HOUSE OF COMMONS

Women and Equalities Committee

Oral evidence: Tackling inequalities faced by Gypsy, Roma and Traveller communities — HC 360

Wednesday 18 Apr 2018

Ordered by the House of Commons to be published on 18 Apr 2018.

Watch the meeting

Members present: Mrs Maria Miller (Chair); Tonia Antoniazzi; Philip Davies; Vicky Ford; Eddie Hughes; Mr Gavin Shuker; Tulip Siddiq.

Questions 38–80

Witnesses

I: Michelle Gavin, Project Manager, Friends, Families and Travellers, Szymon Glowacki, Mental Health Project Manager, Roma Support Group, Shaynie Larwood-Smith, Lead nurse for Gypsy Traveller Health, Cambridgeshire County Council, and Dr Alison McFadden, Senior Research Fellow, University of Dundee.

Written evidence from witnesses:

– Friends, Families and Travellers

- Roma Support Group

- Cambridgeshire County Council

Examination of witnesses

Witnesses: Michelle Gavin, Project Manager, Friends, Families and Travellers, Szymon Glowacki, Mental Health Project Manager, Roma Support Group, Shaynie Larwood-Smith, Lead nurse for Gypsy Traveller Health, Cambridgeshire County Council, and Dr Alison McFadden, Senior Research Fellow, University of Dundee.

Chair: I thank the witnesses for coming in front of us today. We are incredibly grateful to you for taking the time to be here. We understand the amount of time it takes to prepare. To those watching online and to those who might join us in the Gallery, this is the second oral evidence session in our inquiry into tackling inequalities faced by Gypsy, Roma and Traveller communities. After our opening session, which gave us a general overview, we are now starting to look in depth at some specific policy areas. Today we are focusing on health inequalities and health services.

We are conscious that we do not have a representative on the panel from the national commissioning perspective. That was a priority for the Committee, and we contacted NHS England more than three weeks ago. Having initially been told that it would be possible, NHS England then declined to put forward a witness. We were really disappointed about that, because it meant that we could not really factor in the national commissioning perspective today, nor could we understand the NHS's strategic approach in this area.

After further discussions, we understand that NHS England is now willing to field a witness for the inquiry, but it was not able to do it for today's session. We look forward to hearing your views today and being able to put them to the NHS in due course. I hope that explains why we are where we are.

Before we kick off with a series of questions and hear from colleagues, would you all say your name and the organisation you represent, starting with Michelle?

Michelle Gavin: Michelle Gavin. I represent Friends, Families and Travellers.

Szymon Glowacki: Szymon Glowacki, Roma Support Group.

Shaynie Larwood-Smith: I am Shaynie Larwood-Smith and I work for public health in Cambridgeshire County Council.

Dr McFadden: I am Alison McFadden and I work for the University of Dundee.

Chair: That's brilliant. Thank you very much. Tonia will start our questioning.

Q38 **Tonia Antoniazzi:** Good morning, everyone. In the 2011 census, 14% of

Gypsy and Traveller people reported their health as being "bad" or "very bad", which is much higher than any other ethnic group. What do you think accounts for that? I would like to start with Alison.

Dr McFadden: I would say that we need to look at the social determinants of health, which cover everybody's lives and every aspect of their life that influences their health. It is not just about access to health services. It is about the places where we are born and live, employment, housing, the discrimination and prejudice that we experience in our everyday lives, our schooling, our education—they all influence our health. You have to look broadly to understand health inequalities.

Shaynie Larwood-Smith: I agree with Alison. We have to look incredibly broadly. The community has a tradition of being very independent. They are incredibly resilient and stoic in their almost acceptance of ill health, in my experience as a practitioner. Possibly accessing healthcare early in their ill-health experience is not something that would even be considered. Generally speaking, a community member would be incredibly ill before they would actually access healthcare.

Michelle Gavin: I agree with everything that has been said. It is almost like ill health is normalised within the community. People of young age will just accept that they have multi-conditions, chronic conditions—that is just normalised in the community.

There is a connection with not having the public health messages at an early point, and also perhaps with the public health messages not cascading down to the community. In that respect, levels of literacy can be quite low in the community. In FFT, we know that 45% of our clients have said that they have no literacy or low literacy. Some of the health information that comes out, which is produced by NHS England, Public Health England and so on, will not resonate with the Gypsy and Traveller community—it does not have anything to show them that it is for them. When you are looking at something that may be very textbound—it is something that is passing them by.

Q39 **Tonia Antoniazzi:** Do you consider that to be the greatest barrier to improved Gypsy, Roma and Traveller health?

Michelle Gavin: It is one of the barriers. I think there are many barriers. Access to healthcare is still a huge barrier, which is sad, considering it is in the constitution, etc. I remember speaking to Jeremy Hunt in 2015 and raising the question of why there are so many mixed messages coming from NHS England and other Departments about registering. It is very clear that anyone can register at the point of entry there, but there are so many different messages coming down to clinical commissioning groups and frontline workers that it is almost like a barrier to stop people coming in. That is true for people who are living in housing too, not just people from the community who are living in impermanent accommodation or on the side of the road. There have been cases in the past where we have had to represent people where someone has said, "We are not taking you on our books, because we already have too many people with your

surname on these books." That is an actual case. I will not say the name, because it will obviously reveal them. But that access—with the NHS and the large institutions, there is definitely an amount of bias and racism that perpetuates within them, like any institution, whether witting or unwitting. Often when people try to register with a surgery, for example, they are told, "Oh no, you don't register here. You go to that surgery, because they 'specialise' in Gypsies and Travellers." That happens as well. If there is one surgery that is a really good practice, they are kind of sent there, rather than accepted in the surgery they wish to go to. So that is another barrier. There are many barriers, but those are some of the things that I think are really important.

Szymon Glowacki: The thing I am thinking about is the language, because we are also talking about the Roma. The majority of the Roma people we are working with do not speak English. That is a huge barrier. They struggle a lot. Most of them are illiterate or computer-illiterate. So they find it extremely difficult to register with GP services. They find it extremely difficult to make an appointment and to answer questions. It is crucial to know about this barrier, because they cannot access even the primary healthcare services, because of the language barrier.

