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The incidence of common mental health conditions and wellbeing concerns increased during the COVID-19 pandemic.**1** A shift to remote access and consulting within general practice has led to fears that quality of care has decreased for many groups, particularly for migrant communities.**2** Numbering over 2 million, people from Central and Eastern Europe (including Poland, Romania, Lithuania, Ukraine, Bulgaria, and other countries) constitute one of the largest foreign-born communities across the UK.**3** Despite this, their health needs receive relatively little attention from the media or policymakers.

SETTING THE MENTAL HEALTH SCENE

Central and Eastern Europeans in the UK are more likely to live in inadequate housing, have physically demanding employment, lack financial security, and have limited support networks compared with UK nationals.**4** Rates of common mental health conditions are disproportionately high, including anxiety, mood disorders, alcohol misuse, and suicide.**5**,**6** Healthcare models within Central and Eastern Europe differ to the UK, including the option for direct access to specialist services through commercial providers.**7** Patients' expectations for a doctor-led consultation style, rather than shared or self-care, can lead to dissatisfaction with UK general practice.**8** Further differences in expectations include the inacceptability of non-physical assessment, assessing fitness to work, and thresholds for referral to secondary care.**7**,**8**

Central and Eastern Europeans infrequently attend general practice with mental health concerns, including prior to suicide, and may see diagnosis as an inappropriate medicalisation of distress.**5** Even when mental health or wellbeing concerns are recognised by the clinician and patient, views on their management often differ. The National Institute for Health and Care Excellence suggests consideration of cognitive behavioural therapy, structured physical activity, and/or a selective serotonin receptor inhibitor for common mental health conditions.**9** Engagement and implementation of psychological therapies requires more than a working command of English. Non-verbal and contextual communication skills, including sociocultural references, are essential for meaningful application and made more difficult by remote consultation. A predominantly working age population means that appointment times for psychological therapies often clash with work or family commitments. Non-collection rates for mental health prescriptions are high.**5** Such management options can fail to treat a perceived underlying reactive cause.

Alcohol is commonly used as a coping mechanism for poor mental health, particularly by men. Where finances permit, some individuals travel to Central and Eastern Europe for familiar and direct access to consultant-led services, avoiding perceived GP gatekeeping, waiting times, and language difficulties (if present). Alternatively, social networks are used to covertly self-access medication, or talking therapies with private, potentially unregistered psychologists in the UK or via video call in Central and Eastern Europe.**10**

BREXIT, COVID-19, AND THE CONFLICT IN UKRAINE

Over the past 20 years, Central and Eastern Europeans have had lower levels of engagement, service satisfaction, and trust in general practice when compared with the wider UK population.**8** Interactions with primary care have been described as frustrating and inadequate, shaped by multiple system barriers. These include, but are not limited to, translator availability when booking appointments, follow-up or expressing health needs,**11** requirements for documentation, and appointment timeliness. Any of these factors can delay care and worsen mental health outcomes.

Brexit and the COVID-19 pandemic have heightened feelings of insecurity, discrimination, and rejection for Central and Eastern Europeans. Brexit has resulted in residency status, support networks, healthcare provision and financial situations becoming uncertain.**6**,**12** Despite settled status offering uninterrupted NHS access, many individuals are reluctant to seek help from UK authorities or state organisations, including Roma, trafficked,

unregistered, homeless, alcohol/drug dependent, and socially dependent individuals.**12** The conflict in Ukraine has created further urgency for general practice to understand the mental health needs of Central and Eastern Europeans.

RECONCEPTUALISING SERVICE PROVISION: HOW CAN GPs RESPOND?

In the face of such challenges to care quality and continuity, how should GPs respond? The *Lancet* commission on culture and health describes health as *'inseparable ... from culturally affected perceptions of wellbeing'*.**13** Culturally appropriate mental health management requires consideration of how cultural competence, health inequalities, and communities of care overlap. Within general practice, we propose a reflective and culturally empathetic approach to the doctor–patient relationship, reconsidering consultation methods and structures of care.

Reflexivity and cultural empathy

Reflexivity is the examination of one's own (healthcare) beliefs, judgements, and practices.**14** The personal identity, role, and worldview of a GP has the potential to shape the clinician–patient relationship during a consultation and thus its outcome. GP recognition of their own worldview and how this impacts the consultation is a precursor for open and ongoing consideration of the patient's situation and perspective, reducing risk of stereotyping or prejudice. Intercultural empathy requires recognition that the patients' health beliefs may stem from prior culturally different medical encounters. Many people identifying as being from a Central or Eastern European nation share sociocultural, political, migration, and healthcare experiences. It is important to recognise commonalities in health perspectives, including consumer-led, medicalised, and specialist-focused health expectations.**7** Exploration of patient needs and circumstances within this ethnically and demographically diverse population should be explored through the lens of their individual and shared culture and experiences.

Reconsidering consultation approaches

Culture influences a patient's understanding of mental health conditions and its management. Values of compassionate care, respect, and patient dignity are culturally transferable. Further research is needed into UK resident Central and Eastern Europeans'

views of wellbeing, mental health, and management approaches within UK general practice. Taking an active interest in the culture and norms of people from Central or Eastern Europe can facilitate adaptation of consultation and verbal/non-verbal communication approaches to be compatible with what they perceive as effective care (**Box 1**). There is a need to develop consultation models for cross-cultural mental health. Codesign with Central and Eastern European stakeholders, policymakers, and clinicians is required to ensure relevance and deliverability within the time and resource constraints of primary care.

