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A Targeted Health Needs Assessment of the Eastern European Population in Warrington

Executive Summary

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BACKGROUND

This needs assessment aimed to understand the health and wellbeing needs of Eastern European migrants who live in Warrington. This was done by;

1. Reviewing current evidence about health needs of Eastern European populations in the UK and identifying any health interventions aimed specifically at Eastern European populations in the UK.
2. Exploring health attitudes, beliefs and knowledge of healthy living among Eastern European populations in Warrington.
3. Exploring knowledge and experience of health and wellbeing services among Eastern European populations in Warrington.
4. Identifying barriers to accessing health and wellbeing services experienced by Eastern European populations in Warrington.

In order to address points 2, 3 and 4, a qualitative data were collected from 61 members of the Eastern European community in Warrington. The majority of participants were Polish but the sample also included participants from Belarus, Hungary, Latvia, Russia, Slovakia and Ukraine. The majority of participants spoke English but focus groups included some participants with very little English. The focus group participants translated for each other and therefore we have included the views of many people who struggled with English. Three different data collection methods were used:

- Five focus groups (35 participants)
- Five one-to-one or small group interviews (7 participants)
- Two community engagement events (19 participants)

Data were also collected during a stakeholder meeting with 11 individuals who worked in statutory, health, council and 3rd sector organisations. Further information was received from three stakeholders who did not attend the event.

The findings of the literature review, qualitative data from engagement with the Eastern European community and the stakeholder findings are summarised below. Recommendations are also provided.

SUMMARY OF KEY FINDINGS

EVIDENCE REVIEW

The national evidence on the health of Eastern European communities living in the UK is mainly focused on epidemiology, rates of illnesses and language issues. Little research has focussed on the experiences of these communities in relation to public health and what would encourage more healthy behaviour.

The national evidence base shows that, when compared to the UK-national population, Eastern European populations have: poorer mental health; higher mortality dues to heart attacks and stroke; higher levels of obesity; increased risk of sexual ill-health; higher smoking rates and higher lung cancer prevalence. Evidence is mixed on rates of alcohol and drug use in this population. These health inequalities are compounded by poor or insecure housing, low pay, isolation, unemployment or underutilisation of skills and prejudice.

Barriers to accessing health services included language problems, not understanding the UK health systems and lack of money, as well as cultural differences such as differing prescribing practices and frustration with the GP referral model (as opposed to directly accessing specialist care). There are very few published evaluated interventions aimed at Eastern European populations.

STAKEHOLDER ENGAGEMENT EVENT

Stakeholders reported that the Eastern European population in Warrington mainly reside in the more deprived areas and, in addition to a well-established Polish community, there are newer Belarussian, Bulgarian, Czech, Hungarian, Lithuanian, Latvian, Romanian, Slovakian and Ukrainian populations. The stakeholders involved in the engagement event also suggested that the latest available census data on the Eastern European population in Warrington did not reflect their own experiences of the community and the majority believed these data are likely to underestimate the size and diversity of the population.

Stakeholders discussed how the health needs across the Eastern European population would vary and that it was important to acknowledge these diverse needs. Smoking and drinking prevalence was thought to be higher in the Eastern European community. Poor mental health and wellbeing was considered an important issue, particularly for young males who had moved to the UK alone who could experience loneliness and social isolation. Stakeholders felt many people would not access mental health services until they reached "crisis point" due to the stigma attached with mental health amongst Eastern European communities.

It was widely believed that there was a good range of appropriate services available in Warrington but that there was a need to engage with the Eastern European population to promote these services and encourage attendance and appropriate use. Signposting between services needs to be improved and increased.

It was felt key barriers to accessing services included: language; lack of trust in service providers and law enforcement; cultural differences in service delivery and health messages; stigma associated with mental, sexual and alcohol dependency services and, immigration status.

Community cohesion and engagement was believed to be key to ensuring that the Eastern European population and service providers understood cultural differences in health beliefs and healthcare systems and to enable individuals to self-manage their health and access services when appropriate.

IN-DEPTH QUALITATIVE DATA COLLECTION

The main issues raised by members of the Eastern European community related to their experience of General Practice and their dissatisfaction with the service they receive. Few participants understood the concept of public health and most participants were unable to discuss health beyond their experience of the GP.