Shaynie Larwood-Smith: I just want to make it clear—I think this is true for Michelle as well—that because we are frontline practitioners, the people we tend to work with are the most vulnerable of this community. Of course, there are community members who are perfectly able to negotiate and navigate, and do all this stuff that you need to do successfully in our modern world, but we work with the most vulnerable. I think Szymon makes a really interesting point about the digitalness of the world—I don't know how else to say it—and that digital gap is getting bigger and bigger. We see that with universal credit. You cannot ring somebody up any more and if you can't read, that is almost impossible for you to access. I challenge anybody to have a go at signing up for universal credit. There is a huge difference between being literate and being health-literate. The figures for poor health literacy are horrendous for the general population, let alone the community that we work with.

Dr McFadden: I just want to add something about the digital gap. Even to walk into a GP surgery for your appointment, you often have to sign in on the screen. The humiliation—the stigma—for somebody who can't do that and has to ask for help is enough to put people off.

Michelle Gavin: Most registration services will just hand you a leaflet or a bunch of papers that you have to fill in. So many people go, "Thank you, I'll take that home and do that," and then they never go back to that surgery. That has happened. I go round on sites and talk to people generally. So it is about form-filling as well. But also, we developed a health help card with the CCG in Brighton and it had the NHS logo on it and our logo. At the back it said, "I need help filling forms," "I want to see a doctor of my own gender," etc. and you could tick the little box. So many people in the community take that in now and use it, because immediately if you pass that over and they turn it, it takes away some of

the barriers of doing the registration, which still is a massive problem. If you have been turned away once you are unlikely to want to go there again. You will go to A&E because it's a great brand. It's welcoming. You can come in and you will be seen to.

Q40 **Eddie Hughes:** The ministerial working group on Gypsy and Traveller communities made five commitments on health. Have they been fulfilled? If they have, have they made any positive difference to the health of the Gypsy, Roma and Traveller community?

Michelle Gavin: What I will say about the ministerial working group—I think that is Inclusion Health we're talking about—is that it was really welcomed at the time. A lot of work was done and we were able to—

Chair: Can I encourage loud voices? We are competing with the traffic out there. Apologies.

Michelle Gavin: That's okay. The health board was set up to examine the obstacles and barriers faced by all of the vulnerable Inclusion Health groups, which is Gypsies and Travellers, vulnerable migrants, sex workers and the street homeless. Loads of work was done on the challenges around the needs of these groups and the need for practical guidance. The guidance came out, but when no one is driving the engine, the guidance sits on a very dusty shelf. That is what happens. I don't think the Inclusion Health board has sat for quite a few years now. I know it is still active if you go on to the website, but there has been nothing further driving this.

The Department of Health commissioned the Royal College of General Practitioners to provide guidance to NHS commissioners in light of the new duties in the Health and Social Care Act 2012. They put a report out, "Improving access to health care for Gypsies and Travellers, homeless people and sex workers", which was about a co-ordinated response and so on, but again, it sits there on a dusty shelf.

Shaynie Larwood-Smith: I would agree. It does not seem to be disseminated down. Unless, as a worker, I go and look for it, it does not seem to filter down. In fact, the written evidence for this was compiled about a week before and I only found out there was a call-out for it because a friend told me. It did not come through any kind of work channels.

Q41 **Eddie Hughes:** I'm hoping the health and wellbeing alliance, formed by NHS England, Public Health England and the Department of Health and Social Care, is doing a better job. How well is that meeting its aims?

Michelle Gavin: Friends, Families and Travellers, from the voluntary sector, is a member of the health and wellbeing alliance. There are 21 charities involved in that. One of the first items that came up was about Inclusion Health and how many of the other charities were aware of what Inclusion Health actually meant and which groups were in the Inclusion Health groups. As a result, we have worked together with the other charities and produced an audit tool, which will go live next week, for the voluntary sector to assess their practices with the Inclusion Health groups.

It gives tailored advice to organisations on how they can improve their practices across the board, including service delivery, governance, planning and strategy, human resources and communication. It has been co-produced with members of Inclusion Health groups, patients with experience and specialist services working with the Inclusion Health groups. It will be launched in the coming weeks.

As I say, FFT has been a lead partner with Homeless Link on that, but it is driven by the voluntary sector and it is for voluntary sector services. So that is the work that it has been doing, but, to be honest, I think NHS England, Public Health England and the Department of Health are big clunky organisations that tend to work in silos, and when you have a lot of silo working, some of those messages are not passed over to other departments within this massive organisation and things are missed or doubled up. Again, there are mixed messages, although I am hopeful.

The only other thing I can say is that, after Inclusion Health disappeared, Pathway, which is the Homeless and Inclusion Health faculty—we are part of that as well—picked up on continuing to produce good guidance and standards for commissioners. A new version 3 is going through some peer reviewing, but it is available at the faculty, and that includes Gypsies and Travellers, migrant workers, vulnerable refugees, etc., and sex workers. So there is a really good body of guidance, but again that is being done by charity.

Q42 **Eddie Hughes:** My next question is this: how is it helping community voices shape services and policy? I get the feeling that the answer is, "It's helping a bit."

Michelle Gavin: It is. I think the thing about the Health and Wellbeing Alliance is that it's really people-centred. It's so important to get that co-production in there. People don't want things done to them; people are experts in their own health. And having that co-production is really vital, because having that conversation with people—if you don't have that, you're missing out. You can't do something to somebody. You have to bring people on board, and come up with actionable recommendations that they find really important—things that are important to people's lives. With the Health and Wellbeing Alliance and the charities involved, it's really important that they are bringing that patient and expert practice and experienced voice in there.

Q43 **Chair:** Just before we move on, Eddie, may I ask a question? It feels to me like the ministerial working group's commitments in health were all about embedding the needs of GRT people into the key organisations, whether that is the health and wellbeing boards or the institute of health. How well has that actually worked in practice—embedding GRT needs into these important strategic organisations?

Michelle Gavin: I don't think anyone's been driving that. I think the problem is that there's been no scrutiny. If you go to a health and wellbeing board—

Chair: Sorry. There's been no—?

Michelle Gavin: There's not been a lot of scrutiny around it, because of localism as well. Each CCG and public health body are working together, but the actual fact that they are embedded on the health and wellbeing boards and in joint strategic needs assessments that are made, due regard is not—sometimes, there is a disparity of quality in those joint strategic needs assessments. You could have one line about Gypsies and Travellers, or you could have 250 pages. And without strong leadership on the health and wellbeing boards, sometimes that health inequality is just not even looked at.

It's quite difficult actually to have a voice on the health and wellbeing board. There is a statutory Healthwatch representative on there, but I believe that you could change that by having an accountable officer on the health and wellbeing board, who has to look at inequalities.

