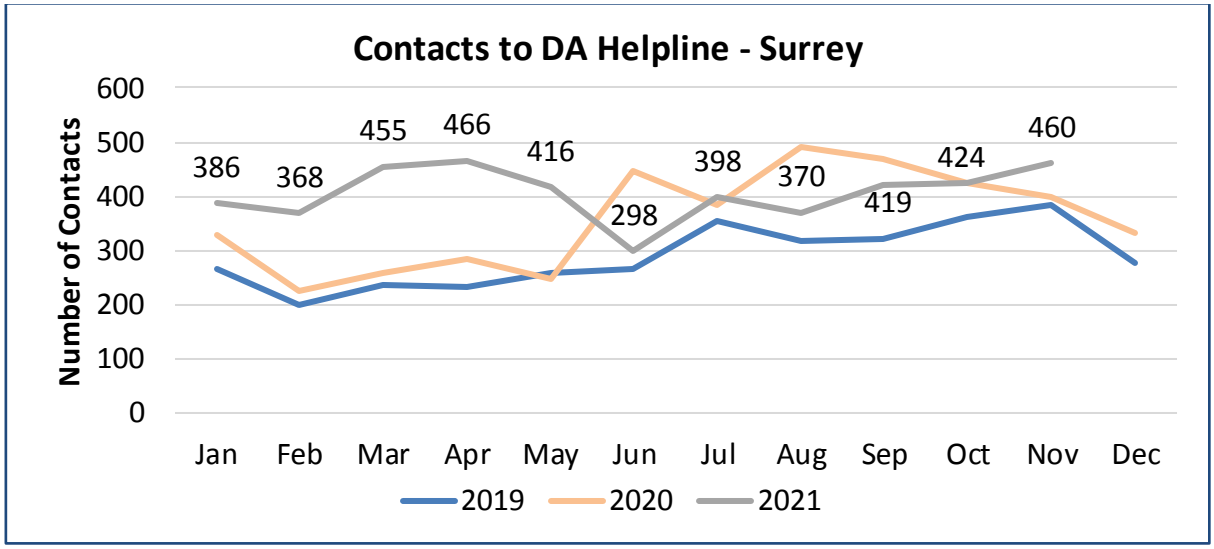
76. Domestic abuse is a comprehensive term. The task group believes that a holistic understanding of domestic abuse needs to be adopted, as only this can help to inform a holistic and comprehensive policy approach toward tackling abuse. Domestic abuse can either present as a pattern of incidences or as a single incident. However, the task

[17] Domestic abuse in England and Wales overview - Office for National Statistics (ons.gov.uk)

group has come to learn that most incidents of domestic abuse can often constitute part of a more consistent pattern of abusive incidences.

77. Incidences of Domestic abuse have increased within Surrey, particularly in the context of the Covid Pandemic and the advent of lockdown restrictions. This is evident in the fact that data on the number of contacts to Surrey's Domestic Abuse helpline indicates an increase in the number of contacts to Domestic Abuse Helplines from the period 2019-2021. Below is an extract from Surrey's Domestic Abuse Annual Report 2020-2021 which indicates this trend:

Figure D:



78. Additionally, data from Surrey Police indicates that approximately 14% of all recorded crimes within Surrey are related to various forms of domestic abuse.

79. The Task Group has conducted witness sessions, as well as received written evidence/documentation from multiple organisations which have provided insights into some of the Health challenges and disadvantages experienced by individuals suffering from domestic abuse. Witness sessions were conducted with representatives from Healthwatch Surrey, Surrey Safeguarding Adult's board, the South-West Surrey Domestic Abuse Service, and the Women's Support Centre. Below are some findings

on some of the common themes identified through the witness sessions as well as from data and research gathered from other avenues that the task group utilised.

Domestic Abuse in Rural Areas:

80. The task group has learnt that geography can constitute a crucial factor in domestic abuse patterns. According to a research project into domestic abuse conducted by the National Rural Crime Network in 2019, Rural Victims of Domestic Abuse are 50% as likely to report abuse when compared to victims in less rural areas[18]. For instance, in its witness session with the South-West Surrey Domestic Abuse Service, the task group heard that the Guilford and Waverly Boroughs have a substantial rural population, and that this has accounted for a reluctance to report domestic abuse in these areas. It is also the case that rural victims are more inclined to suffer abuse that is more consistent and continual relative to other areas. As such, victims who live in rural areas, including those in Guilford and Waverly, often feel a sense of isolation, and a lack of being protected and supported given the difficulties in being able to travel alone and independently through rural areas.