Evaluating structures of care

Care extends beyond the consultation. Central and Eastern Europeans' cultural, social, health system, and clinician experiences differ from the UK general population, and predispose them to being an underserved group.**15** Standardised mental health and wellbeing strategies in general practice risk inadequately addressing their health beliefs and needs. A multilevel 'whole practice' approach incorporating community members would support recognition of barriers and facilitators to access and provision of high-quality mental health care. This could incorporate training packages in knowledge transfer, systems review, and active linking to shape practice change.**16** Examples include exploring: receptionists' role in negotiating service access for patients from Central and Eastern Europe; GP awareness and perspectives on culturally sensitive wellbeing services and brief interventions; and primary care networks' delivery of complex social and psychological interventions for Central and Eastern Europeans.

CONCLUSION

Central and Eastern Europeans form a numerically large, yet underserved patient group in UK general practice. Mental health needs are less likely to be presented to a GP, despite a high prevalence and likely exacerbation due to Brexit, the COVID-19 pandemic, and the conflict in Ukraine. The health expectations of Central and Eastern Europeans often differ from the UK general population; this risks disagreement and dissatisfaction within GP consultations. Greater consideration of how general practice can adapt mental health support through reconsidering service design, consultation, and communication approaches is required. Doing so would improve the quality and experience of GP-delivered mental health care for both Central and Eastern Europeans and their GPs.

References

1. Pierce M, Hope H, Ford T, et al. Mental health before and during the COVID-19 pandemic: a longitudinal probability sample survey of the UK population. Lancet Psychiatry 2020; 7(10): 883–892.

2. Turner A, Morris R, Rakhra D, et al. Unintended consequences of online consultations: a qualitative study in UK primary care. Br J Gen Pract 2022; DOI: https://doi.org/10.3399/ BJGP.2021.0426.

3. Sumption M, Walsh PW. EU migration to and from the UK. Oxford: The Migration Observatory, 2020.

4. Tankelevitch L, Bunn S. Shift work, sleep and health. London: Houses of Parliament, 2018.

5. Gorman D, King R, Czarnecka M, et al. A review of suicides in Polish people living in Scotland (2012-2016). Glasgow: ScotPHN, 2018.

6. Chojnacki S. Psychological wellbeing of Polish migrants: what is the role of the NHS? London: University of East London, 2020.

7. Poppleton A, Howells K, Adeyemi I, et al. The perceptions of general practice among Central and Eastern Europeans in the United Kingdom: a systematic scoping review. Health Expect 2022; DOI: 10.1111/hex.13433.

8. Osipovič D. 'If I get ill, it's onto the plane, and off to Poland.' Use of health care services by Polish migrants in London. Central and Eastern European Migration Review 2013; 2(2): 98–114.

9. National Institute for Health and Care Excellence. Depression. 2022. https://www.nice.org.uk/ guidance/conditions-and-diseases/mentalhealth-and-behavioural-conditions/depression (accessed 15 Jun 2022).

10. Patel K, Bosqui T, Kouvonen A, et al. Unmet need for mental health medication within the migrant population of Northern Ireland: a record linkage study. J Epidemiol Community Health 2021; 75(3): 245–250.

11. Whitaker KL, Krystallidou D, Williams ED, et al. Addressing language as a barrier to healthcare access and quality. Br J Gen Pract 2021; DOI: https://doi.org/10.3399/bjgp22X718013.

12. Zawacki SG. A sense of injustice: experiences of the Central and Eastern European Roma in accessing UK health and public services. Durham: Durham University, 2019.

13. Napier AD, Ancarno C, Butler B, et al. Culture and health. Lancet 2014; 384(9954): 1607–1639.

14. Chew-Graham CA, May CR, Perry MS. Qualitative research and the problem of judgement: lessons from interviewing fellow professionals. Fam Pract 2002; 19(3): 285–289.

15. Riggs E, Gussy M, Gibbs L, et al. Hard to reach communities or hard to access services? Migrant mothers' experiences of dental services. Aust Dent J 2014; 59(2): 201–207.

16. Dowrick C, Chew-Graham C, Lovell K, et al. Increasing equity of access to high-quality mental health services in primary care: a mixedmethods study. Southampton: NIHR Journals Library, 2013; DOI: 10.3310/pgfar01020.

Box 1. Effective care for patients from Central and Eastern Europe

Consultation structures	● Critically appraising patient-centred consultation structures and communication styles ● Consider acceptability of remote consultations
Avoiding medicalisation of distress	● Avoiding medicalisation of mental health symptoms ● Recognising personal limitations in experiential understanding of causative and potentially unrelatable social pressures
Acknowledging health benefits	● Recognition and validation of prior healthcare experiences ● Proactive exploration of common perceived causes and risk factors for poor mental health (such as employment, accomodation, finances, alcohol use, and social isolation) ● Considering the appropriateness/acceptability of medication or psychological therapies
Structures of care	● Taking steps to minimise barriers to care throughout the healthcare system (such as appointment booking, timings, follow-up, and referral) ● Reviewing access and quality of interpreter services