How practices can facilitate access for the gypsy traveller community

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In brief

- Provides dental professionals with more awareness about the traveller community.
- Provides tips on how to communicate and treat this community more effectively in a primary care setting.
- Highlights health inequalities in the traveller community and discusses reasons why these exist.

Gypsy travellers have poor health in comparison to the UK average. They may struggle to access emergency and routine dental care because of social, educational and cultural barriers. General dental practitioners can facilitate better oral health within the community by improving access, which may require some adaptation to conventional practice. This paper discusses the experiences of a practice within West Oxfordshire and highlights areas in which the authors have found small modifications to aid appointment attendance and patient motivation. Primary care dental practitioners come across a wide variety of patients from very diverse backgrounds. Following a year working in West Oxfordshire, one group of patients has particularly stood out – the travelling community. The term 'traveller' or 'gypsy' refers to 'persons who wander or travel for the purpose of making or seeking their livelihood (not persons who move from place to place without any connection between their movements and their means of livelihood)' and includes those who live permanently or temporarily in settled housing. There are many different socio-cultural groups within this broad definition, including Romany Gypsies, Irish Travellers, Scottish Travellers and Eastern European Roma Communities.

Background

Oxfordshire has an estimated 678 travellers[1] although there are between 150,000 and 300,000 within the UK.[2]This figure is most likely an underestimate as many travellers are reluctant to disclose their identity for fear of discrimination.[3] These Oxfordshire residents are spread across thirteen authorised sites, six of which are permanent council-owned sites and the remainder privately run. The site located most closely to our rural Oxfordshire practice is privately owned Bampton.

Bampton has an undisclosed number of pitches and therefore the number of residents is not readily available. It is owned by a private landlord who allows gypsy residents to settle long-term at the site; it is not known whether the landlord is himself from the travelling community. These Bampton residents are relatively 'lucky' in comparison to the 20% of travellers who have no legal place to stop their caravan and are considered homeless, living on unauthorised sites.[4]

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Health demographics

The World Health Organisation on Social Determinants of Health discussed the prospect of 'closing the gap' in health inequalities within a generation in 2008.[5] It is well established that the general health of the travelling gypsy community is worse than that of the UK average, as demonstrated by data summarised in Table 1.

Providers of healthcare have traditionally struggled to engage with traveller communities, as there exists a fundamental mistrust of health services and healthcare personnel by the communities.[12] Decreased trust leads to reduced utilisation of services, poor health behaviours and reduced quality of care.[13]

Barriers to accessing healthcare do include mobile lifestyles,[14] however this does not account for poor health in settled travellers. Cultural barriers include normalisation of ill health and pride in self-reliance.[15]

Young people from the travelling community leave school at an average age of 12.6 years, in comparison to the UK average of 16.4 years.[8] Lower levels of education mean that 'simple' tasks such as reading health instructions for medications can be difficult, and this is further complicated by the fact that many parents within the community will not be able to help.

Changing attitudes

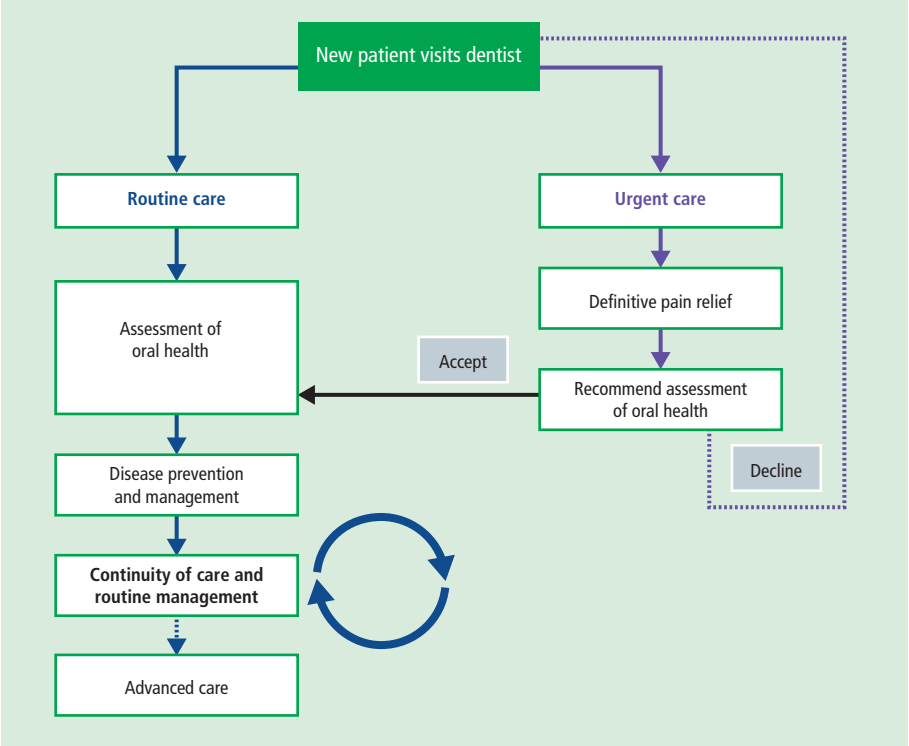
In order for the dental profession and our patients within the travelling community to have a mutually beneficial relationship, attitudes on both sides need to change.