81. The task group heard that such isolation and lack of support can be felt amongst the victims of domestic abuse from the BAME community also. Living in rural areas, combined with taboos surrounding reporting abuse from partners as well as the presence of language barriers can result in some females from BAME communities to suffer in silence.

82. As such, it is imperative that residents in deprived areas are able to also benefit from domestic abuse protection and support services. The task group therefore **recommends for continued efforts to increase awareness of support for domestic abuse available to residents.**

Domestic Abuse and physical Health:

83. The task group learnt that one of the most significant aspects of domestic abuse involves physical harm. Although this does not constitute the sole form of domestic abuse, it nonetheless remains one of the key symptoms of abuse for Surrey residents. For instance, in its witness session with Women's Support Centre, it was heard that Women (who are statistically more prone to being victims of abuse) often present with direct harm or injuries in any parts of their bodies. Women who approach or who are referred to the Women's Support Centre for domestic abuse can often present with bruises or long-term bodily pain and aches in the back and shoulders. Often such victims have been physically beaten, tossed around, or slammed against objects or furniture.

84. That victims of domestic abuse can often suffer immense physical harm is also manifested in the fact that, according to data from the Femicide Census, 1 woman is killed by a man every 3 days in the UK, and that over 70% of these killings are perpetrated by partners, ex-partners, or family members[19]. Domestic abuse can also

[18] Captive & Controlled - Domestic Abuse in Rural Areas - National Rural Crime Network
[19] https://www.femicidecensus.org/

constitute a key factor in morbidity for Women. Indeed, according to the Safelives Pathfinder Project, domestic abuse is the highest cause of morbidity in women between the ages of 19-44, which is higher than morbidity from cancers, wars, or road traffic accidents.

85. Moreover, the task group heard that Domestic Abuse victims are more prone to developing dental health problems. This could be due to a multitude of factors including poor diet and nutrition, not being able to independently book dentist appointments or to travel to a dental practice, or due to being afraid and reluctant to approach health services for fears that this may result in their abuse or abuser being exposed. More insights into refraining from health services due to fears of exposure of abuse are outlined in further detail in this report in a section below.

Domestic Abuse and Miscarriages:

86. The task group heard that domestic abuse can often increase against Women during times of pregnancy. In its witness session with the Women's Support Centre, it was heard that such abuse can often elicit miscarriages in pregnant Women. There are two reasons that account for this:

    1. *Physical abuse* can often result in physical injury and trauma to the body. Such physical assaulting or sudden trauma can result in a miscarriage.

    2. *Mental abuse*, or even the proclivity to feel under a consistent pattern of mental distress due to extreme anxiety, can also result in Women experiencing a miscarriage. Indeed, according to research conducted by the University of London, Pregnant Women who experience extreme forms of stress and mental anxiety are over 50% more likely to experience a miscarriage.

87. As such, **the task group recommends that greater support is offered to tackle mental health as well as domestic abuse for Women during pregnancy, and that efforts are made to raise awareness of such support amongst pregnant Women.**

Victim's difficulties in gaining access to healthcare:

88. The task group learnt that it can often prove challenging for victims of domestic abuse to gain access to healthcare services. There are three reasons as to why this could be the case.

    1. *Fear of Abuser:* Victims fear that if the abuser discovers that they are seeking healthcare support, that could infuriate the abusers further and aggravate the victim's experience of abuse. Abusers may be suspicious that healthcare professionals may identify evidence of abuse.

    2. *Health records being used against Victim:* Victims can feel that if they report poor mental health as a result of abuse, that this could result in them permanently being labelled as suffering from mental health conditions. Victims may therefore feel that they may not be taken too seriously by health practitioners when reporting genuine

physical symptoms/poor physical health due to their records indicating that they suffer from poor mental health.

3. *Lack of awareness of Support Available:* Victims may genuinely not be aware of support services available, be this domestic abuse support, or even mental health support. For instance, many victims who suffer poor mental health do not know who to approach regarding this, and can often assume that GPs cannot help them with mental health issues but exist for the purposes of primarily dealing with physical health symptoms. This results in victims refraining from seeking to access mental health support. If victims were aware of their GPs ability to refer them for mental health support, they may be more inclined to bring the mental health ramifications of their abuse to their GPs attention and would therefore benefit from mental health support services available for domestic abuse victims.