Dr McFadden: May I just come in there? Our research was looking at community engagement and we did some in-depth case studies. There are some good examples. Leeds would be one good example where there is engagement with the health and wellbeing board and with the clinical commissioning group. But I think it's too dependent on having a strong third sector or civil society organisation that is a focal point for that work and that can drive that work forward. As Michelle has said, it's too fragmented in other areas.

We did a sort of documentary analysis of our case study sites, and while all the health and wellbeing board strategies talk very eloquently about health inequalities and about community engagement, there is very little reference to GRT health needs, really. I think that, as Michelle says, it needs scrutiny and it needs a point of accountability.

Of course, one of the reasons that there is a lack of accountability and it is difficult to hold these bodies to account is the lack of good data on what the size of the population is in areas and what their health needs are.

Q44 **Eddie Hughes:** Cambridgeshire Traveller Health Team told us that community contact with the NHS is being largely developed through local personal relationships, rather than through a structured national one. Is that your experience?

Shaynie Larwood-Smith: Yes. I cover the whole of Cambridgeshire, apart from Peterborough—I don't know why that is—and as with so much that is successful within the world of health and government, it is based on personal relationships and building of trust. There doesn't seem to be any huge strategic driver, but I have got contacts now in the CCG, in most of our acute trusts, in the community trusts and with the GPs, one of whom has joined us. So it is very much done on a local level, and often developed through individual casework, and then it grows out of that.

Q45 **Eddie Hughes:** And you see that as a strength?

Shaynie Larwood-Smith: The reason I said I would come is because I can do fabulous work with individual clients and I can make people's lives better; I can make a difference on an individual basis, but that's not

enough. The whole system needs to meet the needs of this community better.

Eddie Hughes: So, it's a strength but it's a start?

Shaynie Larwood-Smith: Yes.

Q46 **Vicky Ford:** That leads beautifully into my first question. When commissioning bodies are commissioning services, what sort of challenges do they face for the community?

Shaynie Larwood-Smith: I would come back to the lack of data. It is really hard to commission something unless you know what the need is that you are commissioning to meet. Because of the lack of data it is really hard to prove that there is a need for a me. In the very long term, hopefully there will not be a need for me because the system itself will have changed sufficiently that they will not need a me.

Q47 **Vicky Ford:** But if community members don't come forward, how do you get that data?

Shaynie Larwood-Smith: At the moment in the NHS, even if a community member wanted to tell the receptionist at the hospital their ethnicity, it would not be coded anywhere, because it does not exist on the forms. They are unable to ascribe their ethnicity accurately and so they get lost in "White British".

An example is a small village in south Cambridgeshire. South Cambridgeshire is one of the best places to live in the country, apparently, and has really good health outcomes. But within that village there is a huge private site of Irish Travellers and they are lost; they are lost in all the data. I can tell you stuff but they are lost in all the data, so I can't prove the need.

Szymon Glowacki: I would say it is the same in terms of the Roma population. Usually, because of the discrimination faced in the countries of origin, they would not disclose their ethnicity. If they would say anything, they would rather say they are Polish, Romanian or Slovak, but usually they would not say that they are Roma. This is why there is a lack of data. We do not know the numbers of the Roma population in the UK.

Q48 **Chair:** That's slightly different from not coding it. That is not being willing to say because of prejudice.

Szymon Glowacki: Also there is not a box which you can tick and disclose your ethnicity.

Q49 **Vicky Ford:** You have been in Poland. Is the system in Poland the same or different ?

Szymon Glowacki: It is very similar but in Poland we are highly visible, so we do not even have to say that we are of Roma origin. Actually, there is not a box on any health forms—I checked—that may suggest that you are Roma or that you may tick and say that you are Roma. If we are born

in Poland, we have a Polish passport, Polish ID, we are Polish, but there is not anything about being Roma in any health forms.

Dr McFadden: I want to add to that to emphasise that we have to look at why people are not willing to self-identify as Roma or Gypsy Traveller. There are huge risks to people of doing so because of the stigma and discrimination, both within health services and day-to-day life. That impacts on whether you can get a job, rent a house, have a taxi come and pick you up and take you for your appointment, whether an ambulance will come to your site, and so on.

Shaynie Larwood-Smith: I think we have to allow people the opportunity to ascribe, because until we do, we won't know that they won't. Then, if they won't, we can work on that and tackle that. The 2011 census was the first that allowed people to identify as English Roma Gypsy or Irish Traveller and some people did. As a frontline-facing organisation, we went out and tried to persuade people and help them to ascribe, and explain the benefits of ascribing. But if they are not actually able to, they are certainly not going to, are they?

Q50 **Vicky Ford:** Every local authority has to have an up-to-date joint strategic needs assessment to guide those commissioning decisions. You have probably answered this already, but do you consider them to be adequate and appropriate for reflecting the needs of the communities?

Shaynie Larwood-Smith: My team actually came out of a joint strategic needs assessment in 2007. So, yes, that one; but the quality is immensely variable. It will depend. If the JSNA is looking at falls, it may not think about the specific differences for someone who lives in a trailer and cannot have safety rails put up because the walls are too flimsy, or cannot have safe steps put up because there is nowhere to fix the grab rail. They can be broad-brush documents that lose sight of the fact that not everybody lives in a house.

Q51 **Vicky Ford:** Okay. Where they collect more data and do not use those broad brushstrokes, are there more issues that we should take into consideration?

Michelle Gavin: I think the data should be disaggregated. In education rolls, they put Roma and Gypsy in the same category. That has to be clearly disaggregated, with different Traveller, Irish Traveller, Roma Gypsy and Roma. Otherwise you are not going to get the right picture, because each group has its own distinct ethnicity and culture around that. They also have different problems, although some come under the same umbrella. It is really important that the data is disaggregated.

Dr McFadden: I would just make a more general point. People get very disillusioned and cynical about having their needs assessed over and over again and nothing happening. Engaging with those processes becomes a pointless exercise in their view, because nothing ever seems to happen or to change. That applies more broadly than the joint needs assessments, to surveys and research. People are sick of talking about what their needs

are and nothing happening. There needs to be some action and some follow-up.

Q52 **Vicky Ford:** But clearly, as we have heard, there has been action: this particular unit was set up 10 years ago in Cambridgeshire. Are there more examples where areas have included the GRT communities in their JSNAs and it has had a practical effect? Are there more examples like Cambridge?