It is particularly difficult to establish a substantive professional relationship with patients of the community when they are seen solely during urgent appointments. The formation

Table 1 General health measures in the gypsy community and UK comparators

	Travelling community vs UK comparators
Life expectancy[6]	Females = -11.9 years
	Males = -9.9 years
Mortality rates[7]	350% increase
Health status rated as poor[8]	30% vs 14%
Presence of long-term condition[8]	42% vs 31%
Measles rates[9]	100 × higher incidence
Infant mortality[10]	4 × higher incidence
Anxiety and depression[8]	39% vs 13%
Suicide rates[11]	3 × higher incidence

Fig. 1 Demonstrates the 'proposed patient pathway'. Reproduced with permission from J. Steele, *NHS dental services in England*, NHS, 2009



of an empathetic and constructive dialogue is hindered by the significant distractions of dental phobia and pain. Professor Jimmy Steele discussed the 'proposed patient' pathway in his 2009 Independent Review of NHS dental services; see Figure 1.[16] This pathway demonstrated that patients may either attend for routine or urgent care. Those of whom have attended for urgent care may not want to progress into routine dental care. This is a choice we must respect, despite it being potentially frustrating for the dental professional. However, we should try to encourage urgent patients to attend for routine care, and must make them aware of the benefit of services that are on offer to them.

Transgenerational beliefs within the community are strong. Fear and experiences of previous generations still resonate and inhibit current patients from taking advantage of treatments offered to them. Anecdotally, following an examination on a young child and his mother I explained that the child would need numerous restorations and extractions, suspecting they would only tolerate this with inhalation sedation. This is something the mother became distressed about and refused referral as she stated her husband knew of a child who died following 'gas' for dental treatment. As dental practitioners are aware, there has not been a death from general anaesthesia in a UK dental practice since it was banned in 2002. This conversation highlighted to me that despite the huge improvements in the safety in dental sedation in recent decades, the knowledge of past adverse events still prevents consent from the older generations for younger patients' care.

For many Romany gypsies the concept of 'marime' is fundamental, particularly as it applies to personal hygiene. 'Marime' relates to being polluted in both a moral and physical sense.[17] Romany patients may find being treated by a non-Romany healthcare worker, particularly a female, a risk to their own purity, and so reassurance about the sterility of equipment such as needles always being used only once may be integral in gaining their trust.

Practice modifications

Our aim as dental professionals is to help patients achieve optimal oral health. To effectively treat the travelling community we need to modify our approach to better suit their specific needs. After discussions with matriarchal figures within the community it was highlighted to me that a few simple measures could increase engagement with dental practitioners. The following is an explanations of how we have implemented changes to suit the community better within our practice:

1. High levels of illiteracy within the community, estimated up to 90%,[18] mean that usual text/email reminders are fruitless. As a countermeasure we have tried to ensure all known traveller patients are identified by reception staff within 24 hours of their appointment, and are prioritised for phone call reminders to verbally confirm appointments
2. High illiteracy rates also indicate there may be complexities with relatively 'simple' tasks – such as reading medication instructions or signing consent forms. It is therefore essential these are discussed verbally. Patients should be reassured that if they need further assistance regarding how to take medications, for example dosing schedules, they are able to phone the surgery or speak to a pharmacist
3. Difficulties in ability to tell the time can also result in conflict between the community and dental practices. Patients can often arrive very early or late to appointments,

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Box 1 Hints and tips for the general dental practitioner on how to engage with the gypsy travelling community

- Consider using verbal methods of appointment reminders
- Be flexible with appointment timings
- Highlight 'cosmetic' benefits of completing treatment plans
- Discuss improvements in the safety of treatments, such as sedation
- Arrange exam appointments after pain appointments

and if they are refused appointments can feel isolated or rejected enough to limit future engagement with the service. If possible we have aimed to schedule appointments around the dentist's lunchtime, to try and cause as little disruption as possible and provide a degree of flexibility

4. Limited health knowledge can mean the traveller community see little benefit in primary prevention or treating disease which is not causing pain. First-hand experience suggests it is easier to encourage these patients into routine preventative and restorative care by highlighting the 'cosmetic' benefits. Examples of such include emphasising the importance of fresh breath for social interactions, and offering restoration of numerous carious lesions before placing a resin-retained bridge in the aesthetic zone. Young adolescents in particular are interested in orthodontic referrals, for which numerous prevention appointments can be justified before a referral can be made. By improving their oral health understanding and status before their primary concern is addressed, we increase the knowledge within the community as the information is likely to be disseminated
5. Following urgent appointments the patient should be encouraged to book an exam within a relatively short time frame, whilst the experience of negative health outcomes is still present. This has proven to be the most useful tool in my practice to encourage patients to want to engage in a course of treatment.

Box 1 summarises the proposed changes that any general dental practice within the UK could make to engage this community more effectively. Of course, depending on the region, there may be variation in gypsy attitudes to health and their level of education, which may influence the extent to which modifications may be necessary. Practice-based training about the particular needs of this community would be valuable, to ensure the whole dental team are aware of the need for flexibility.

Conclusion

In the UK, even though our population is very diverse and oral health is generally good, there are still some patient groups who are less likely to access care and have poor oral health. We as general dental practitioners have a duty to provide care to our local communities, of which the gypsy travellers are a part. Through a different approach, encouragement and increased engagement we can help to reduce reluctance to seek dental care. The adoption of simple measures by practices can facilitate access and help ensure future generations of gypsies and travellers benefit from the increased quality of life that good oral health can provide.

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