The majority of participants believed that the Eastern European population is healthier than the UK-national population; this was due to healthier diet and more active lifestyles. Use of alcohol, smoking and drugs was thought to be similar to that of UK-nationals.

Participants felt mental ill-health was a taboo subject in the Eastern European community and not a topic people talked about. Participants talked about how, in their country of origin, most people could access a psychologist or psychiatrist directly if they wanted to and did not need GP referral. Most participants thought people would try to deal with mental ill-health themselves or may talk to family or friends. Participants thought few people were likely to access a mental health service. However it was suggested that any mental health services needed to include health professionals who speak their language and ideally have a similar cultural background to the patient. This would put them at ease and allow more relaxed communication.

Language was thought to be a barrier for some people, especially when needing to discuss complex or sensitive health topics. Some participants had used interpretation services but many relied on family and friends to translate. Language was thought to be a barrier mainly when people first moved to the UK as language skills improved once they had lived in the UK a couple of years. Interpretation and translation services were thought to be less important than seeing a health professional from the same country as oneself. The ease of communication, shared culture, body language and facial expression of someone from the same country was discussed as being very important. Many Polish participants expressed disappointment that there were no Polish GPs working in Warrington.

Although the participants described that they now understood the UK health systems they had found it confusing when they first moved to the UK. They had not been able to find any official literature (from the council, Department of Health or GP) about the UK health services available and relied on advice from friends and work colleagues.

All participants were registered with a GP and most fully understood how to access primary care and secondary care. However the majority of participants were dissatisfied with the system and expressed frustration at not being able to access secondary or acute care without a referral from the GP. The GP themselves was seen as a barrier to access with participants feeling their GP was too powerful and sometimes obstructive. There was a lot of discussion about how this differed to the ease of access to services in their country of origin. There was a lack of awareness which public health and prevention services could be accessed without GP referral.

All focus groups and six out of seven interview participants were unhappy as they felt the GPs did not take their health complaints seriously and usually suggested paracetamol and rest. They felt GPs in the UK were disinterested in their patients and not as competent as the doctors they saw in their country of origin. Interviewees referred to the GP in terms of their health and wellbeing needs, therefore many were not able to talk beyond their experience of primary care and the difference between prescribing practices in their country of origin and the UK. For some participants this distrust in their GP discouraged attendance at their GP.

Although not included on the discussion guide, pregnancy care was brought up by all focus groups. Antenatal care was thought to be inferior to the care received in their country of origin. All four focus groups discussed how pregnant women were unable to have as many scans in the UK and they expressed frustration that the system stopped them receiving the scans they wanted. Gynaecological care was discussed by many women who felt frustrated they were not able to access annual cervical screening like in their countries of origin. Most participants were unaware that sexual health services offered many of the services that are offered by gynaecologists in their country of origin.

Participants reported that, although waiting times at A&E were too long, they had a generally positive experience of hospitals. Most Polish participants thought dentists in the UK were not as well trained or competent as dentists in Poland. Although they took their children for free dentistry in the UK, many adults accessed the dentist when they returned to their home country on holiday. Few participants used pharmacy services.

It was challenging to lead participants to discuss topics beyond their dissatisfaction with primary care, hospitals and dentists. There was limited understanding of wider public health and health promotion and participants struggled to discuss these topics.

KEY FINDINGS FROM THE ENGAGEMENT EVENTS

TRIANGULATIONS OF FINDINGS

The findings form the various research components were triangulated to enable identification and exploration of common themes.

HEALTH PROMOTION AND PREVENTATIVE HEALTH SERVICES

Most participants found it difficult to discuss public health and preventative services; there was little understanding of these types of service and for most they understood healthcare as only the services provided by the GP and hospital. Most participants talked about smoking and alcohol in relation to how many people engaged in these behaviours; when questioned about support to reduce drinking few felt this was something a service would help with. Alcohol problems were thought to be something a person sorted out for themselves, however there was more interest in and acceptance of smoking cessation services.

Few participants were able to offer an opinion on what could make mental health services effective; few participants knew anybody with mental health problems, they felt it was rarely talked about and that people tended to sort out problems on their own. However the literature shows a high prevalence of mental health problems in the Eastern European migrant population in the UK (Toni et al 2010; Patel 2012). Participants felt the Eastern European community was unlikely to use mental health services, however any counselling or support services needed to be provided by a professional who spoke their language if they were going to be taken up. Evaluation of a smoking cessation service in Crewe has shown a Polish speaker providing support increased uptake and effectiveness of the programme (Eida and Ehata 2010).