Michelle Gavin: Brighton is one. One of my projects is funded by the CCG as well. There is also Kent. There is a programme and they have bought in health champions—people from the community. Their JSNAs were very good. In south BANES—Bath and North East Somerset—a specific project worker for Gypsies, Travellers and boaters came out of the JSNA. So there are pockets of good practice, and it really works. The information and intelligence gathered will help to determine how local authorities and CCGs can develop their services to be inclusive and specific.

You have to take into account the review that we did on joint strategic needs assessments in the south-east. Only two of the 33 boroughs in London included a chapter on Gypsy/Travellers. Hounslow has produced a one-page briefing, and it was mentioned under "adult sexual healing". Sometimes it is difficult to find where they are in a JSNA. It could be under one section or another. There is no equity at all, and there does not seem to be a driver to say, "This is happening." Some local authorities will just say, "Oh! Have we got a Gypsy/Traveller community?" That is how problematic it is.

Going back to the data dictionary and getting that on there, the best chance people have to get people to enter their ethnicity is through health.

Q53 **Vicky Ford:** Alison, do you want to come back to that? You commented that people were fed up of giving evidence and then nothing happening. We have just had these examples of a number of areas where things did happen.

Dr McFadden: Yes, but like Michelle said, it is in pockets; it is not across the board. The other thing that I would like to say is that where there are good examples, we need to bring them together so that it is not all local and there is wider learning from those examples. We did as broad a literature review as we could around Gypsy, Traveller and Roma health needs and access to health services across Europe, but a lot of the information is not in the published literature that would be easily accessed. It is on websites, and sometimes it is not even accessible. Some way of bringing all those examples together would be really helpful.

Q54 **Chair:** Michelle, you just said the best way to get data might be through health.

Michelle Gavin: Yes.

Chair: If the little box was there and people could tick it, or whatever, you feel that that would potentially be the best way to get that data. Has there ever been any work done using third sector organisations to collect

data?

Michelle Gavin: Third sector organisations are another area. We have gone out—I think you said about voting and getting people registered to vote—with that service for the last census, which encouraged people to put their names down. We explained to them that this will not be—that this is a private area, and about informatics and data sharing particularly.

I did a small sample study in Brighton about informatics and being able to share information across services. Most people were unaware that that was maybe coming in and they would have to tick a box so that housing, for example, could automatically have consent to know someone's situation. When it was about their doctor or someone from the health service, people were really happy to reveal their ethnicity, but when it was someone from the council or children's services, they did not want it shared. That really worried them. In fact, I had a quote from someone saying, "We'd be the first people up if Hitler ever came back," because they would have that information. They were worried. I spoke to Jeremy Hunt about that as well, and he said Dame Fiona Caldicott was looking at that to ensure that there was good practice around that data sharing.

Q55 **Chair:** Commissioning bodies would say that resources are tight, so they cannot throw money at tiny communities and they need to look more holistically. How would you all respond to that?

Dr McFadden: I would respond by saying that in small communities, where we have already started today, there is the greatest need. Poor health outcomes cost the NHS a lot more than doing preventive work. If we can focus on the communities that have the most need, we will save money in the long run. From a research point of view, we need good data to be able to do robust economic evaluations that would provide the evidence for return on investment.

Michelle Gavin: Literally, the savings to the NHS—I have done some work on a case study scenario about how much money would be saved just by, for example, putting a Portaloo in and stopping someone having to constantly go back to A&E services for bladder infections that get worse. The cost-benefit analysis for the NHS of that scenario over a 10-year period, compared with the constant evictions that were going on and the disparity—it seems that there was more joined-up thinking. Looking at it over a wider area, rather than just focusing on one, would definitely improve things.

Local authorities are obviously budget-bound, but public health is very much on a postcode basis. If you live on a council estate in a deprived area, we know that there is more smoking, more of this, more of that and so on. Money is often put forward to patient participation groups to dig in, which goes to the same people. They are usually people from the middle classes who have the time and energy to sit on those groups and steer the CCGs and their local practices. Actually, some money should be put aside to focus on those inclusion health groups, particularly Gypsies and Travellers, to improve the engagement so the argument can be put

forward to say, "This particular client, because of their health problems, is costing this, but if we do this—" so we could really look at it in a more joined-up way.

Shaynie Larwood-Smith: We really need to remember how much money the community saves the NHS. The 2011 census said that they are the largest providers of unpaid care. I cannot think of any of my clients who are not cared for predominantly by family members. I think in my 10 years of practice I have known one family put a gentleman into a care home, and one family access care from outside the home—carers coming into the trailer. Even then, they were still predominantly cared for by their family.

Q56 **Tulip Siddiq:** Michelle, you have talked quite a bit about the experience of not being able to register with GPs. You mentioned about someone saying, "Oh, it's the same surnames." That is quite incredible. Is that the reason they were not allowed to register, or did they say, "It's overcrowded, therefore—"

Michelle Gavin: No, they said, "We've got too many of this surname on our books already, and we don't have to take you." That was actually with one of our support workers who went into the surgery, because we had rung them up the day before to check that there were spaces, and they did have spaces, and that happened. We obviously took it through the complaints process, but that was a terrible experience for this particular Traveller lady, and had a really bad knock-on effect. It was awful.

That is an indicator of people in housing. You can imagine going in if you are on the side of the road, and are trying to register with no fixed address. Even though we know you can, many surgeries will block that.

Shaynie Larwood-Smith: And even if you can register, if you then need tier 2 referrals or access with no fixed address, it really becomes difficult. Some GP practices are forward-thinking and will use their own address as the address for that client, and will then ring the client and say, "Right, your appointment has come—can you come and pick up your appointment letter?" However, that is not everywhere; that is about individual will within the GP practice.

Dr McFadden: We looked at this as well across our case study. These are not isolated; this is a common theme. Registering possibly came top of the list of barriers. We looked at GPs, and also at dentists. It is even more difficult with dentists. There are subtle and not-so-subtle ways that people are restricted from registering with GPs. Sometimes it is not having the right paperwork and documentation, or not understanding what is required for proof of address, or simply not being able to provide it. We heard cases where a surgery had asked to see a bank statement prior to registration.

The other issue is the move to punitive approaches when people miss appointments or are late for appointments. That applies to GPs and to dentists. Although that applies to everyone, I think it has a disproportionate effect on people who have greatest need, and who have

probably waited until their health problem is urgent, as Shaynie suggested, before they accessed healthcare. Also, some people cannot read the letters that are sent that tell them that they have missed the appointment, or when their appointment is. I think all of that has a real effect in putting a barrier up to healthcare.