89. As such, the **task group recommends for the continuation of efforts to increase awareness of support for domestic abuse available to residents.**

Domestic Abuse and Children:

90. As part of its holistic approach to domestic abuse, the task group understands that domestic abuse can have negative impacts on the health and wellbeing of Children. Through its witness sessions with Women's Support Centre as well as with the South-West Surrey Domestic Abuse Service, the task group heard that Children could suffer from domestic abuse either *directly* or *indirectly* as is outlined below:

1. *Direct abuse*: This could take the form of being physically abused, either through being beaten aggressively by a parent or close loved one. Or in some instances, and to a lesser extent, children could also be subjected to sexual abuse.

2. *Indirect abuse*: This could be from experiencing neglect due to being in a household where abuse is prevalent towards a parent. Or, in some cases, Children are indirectly affected by abuse through having to witness traumatic experiences of abuse between parents; which can result in prolonged mental health issues. In one study published by the journal of brain sciences in 2017, it was found that children who witness domestic abuse in their household are more susceptible to developing strong anxiety and depression; both during childhood as well as into adulthood[20].

Therefore, the task group believes that Children should also be considered as victims of domestic abuse in their own right, and hence should also benefit from receiving protection and support against both *direct* and *indirect* abuse so as to avert threats to their overall health and wellbeing.

Domestic Abuse and Safe Accommodation:

91. Victims of domestic abuse often require support which involves the provision of accommodation that is separate from the abuser. The logic is that if separated from the

[20] https://www.mdpi.com/2076-3425/7/10/133

abuser, the victim will suffer less physical, mental, or emotional harm, which can reduce poor health and wellbeing as a whole.

92. However, the task group discovered that it is not always the case that victims who require safe accommodation are provided with this. In some instances, despite receiving accommodation, the accommodation may not be entirely appropriate for them. This can have a knock-on effect on their overall health and wellbeing.

93. In 2021, the *Surrey Domestic Abuse and Safe Accommodation Needs Assessment* was published. This was undertaken to assess the current safe accommodation offer in Surrey and to identify any needs and gaps in the provision of safe accommodation for domestic abuse victims. This covered the provision of support to victims and their children residing in some/all of the following; Specialist Safe Accommodation, Refuge accommodation, Sanctuary Schemes, Dispersed Accommodation, Moved-on or Second Stage Accommodation.

94. Overall, the Needs Assessment concluded that there were gaps/needs that require further efforts to address. These include:

- There are no caravan or mobile homes for the Roma Gypsy and Traveller Communities.
- There is little (if any) accommodation provision for victims who are adult males.
- Accommodation may not be sufficiently large so as to meet the needs of larger families.
- Some of the accommodation provided does not suit the specialist needs of victims from BAME backgrounds.
- Social Housing staff lacked strong knowledge and understanding of the nature of domestic abuse and its various forms, and the associated impacts on victims who may urgently require accommodation separate from abusers.
- There is need to support letting agents and private landlords to improve how they deal with and respond to domestic abuse.

95. There is also a Sanctuary scheme as an initiative that is multi-agency. The objective here is to allow households who are at risk of physical abuse to remain in their homes whilst benefiting from the provision of increased security measures. This may also involve the designation of a 'sanctuary room' within the victim's homes. However, this scheme is only implemented when abusers are no longer residing in the victim's homes. Below is a table extracted from the Surrey Domestic Abuse and Safe Accommodation Needs Assessment, which provides a breakdown of existing data on referrals. It demonstrates that the most referrals for sanctuary schemes are from Woking.

Figure E:

District/Borough	Referrals
Woking	52
Guildford	20
Waverley	5
Epson & Ewell	19

Hence, based on all the accommodation-related information outlined in this section, **the task group recommends for the continuation of efforts to provide domestic abuse victims with an easy point of access for support, including for accommodation, in the event of victims seeking refuge.**

Post-Separation Abuse:

96. The task group heard that domestic abuse is not a phenomenon that is limited to the period in which an individual is within a relationship with another abuser. Rather, there also exists a tendency for abuse to occur even subsequent to separation. This is particularly the case for Women who have been victims of abuse in a former relationship.

97. According to funded research conducted by domestic abuse scholars in 2022, approximately 90% of victims of coercive abuse experience post-separation abuse[21]. Hence, the assumption that victims of abuse are safer once they leave a relationship is misleading. For instance, victims can continue to be subject to abuse for several years after leaving a relationship with an abuser.