Lack of trust in their GP seems to be acting as a barrier and may stop Eastern European population from seeking help for issues like mental health or for help with smoking or alcohol. This may be exacerbated by their experience that their GP is reluctant to refer them to a specialist. The data we have collected show that this population does not prioritise preventative healthcare and would rarely access services to help with mental health or alcohol, this is even less likely if they would have to request this from their GP. It was not clear to participants which services they could access independently of their GP and they were unlikely to seek out any additional health care services independent of their GP. To encourage access to public health and preventative healthcare services (i.e. IAPT, sexual health, smoking cessation, drug and alcohol services) potential patients need to understand the care pathways in place that do not need GP involvement.

Dissatisfaction with being unable to access gynaecology services may be due to lack of understanding of what are offered by sexual health services. Differences in terminology may contribute to this as in the UK most women will not regularly see a health professional with the job title ‘gynaecologist’. However in the UK many women receive ‘gynaecology’ services from their GP, community contraceptive clinics and the genitourinary clinic. Promotion of sexual health clinics as providing many of these ‘gynaecology’ services could improve access for Eastern European women.

PRIMARY CARE AND SELF-CARE

Although we found a small amount of literature about dissatisfaction with GP attitudes and prescribing practices, this was by far the main issue focused on by participants in this needs assessment. We did not ask any direct questions about medication and participants started discussing GPs as soon as they were asked the initial questions about their understanding of health and being healthy. Throughout the focus groups and interviews the conversation regularly returned to primary care and prescribing, even when researchers were asking unrelated questions.

The majority of participants focused their discussions on dissatisfaction with primary care and prescribing practices. Almost every participant reported they regularly felt their GP did not take their concerns seriously and advised them to 'take paracetamol and rest'. This caused a lot of frustration within the Eastern European community and many participants spoke about how their friends and colleagues reported the same experience. Although this issue is mentioned in the wider literature, the importance of this to the Eastern European community in Warrington cannot be understated. Many participants reported their GP had refused to prescribe antibiotics when requested and they felt very frustrated by this; some thought the GP was trying to save money. The literature also highlights a lack of understanding of the appropriateness of antibiotics in the UK national and Eastern European population (ECDC 2014) and specific work needs to target the Eastern European community in the UK to reduce antibiotic resistance.

This difference in ethos and approach to healthcare is causing distrust in their GP which creates barriers and can stop patients accessing other healthcare services. If a patient feels dismissed and not listened to by their GP they are unlikely to approach their GP for support for issues such as mental health, alcohol or smoking cessation.

Although some of this may be due to actual GP behaviour, their perception of disinterest and dismissal by their GP suggests the problem is twofold. Firstly the Eastern European communities appear to access GP services for issues and illnesses that can be treated at home or by a pharmacist. Experience in their country of origin may have encouraged individuals to attend their GP for all health concerns and participants reported more varied medication being prescribed; more promotion of self-care needs to be targeted at this population. Secondly the GP needs to promote the importance of self-care and the efficacy of paracetamol. The affordability and availability of paracetamol seems to suggest to people in the Eastern European community that paracetamol is a very basic and ineffective drug.

SERVICE DESIGN AND GP AS GATEKEEPER

Although the literature shows Eastern European migrants to the UK do not understand the UK health system and use inappropriate services this was not the case for the participants in this needs assessment. The majority of people we spoke to are registered with a GP and understand the role of the GP in the UK health service. However, as mentioned in the literature, the GP was often seen as a barrier; they were seen to hold the power to refer for specialist services and many participants talked about having to 'prove' how ill they were before they could be referred. This general role of the GP is different to the family doctor in many participants' country of origin and the majority of participants expressed dissatisfaction with this.

The literature states this dissatisfaction and frustration is a result of not understanding the UK health system, however we found good understanding of the UK health service amongst the participants. Therefore it is not that they do not understand the system, it is that they do not like it and think it is inferior to the system they are used to. The reasons for the design of the UK health system and the ethos behind the NHS need to be communicated and explained including what is appropriate use of primary, secondary and acute health services. On top of this the role of the GP also needs to be better communicated to ensure that people understand the GP has very broad training and can treat the majority of illnesses and most patients do not need to be referred to a specialist.