Q57 **Tulip Siddiq:** Do you have any suggestions of how to tackle the barriers? I think it is astonishing that people are not allowed to register. Missing appointments applies to everyone; I do not know if there is much that we can do about that, just because of the strain on the NHS. Are there practices that we can put in place that tackle the fundamental issue for people who are travelling, and for those who are in accommodation? From what I can gather, the health inequalities are worse for people who are travelling.

Shaynie Larwood-Smith: *indicated assent.*

Tulip Siddiq: Is there something that you would suggest? I will go through everyone in the panel, starting with Michelle.

Michelle Gavin: When I first started working with Gypsies and Travellers there was no text-based service or anything like that to remind people of appointments. These days, people have phones. If you are street homeless, if you are a Gypsy or a Traveller, even if you have low literacy, you generally have a smartphone. Having those appointment reminders helps.

A lot of our clients get their appointments sent, particularly if it is from a hospital, in paper copies still. At FFT, many Travellers use our office address as a care-of address. All their correspondence comes to us—they could be anywhere in the country. If they get a changed appointment at a hospital, unless they are ringing us up within that timeframe they are going to miss that appointment. That is so common. GPs are getting better at the texted services, but at hospitals it is still very much paper-based. I think that is a massive problem.

I just want to add, before I forget, that when you do not have that primary care with a GP service you will miss out on things such as national screening as well. That is a massive problem. If you do not have that GP, you are not going to have the health checks that are offered. All of that preventative stuff is being missed totally.

Q58 **Tulip Siddiq:** Szymon, did you have anything you wanted to add?

Szymon Glowacki: I absolutely agree; there is nothing I can actually add. Although I am thinking of course of the language, because a lot of our clients are missing appointments. They are getting letters that, first of all, are in English, so they cannot understand. Secondly, most of them cannot read. Very often the appointments are cancelled for them and they cannot rearrange the appointment, so they are being taken off the waiting list.

Shaynie Larwood-Smith: I would agree. I seem to be working quite a lot with older members of the community and they do not have

smartphones. They have the old Nokia on a pay as you go, so it is very dependent on whether they have topped it up or can get their texts. They do not have contracts that allow them to get a zillion texts in a go.

So, actually it is a phone call. Ring them up and say, "Don't forget." I find that members of the community have amazing memories and street knowledge. I could not exist without my diary, but if you ring them up and say, "Don't forget: your appointment is next Wednesday at nine," they have that brilliant ability to retain verbal messages.

Q59 **Tulip Siddiq:** Szymon, you mentioned the language barrier. If they do call, does that solve the problem, if we ask for a call? You talked about the language barrier and people who do not understand English, I assume. If we took up the suggestion of people calling for appointments, does that solve the problem?

Szymon Glowacki: It could work in some cases but I am not saying in all cases. There are Roma people who have been in this country for 10 or 15 years, so they have a basic understanding of English. If you say Wednesday and 3 o'clock, I think they will be able to remember that.

But sometimes I think they get confused, especially if someone talks fast or talks about cancellation or adds some extra words. My suggestion is always to speak as simply as possible, so that they can understand, and double-check that they have understood.

Q60 **Tulip Siddiq:** Okay. Alison, do you think health inequalities are worse for families who are travelling than for those who are in bricks-and-mortar accommodation?

Dr McFadden: I don't think we have the evidence to suggest that. It is dangerous to think that this is just a problem of travelling because I think it is not. Most of the people we talked to lived on council-run sites and their health needs were every bit as great. We also talked to people who lived in brick- and-mortar housing and their health needs were great as well.

It is not just about transience, which is the term we prefer to use. It is not an all-or-nothing. Some people travel for part of the year and are settled for part of the year. In terms of accessing health, we found, similarly to what has been said, that text messages or a phone call help.

There are some very good initiatives that have health champions or health navigators who will support the community. They are often community members themselves who have done the training and are a bit more educated. They will attend appointments or work with people to help them navigate the health system.

The more flexible the services can be, the better. For example, we know of a GP practice in Sheffield with a Slovak Roma community that has drop-in sessions where they will attend to the whole family and to different needs. The children can be immunised, there can be antenatal care and so on.

That does work better. Those health champions or ambassadors can be present and help people.

One issue that came up a lot in our research was the role of receptionists in doctors' surgeries. Unfortunately, it mainly was not positive but there was a suggestion that we could reimagine the role of a surgery receptionist as a health navigator—someone who is there to help people understand the system. Then they can know who they need to phone to remind them of the appointment.

It is the same for dentists. The need for access to dental healthcare is huge. There has been very little focus on dental healthcare for Gypsy, Roma and Travellers.

Q61 **Tulip Siddiq:** That neatly fits with my next question. The research into GRT health seems to focus on certain public health issues, such as maternity care and immunisation. Are there important things that we are missing in healthcare? You have already mentioned dental care.

Dr McFadden: In terms of the specific health topics, I would say dental care and mental health. We ran a public and patient involvement event towards the end of our study. There were 20 members of the Gypsy and Traveller community in attendance and we asked them that very question. Their top three priorities were all related to mental health: the level of suicides, the amount of depression and postnatal and perinatal mental health.

Tulip Siddiq: I am going to ask the other panel members in turn. Shaynie, is there anything that you feel we have missed?

Shaynie Larwood-Smith: I am going to go with mental health. That would be my No. 1. We recently had a community member attend the suicide prevention training, and she said it really opened her eyes. It was a two-day training and she is going to disseminate that out to her site.

Szymon Glowacki: I would definitely say mental health, but also sexual health.

Michelle Gavin: Definitely mental health, and oral health. We did an oral health project and it was quite surprising what level some people were coming from on dental care. That is a big preventive thing. We had a specific Gypsy/Traveller worker from the community who went out and taught people with a toothbrush and taught what not to put in a bottle—there were things like custard in a bottle. We are going back a while, but some of the information that some of the very marginalised community members have around dental health is poor. A lot of children were literally having to have all their teeth taken out and then start again. I think that is something that is missing. It is really hard to get a dental appointment, not being from the community; so you can imagine how hard it is when you are in the community. We have a specific worker who is really good at getting people in. That is Brighton-based and Sussex-based, so there are pockets of things that work already.

Mental health is definitely up there. A lot of the clients I work with do not just have one condition such as arthritis, but may have arthritis, kidney problems and heart conditions. They have multi-complex conditions, and that will have a massive negative impact on their mental health. It certainly exacerbates it.