98. According to the Women's Support Centre, of the 888 women killed by partners or former partners in the ten-year period 2009-2018, at least 378 (43%) were known to have separated, or taken steps to separate, from the perpetrator. Additionally, according to the Femicide Census, of the cases where women had separated, or made attempts to separate, the vast majority, 338 (89%) were killed within the first year and 142 (38%) were killed within the first month of separation[22].

99. Hence, it is imperative that victims of domestic abuse continue to receive support even subsequent to a separation from an abuser. Therefore, assuming that domestic abuse ceases once an individual is no longer in a relationship with an abuser is highly problematic and could risk continued harm to a post-separation victim's physical and mental health.

Conclusions:

100. Throughout this project, the Task Group has received a substantial amount of valuable evidence from witnesses. The Task Group members wish to express their thanks,

[21] https://www.domesticshelters.org/articles/legal/8-common-post-separation-domestic-abuse-tactics
[22] https://www.femicidecensus.org/wp-content/uploads/2022/02/010998-2020-Femicide-Report_V2.pdf

gratitude, and appreciation to all of those who dedicated their time to share their insights, expertise or experiences.

101. This report has summarised these insights, expertise and experiences to further understand the nature as well as the sources of the Health Inequalities and disadvantages experienced by the three population groups it has selected. The evidence accumulated during witness sessions was utilised to inform the development of recommendations for consideration by the Adults and Health Select Committee, Surrey County Council's Cabinet and other health partners.

102. The Task Group's recommendations are predicated on key themes identified during the witness sessions, as well as the frequency with which such themes were raised. The Task Group has also sought to develop recommendations that adhere to the SMART (specific, measurable, achievable, realistic and timebound) criteria.

103. The Task Group feels that the recommendations outlined in this report will contribute to reducing Health Inequalities.

Next steps:

104. The Task Group's report will be considered by the Adults and Health Select Committee.

105. The Task Group's report and recommendations will also be submitted to relevant commissioners and providers.

106. The Task Group will review the implementation of its recommendations every 6 months.

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Annexes:

Annex 1 – List of Health Inequalities Task Group witness sessions

Annex 2 – Health Inequalities Task Group key lines of enquiry

Annex 3 – A graph published by Public Health England, indicating the Age standardised mortality rates in laboratory confirmed Covid-19 cases by ethnicity and Sex in England.

Annex 4 – Extracts from a report from Health Watch Surrey submitted to the task group, which includes qualitative data into key Health disadvantages experienced by Individuals from BAME Communities.

Annex 5 – An extract from the Surrey Homelessness Health Needs Audit of 2016, which indicates the Mental Health challenges/Disadvantages experienced by individuals experiencing Homelessness within Surrey.

Annex 6 – An extract from the Surrey Homelessness Health Needs Audit of 2016, which indicates the Physical Health challenges/Disadvantages experienced by individuals experiencing Homelessness within Surrey.

Annex 7 - Extracts from a report from Health Watch Surrey submitted to the task group, which includes qualitative data & insight into key Health disadvantages experienced by Individuals suffering from homelessness.

Annex 8 - Extracts from a report from Health Watch Surrey submitted to the task group, which includes qualitative data & insight into key Health disadvantages experienced by Individuals suffering from Domestic Abuse:

Annex 9 - Extract from Surrey's Domestic Abuse Annual Report 2020-2021, displaying data on referrals to refuges for refugees experiencing Domestic Abuse. The data indicates an increase in the number of referrals for refugees from 2018-2021.

Annex 10 - Extract from Surrey's Domestic Abuse Annual Report 2020-2021, displaying data on the number of contacts to Surrey's Domestic Abuse helpline. The data indicates an increase in the number of contacts to Domestic Abuse Helplines from the period 2019-2021.

Annex 11 - Extract from Surrey's Domestic Abuse Annual Report 2020-2021, displaying data from Surrey Police on the number of contacts to Surrey's Domestic Abuse helpline. The data indicates the number of Domestic Abuse related incidents and crimes in 2020-2021. Although there has been a slight decline in Domestic Abuse crimes and incidents, 14% of all recorded crimes in Surrey were classified as Domestic Abuse related.

Annex 12 - Extract from Surrey's Domestic Abuse Annual Report 2020-2021, displaying data percentages from Domestic Abuse Outreach Services on the type of abuse experienced between April-September 2021. The data also indicates percentages for the victim's relationship to the perpetrator.

Annex 13 - Data supplied to the task group by Women's Support Centre, displaying Women's Support Centre referrals for 2021/22 and 2022/23 by district and borough.

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