Although the majority of participants with whom we had conversations at the engagement events reported a positive experience of their GP, when this was discussed in depth in interviews and focus groups the majority of participants revealed they were unhappy about the service they receive from their GP.

RECOMMENDATIONS

HEALTH PROMOTION AND PREVENTION SERVICES

1. Public health messages around healthy eating, alcohol consumption, smoking and drug use need to be consistent and inclusive across the whole Warrington population particularly in the most deprived wards. Ensure that messages are translated into the appropriate languages and are visible in areas that are accessed by the Eastern European population. Build on existing campaigns such as The Five Ways to Wellbeing or Happy Sad Ok and translate these into key Eastern European languages.

2. Consider adapting current smoking cessation services to ensure promotion is in the appropriate languages and appears relevant to Eastern European populations. The published literature suggests that smoking is higher among Eastern European migrant populations in the UK; however opinion on smoking prevalence among study participants was mixed with some citing cost as a limiting factor. Both the published literature and study participants agree that Eastern European populations would be unlikely to access smoking cessation services; although awareness of such services and stop smoking messages seemed fairly high. Findings from a smoking cessation pilot for Polish communities in Crewe (Eida and Ehata, 2010) could be used to inform this development.

3. Promote sexual health services as an appropriate alternative to gynaecology services. Different terminology and expectations of service is leading many Eastern European women to feel they cannot access any gynaecology services without referral to a specialist by the GP. Promote what gynaecology services are available within sexual health services in Warrington and promote Warrington Centre for Sexual Health as a holistic service, not just for the treatment of STIs.

MENTAL HEALTH SUPPORT

4. There are a good range of mental health services available in Warrington many of which have signposting/self-referral mechanisms in place. However, there is a need to engage with the Eastern European population to promote these services and encourage attendance and appropriate use. Exploring existing models, such as Wellbeing Mentors, will ensure that the Eastern European population are supported in accessing the services they are signposted to.

5. As stigma, shame and distrust of their GP can stop some people accessing mental health services, pathways need to be as simple as possible to ensure potential users do not feel they have barriers to overcome to access services. Warrington Psychological Services (IAPT) accept self-referrals; promote this to the Eastern European community so they understand they do not have to ask their GP for a referral.

6. Explore the feasibility of employing wellbeing mentors or psychological wellbeing practitioners who speak Eastern European languages, especially Polish. Health professionals who speak Eastern European languages were thought to be more important and approachable than translation services, this is particularly important when discussing sensitive and distressing mental health issues.

7. Consider ways in which social isolation can be reduced particularly among young, single males. This could be through the introduction or funding of formal Eastern European organisations/support

services/social groups. Currently the only formal organisations are church and school based which may not be appropriate for some younger people.

8. Increase support for employers and recruitment agencies to recognise mental health problems. Some evidence from participants, stakeholders and literature shows that young males who are more isolated suffer higher levels of mental health and that this topic is not frequently discussed in the Eastern European community. The workplace may be a key setting to intervene, so ensure that HR in big employers like warehouses and recruitment agencies are prepared to respond and recognise mental health problems. The latest DH Mental Health Policy document (Closing the Gap, 2014) recommends that employers not only promote workplace wellbeing but also improve information available to managers so they can recognise the signs of stress and mental health problems and talk about them with staff.

HEALTH SYSTEMS IN THE UK

9. Increase communication around how prescribing and medication is approached in the UK. This is especially important around the practice of self-care, recovery from viral illness and the benefit of paracetamol for many ailments and illnesses. The effectiveness of paracetamol needs to be more clearly communicated and people made aware that, although cheap and easily available, paracetamol is highly effective for many health conditions. Our needs assessment found that this lack of communication appears to be causing distrust in GPs for the majority of the Eastern European population we spoke to. Although this was mentioned briefly in the literature this is a key issue for the Eastern population in Warrington.