It is a difficult subject because there is a lot of stigma attached to mental health. I just did a piece of work in Brighton and I was really surprised. I asked Traveller men—the work was around suicide prevention and keeping well—and I have never, ever had so many men turn up to sessions. They were closed sessions with a therapeutic element, but they felt that the time was right to talk about the issues within the community, particularly for male Travellers. We know that suicide and parasuicide is high because of mental health issues. That was interesting.

Shaynie Larwood-Smith: I am seeing an increase in drug use in Cambridgeshire. Whereas alcohol used to be the choice, among some of the younger members of the community there seems to be an increase in drugs and novel psychoactive substances.

Dr McFadden: I just want to come back in with another couple of research priorities that are not focused on particular health needs. First, we need to know what works. There are lots of studies on what the health needs are, but we need robust studies on what actually works to improve health and to reduce health inequalities.

We also need a lot more work on cultural competence for staff, because a lot of the barriers are around misunderstandings. It is about training people to have the interpersonal and cultural skills to work with a whole range of disadvantaged groups, and to understand their own attitudes, prejudices and unconscious biases.

Picking up on the oral health, we saw a couple of really good initiatives. One is in Scotland, where they have a national programme called Childsmile, which brings together education and health so that the health messages about oral health are backed up in all nursery schools and in primary schools in deprived areas, where the children brush their teeth at school after lunch. There was a similar project in Sheffield with Slovak Roma in a primary school.

Michelle Gavin: I was just going to add something on talking about good ways to promote positive practice. That is really important. What we do at FFT is that we promote Royal Society for Public Health training. We are a delivery centre for two exams, which are the Royal Society for Public Health level 1 in understanding healthcare and level 2 in behaviour change and health improvement. We deliver culturally bespoke training to Gypsies and Travellers, free, and at the end of it they have the opportunity to take the examination, which is multiple choice. We are on hand to help with any literacy issues. At the end of that, the training that they have received embeds in them the ability to go out to the community and cascade the information about how to signpost people and how to initiate behaviour change and how to do brief interventions. So it is actually training the

community members up to deliver these health messages, which are all public health messages.

For many, often it is the first qualification that they have ever had, because a lot of Travellers that have come in to take this qualification have not had schooling or had limited schooling. It really is a fantastic tool that could be used to improve the health and wellbeing of Gypsies and Travellers across the country. I have just done an evaluation on the three-year project and the results are quite outstanding. I think that is really important—for community members to be able to pass on that information, not someone doing it to them, but allowing people from the community to be their own health champions and navigators. That is really important.

On health information, we were talking about health literacy. I think it is really important that that is co-produced with the community to make it relevant.

Szymon Glowacki: Absolutely. I remember at the beginning of our project we produced a leaflet about mental health conditions and the feedback from the community was not very good. Basically, they said it was too complex and they did not understand it. Especially in our language, Romani, we lack vocabulary to describe certain emotions and abstract things. You always have to communicate with the community and find out from them what they actually need.

That leads me on to what Alison was saying. It would be amazing to have bilingual advocacy—to have a member of your community in a GP surgery who understands you and your culture, all the taboos and all the issues you are facing. That could have a really positive impact on the communities.

Q62 **Tulip Siddiq:** I will come to Szymon and Alison for my final question. What do you think the specific challenges in supporting the Roma communities are, in terms of how different they are to the challenges in supporting the Gypsy/Traveller communities?

Szymon Glowacki: I would start with the language again. First of all it would be the language. Basically, they don't understand much. Secondly, they are not very well educated. As I was saying before, they lack specific vocabularies to express themselves. When we started our mental health project, we didn't say anything about mental health, because there is a big stigma attached to having mental health issues within the community. Roma people tend not to speak about any health issues in general. I would say that's another barrier.

Dr McFadden: This is just based on Slovak Roma in Sheffield, which is where we did our case study. Transience is an issue with this population as well. Although they don't travel in the sense that the Gypsy/Travellers might, they often go back to their countries of origin. We were focusing on maternity services, child health services and child dental health services.

Often they will go back to Slovakia to have their babies, but they don't always tell health services. So there is that kind of transience.

If there is the slightest hint that there might be social service involvement, they often disappear, either within Sheffield or back to Slovakia. That is an issue.

On navigating the health service, I think health services across Europe are very different from the NHS. Just understanding that you can't just turn up and expect to be seen other than at accident and emergency seems to be an issue.

Of course, there is the language. We were having this discussion. Often, the NHS cannot provide a Romani interpreter. They will provide a Slovak, Czech or Polish speaker, but that is still a second language, so there is a real issue there. That is why projects that use community members with that understanding and who can speak the same language can be more positive.

We were told by health professionals, rather than the Roma people themselves—I think there is a bit of caution around interpretation—that there is a misunderstanding that they might have to pay for health services, so they won't come forward if they think they might be charged. In terms of children's dental healthcare, there is a belief that the first teeth don't matter—I don't know whether that's true. Therefore there is a laid-back attitude about oral health in the early years, which of course has huge implications. I don't know whether that's a myth.

Szymon Glowacki: It is the same about healthy diets. I remember once working with a client, and the social services were involved. One of the concerns was a healthy diet for the children. It was a low-educated Romanian lady, and she had to go to a dietician to speak about healthy diets. They were talking about the ratio of carbs, nutrition and proteins, and at the end of the session she said, "A healthy diet for my child means that he has something to eat." That is one of the other barriers.

Q63 **Chair:** Let's move on to the next set of questions. Szymon, can I ask you a couple of things? You have talked about the lack of English language skills being a real barrier to improved health in the Roma community. Would improved English skills solve the problem, or are there other things too?

Szymon Glowacki: Improved English, right? A little bit. When I was consulting with the community members, they said they really would like someone to speak their own language as an interpreter. I may have misunderstood the question—I'm sorry.

Q64 **Chair:** No, that's okay. The solution may not be offering improved English skills. What you are saying is that getting somebody who speaks the language is more likely to be a solution.

Szymon Glowacki: Absolutely. Improving English would be brilliant, but I think it may take time, especially when it comes to professional jargon.

Even in a second language—Polish, Slovak or Romanian—they get lost. If there is professional jargon or medical terms, they do not understand it. They can improve their English a little bit, but to get to the level at which they are able to understand professional jargon will take ages. Having an advocate who speaks your language and can break it into chunks and explain it to you would be very beneficial.