10. There needs to be clear promotion of self-care and signposting to appropriate services, including when it is appropriate to visit a pharmacist or your GP. The promotion of self-care, self-management and independence across the population is a key role of the Director of Public Health under the Coalition Government's vision (DH, 2010). Promote the importance of self-care and the role of the pharmacist in treating minor ailments, coughs, colds and high temperatures. Specific promotion could link in with the NHS self-care week campaign which runs from 17th-23rd November 2014 and encourages individuals to 'Be healthy this winter'. Translate the levels of care information and promote to Eastern European communities. Promote the NHS Choices website which includes translation into many different languages, and advice for visitors to the UK.

11. Develop printed information about antibiotic resistance in key Eastern European languages explaining resistance, differences between bacterial and viral infections and reasons for not prescribing antibiotics. Reducing antibiotic resistance is a key concern both nationally (CMO, 2014) and internationally (WHO, 2014). Provide information sheets to all GP practices to ensure patients understand why they are not being given antibiotics and why paracetamol is often appropriate. These should be provided as standard as many Eastern European people will not challenge the care they receive when they feel the GP has tried to appease them.

12. Encourage GPs to engage with activities for European Antibiotic Awareness Day (EEAD) on November 14th and in particular to ensure these activities are relevant, accessible and visible to Eastern European populations in Warrington. Evidence from this needs assessment and the literature suggests that

expectations and misconceptions about antibiotic prescribing in General Practice are particularly high amongst the Eastern European population. The CMO encourages all GPs in the UK to join the EAAD pledge and make use of the online resources (CMO, 2014) and this presents an ideal opportunity to raise awareness among the Eastern European population in Warrington.

13. Increase understanding of the role of primary care in the UK and referral systems to secondary care. This needs assessment found that many members of the Eastern European population do not understand the role of primary care in referral to other health services. GPs should provide clear communication about referral pathways and the timescales involved. Continuation of translation services across appointments is needed.

14. Develop a website about health services in Warrington that is available in multiple Eastern European languages (or with a Google Translate button as a minimum) to include information about UK health systems design, the role of the GP and antibiotic resistance. The website would not necessarily contain information about specific services but could link to the NHS Choices list of services. The site should include detailed explanation about why patients cannot access all secondary care directly, which services they can self-refer to (especially highlighting mental health, smoking cessation, sexual health and drug and alcohol services) and the effectiveness of paracetamol. Widely promote the website to the Eastern European community in Warrington. Lancashire Council has produced a website and information pack for migrants new to the area. (Available at: www.Lancashire.gov.uk)

15. Train health care professionals, especially GPs, on the differences between health systems and culture around medication. This would enable them to more effectively explain why they may not be prescribing antibiotics, explain the effectiveness of paracetamol and explain why the patient cannot make an appointment directly with specialist services.

16. Improve monitoring and recording of country of origin and migrant status of patients accessing healthcare and social support services. Currently most monitoring computer systems only collect ethnic origin which often does not capture whether a patient is of Eastern European origin. Improving monitoring would allow services to understand the population using their services, where they are not meeting the needs of specific groups and where they need to target services. Housing associations are collecting this information about their tenants and use it effectively to target and improve their services; this could be used as a model for collecting data within statutory and third sector organisations.

17. Building on the experience of this needs assessment, effective communication channels for health promotion and promotion of services include; Polish Saturday School, selected recruitment agencies, SureStart centres and groups, Warrington.pl online forum, leaflets within the Polish section and computer areas of Warrington Library and the church.

LANGUAGE AND TRANSLATION

18. Look at ways to increase the number of primary care health professionals who speak Eastern European languages, particularly Polish, working in areas with high numbers of Eastern European migrants. This should include GPs and nurses. This could be achieved through including Eastern European language as a desired skill on a job description and advertising directed at the Eastern European community to encourage applicants who happen to be bilingual.

19. Look at ways to increase the number dentists in Warrington who speak Eastern European languages, especially Polish. This is especially important for NHS dentists as cost is another strong barrier to use. This could be achieved through targeted recruitment of bilingual staff. Dental practices with bilingual staff should actively promote this on their websites.

20. Ensure interpretation services are easily available, well-advertised and accessible. Highly visible advertising (in multiple languages) should be displayed in GP waiting rooms, IAPT, in hospital entrances and on practice websites.

21. Review language line contracts to see if this interpretation service can be unified under a single contract. Set a minimum requirement in all service specifications to ensure that interpretation services are available across all services including smaller community organisations.

22. Ensure all letters about personal screening (such as cervical, breast and prostate screening) include information about interpretation services as standard.

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