Q65 **Chair:** A few moments ago, you referred to taboos. You used that word, so I am presuming you are using it in the same way I would to refer to things you don't talk about—socially unacceptable things. You talked about taboos within the community. You said that health issues are not spoken about. Are there are other taboos—things that are not spoken about—within a health context?

Szymon Glowacki: Absolutely. Mental health, substance misuse, pregnancy, sexual health—

Q66 **Chair:** What do you mean by pregnancy? You wouldn't say you are pregnant or you wouldn't want to talk about—

Szymon Glowacki: You wouldn't. Usually, a mother would know that her daughter is pregnant when it is highly visible. They wouldn't disclose to their mothers that they are pregnant.

Chair: Even in a settled family environment?

Szymon Glowacki: No.

Chair: Okay.

Szymon Glowacki: When we talk about Roma, we need to remember that we are talking about 11 million Roma around the world. There are many different tribes and different groups. Some of them are more old-fashioned, and the more old-fashioned Roma would not say anything about pregnancy. They would not disclose anything about having a mental health illness.

Some of the modern Roma families—a majority of them—would say they do not talk about health in general, so it is difficult. When we started our project, it was really difficult for us to talk about health in general.

Q67 **Chair:** Why?

Szymon Glowacki: Because what is inside your body is considered to be impure if you are not well. It is just considered impure in our culture.

Q68 **Chair:** Impure or weak?

Szymon Glowacki: Impure. If you have a mental health illness, you might be perceived as a weak person, but talking about your body and your health is considered to be impure.

Dr McFadden: There are parallels we can see in the Traveller community as well. With a lot of people there are a lot of taboos. Some people will not

use the word "cancer" because they think that if they say it they will get the disease. Body parts can be challenging.

Q69 **Mr Shuker:** I just want to drill down into the data issue, which you have all alluded to in different ways. Practically, what difference would it make if we recorded the GRT terminology when people present for healthcare?

Shaynie Larwood-Smith: We would be able to focus our interventions more accurately on a commissioning level, on a big strategic level. The data is one of my favourite hobby horses. On an individual basis, working with my individual clients, it probably would not make much difference, but on a big national level, even on a county council level or on an NHS level, you cannot commission for what you do not know. You cannot go and do cultural competency in a hospital that does not even recognise that it might have a Gypsy/Traveller community that it serves. You cannot make change until you can prove need, is my feeling.

Q70 **Mr Shuker:** So would I be right in thinking that you would find it more possible to argue for the provision of services if you could show that data?

Shaynie Larwood-Smith: *indicated assent.*

Q71 **Mr Shuker:** Do you think there would be more people around the country in a role similar to what you do within Cambridgeshire if we took that data?

Shaynie Larwood-Smith: I am a little Pollyanna and I live in hope. Actually, eventually, there should not be a me, because the system should be flexible enough to enable the clients I work with to access the healthcare they need in the same way as everybody else.

Q72 **Mr Shuker:** That is really helpful. There is also a range of opinion, even within the community, around whether specialist services is the most appropriate model or whether it reduces the barriers to general healthcare.

Dr McFadden: I can—

Q73 **Mr Shuker:** I was going to say I am sure all of you will have an opinion on that.

Dr McFadden: I can talk to that. I think there is space for both. The risk when you focus on specialist services, or dedicated services, for Gypsy, Traveller or Roma people is that it becomes more stigmatising. It risks providing a substandard service. I am not saying that Shaynie provides a substandard service, but there are examples of outreach services that are substandard. It allows people in mainstream services to say, "We don't need to worry about Gypsy, Roma and Traveller people because Shaynie is dealing with all that," and therefore they are not getting the full range of services. Also, it often depends on developing trust with an individual or a small group of individuals, and that is where you might need to start. But when that role disappears because somebody decides we can't afford Shaynie any more, or Shaynie retires or decides she wants a change, all

that trust is lost, and we have not built up the trust with the mainstream services, so we are almost back a step. So we have to look at both. Where there are specialist services and a lot of need and mistrust, that is the only place you can start, but there has to be a plan or a strategy as to how you move mainstream services to provide the care that is needed.

Q74 **Chair:** It is quite interesting. If you look at trust levels across different sectors, medics have some of the highest levels of trust. Why is there a difference nationally, I would say, within the UK? Why would there be a high level of trust nationally, but a particular deficit within the GRT community when it comes to the provision of NHS medical services?

Dr McFadden: I have just spent three years studying this and there are lots of different reasons. One is fear and past experiences. Sometimes that's fear that's built around a personal experience, so you have had a personal experience of having a hostile reaction, being spoken to rudely, being refused a service, or you have had an experience where the doctor hasn't listened to you, has dismissed your concerns and has got the diagnosis wrong. There's the personal experience.

You might have your very close-knit community; your friends or your relatives have had that experience, and then that becomes a story. They're spread by social media. Historically, there's even worse, so there's a cultural memory about health services. So that all has a huge impact on trust.

Then there are all the things that we've been talking about. There's the general discrimination and stigma that means that people are generally distrustful. One of the quotes from one of our Gypsy mothers was, "We're always mistrustful, because we don't know whether they're out to get you or to help you," and I think that's the kind of frame of reference. And if every time you access health services, you see a different person, you never have that opportunity to build up the trust.

I would say that the most successful service, from our work, was in maternity service, and particularly where there is a move to continuity of care, such that I would say that the current maternity service policy is to provide continuity of care for everyone in England, Wales and Scotland. So, if that's the mainstream service, that will work for everyone.

Q75 **Chair:** That is quite a challenge, isn't it, when we meet the NHS, to say—what you're basically saying is that the discrimination that people suffer within the NHS means that they mistrust the NHS? They might trust the individuals, but they are mistrusting the NHS. There is an institutional issue.

Dr McFadden: Yes. There are two kinds of trust. There is interpersonal trust, where you trust the person that you know, and there is institutional trust, and we have to build from one to the other.

Q76 **Mr Shuker:** On the issue around specialist services and reducing barriers

to all services, is there anyone else who wanted to say anything briefly on that, before I move on?

Michelle Gavin: I think third sector organisations can be a bridge into mainstream services, and they do that successfully, because if you have got a trusting relationship with a group of Gypsies or Travellers, for example, you can bridge them successfully into mainstream services, by being supportive. Maybe enhanced social prescribing—that type of thing.

The general consensus is that most people want to have equity of provision; that's the deal. People want to be treated the same as anybody else. When you have these pockets that grow up—Shaynie is a great example. She does brilliant work. And in Brighton as well, we have a homeless healthcare specialist that has homeless healthcare, and Gypsies and Travellers. Of course everyone says, "Oh, you go to register," and they'll say, "Oh no, just go down to Tim Worthley, down there, because he specialises, and he knows about the culture."

I think the problem is that you should know about other people's cultures; it's respectful, from whatever culture you come from. So, to have a level of cultural competency is really important. And I think you said something earlier about, you know, you've got to look at yourself as an individual, and say, "What am I doing wrong, actually? I'm not getting through to that person." Of course, with big organisations like the NHS, there are going to be levels of discrimination in there, as with any institution.

Q77 **Mr Shuker:** I have just got two other areas and probably about two more minutes. And they are quite big ones. But if there is any insight that you want to offer—the first, and we have obviously touched on this, is around mental health provision. Are there any particular specialist needs that need to be met there? And the second one is around social care; you referred to that, as well. If anyone would like to offer anything to me on that, that would be helpful.

Shaynie Larwood-Smith: Can I talk about social care?

Mr Shuker: Yes, of course.

Shaynie Larwood-Smith: I can give you lots of case examples where, actually, if the social care budget could be spent more flexibly to enable appropriate accommodation to be provided for the client, they would not be blocking a bed and we would not be trying to force people from their site, from their family networks, from their care networks into housing where, inevitably, their mental health will decline. We need to be able to think outside the box about a way to provide a wet room for somebody, which we would do if they lived in a bungalow. Just because they live on a site in a trailer surely does not mean that that money should not be available. We could use it to put a deposit down on a chalet that would then be paid for by housing benefit, but the delivery cost and the deposit are so prohibitive that you cannot actually do that, so somebody gets discharged home to very inadequate accommodation and they end up back in hospital. We need much more creative thinking about that pot of

money, which is meant to enable people to live independently and well in their own home, whatever the shape or form of that home.

Q78 **Mr Shuker:** On that, presumably, the good intention behind that is to provide really good-quality provision, sturdy facilities and so on, but you are saying that that can sometimes be a barrier to the flexibility and the lifestyle of someone who wants to live in that way.

Shaynie Larwood-Smith: Yes, and I think there is an inability to see that if you invest £1,300—to be precise—in the delivery cost and the deposit, that person will be cared for by their family, which is what they all want. If you do not invest that—I had to go and beg a charity to get it—the person will not be able to come home from hospital and will end up in a care home. For the sake of £1,300, which is less than a month's care in a care home, we could have—and I did, but it took me 10 months. In that 10 months, the person was back and forth to hospital, which would have been entirely unnecessary, if I could have just laid my hands on £1,300, to be precise.

Michelle Gavin: Around personal health budgets and social care budgets as well, there needs to be more flexibility about who is giving those budgets out, about indicative budgets, and about how they are managed. One of my clients in Brighton is a Traveller man. His health meant that he had to come off the road. He really needed some support, but he did not want support from outside the community, because he had early-onset dementia and he did not want to have to constantly explain what his culture was about.

We were successful, because we did a pilot with NHS England, in securing him a personal health budget where he could employ people from the community to deliver competent services to him. It was through the NHS and it worked really well. He was able to choose people—interview people—from his community and the budget was managed by a third party. That is really successful, and it can be successful in adult social care and for care needs too, but there is a lot of culture push against giving money to people within the community to actually provide those services. People quite rightly want to be cared for by people who have knowledge of their culture and an understanding of their customs and traditions as well.

It is really important that that type of personal health budget is looked at and made easier for Gypsies and Travellers to access, particularly Gypsies and Travellers who may not have the ability to manage the budget themselves, but could use third-party management. Looking at it in more of an innovative way would make a big difference.

Shaynie Larwood-Smith: Some of that does happen in Cambridgeshire.

Q79 **Mr Shuker:** That is really helpful. Lastly, on mental health, are there any particular specialist requirements or needs to commission for that you perceive in the community?

Shaynie Larwood-Smith: I am a general nurse, and I would love to be able to ring somebody up and say, "I think this about this person. What do

I do? Where do I go? Am I right in thinking this about this person?" Just a point of contact within the organisation who has some awareness of the cultural differences, so they are not going to say, "Well, they need to ring up the triage, and then they could do some computer-based improved access to psychological thingy"—someone who will actually get the community, and who can give me the advice that I need.

Mr Shuker: Okay.

Dr McFadden: A slightly more general point on that is that cross-sectoral working is a key, so that you bring together at a strategic level the mental health services with the general health services and any specialist services. We had a good example of this in Scotland, where the health and equalities committee for a health board had a subgroup for Gypsy/Traveller health. That brought together all the sectors.

The other thing is that fear around social services removing children is really high in this community. A lot of their experiences reinforce it and they are very worried about disclosing information and who it will be shared with. If you disclose, for example, any domestic abuse scenario or a mental health problem, will that information be shared with social services? Will you have a social worker knocking on your door the next day, looking at your children? That is a fear.

We had an Irish Traveller who had disclosed a coercive kind of control scenario. She had had support and she had moved on from that—I think it was five to 10 years ago. Still, every time she engaged with health services, that was on her record and people asked her about it—even an ambulance that came because her child was ill asked about the situation that she had had. That fear is reinforced.

Michelle Gavin: Absolutely, and I think a lot of people who I work with do not seek any support for their mental health issues until their children are grown up. It seems to be a lot of slightly older individuals who come in for support, after not having that support for so many years. We know that early intervention is really helpful. Of course, there are barriers, because the fear is real and perceived. My husband, when he was alive, was put into care for a short time for being a Traveller. There are historical issues, and they go round the community very quickly, so people are very cautious about being honest to their doctor about mental health and having medication. It is really worrying.

Dr McFadden: It applies to the Roma community—fear of children being removed.

Q80 **Chair:** Could I press you a little on what interventions would improve mental health in Roma communities?

Szymon Glowacki: I would say definitely raising awareness, but in two ways: educating the Roma community about mental health illnesses, what services are available, and making sure that they access mental health services, because that is very difficult for them. At the same time, by educating the health professionals—cultural awareness sessions for health

professionals—they will have a better understanding of the Roma culture and why there is such a big stigma attached to having a mental health issue in the community. They are really afraid of being marginalised in the community.

Mr Shuker: Thank you.

Chair: I thank you all very much indeed for coming along this morning, and for taking so many questions from us. It has been incredibly helpful. Your evidence will form an important part of the report that we will write at the conclusion of this inquiry. We will now close this evidence session.