OVERCOMING BARRIERS BETWEEN RESEARCHERS, PRACTITIONERS AND COMMUNITIES

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The general health of a community largely relies on health care access, policies and practices in place, as well as the use the community makes of such health cares. As the community evolves, so do their needs in terms of health care. It is crucial to be able to evaluate, study and readjust policies and practices in order to better meet the needs of the community. As the title of this paper implies, researchers, practitioners and health care users should all be equally involved in the identification of the needs, establishment of policies and evaluation of the practices. However, evidence shows that it is not always easy to make these three worlds work together. The purpose of the present paper is to expose the barriers that we have encountered during our study on access to health care in English in the Eastern Townships and the strategies we have used to overcome these barriers.

As a first note, I'd like to underline the fact that the population studied in our research has particularities that may not apply elsewhere. In this area, the vast majority of the population speaks French but there is historically well-implanted English-speaking community of Canadian natives. Approximately 40,000 people's first language is English. Many individuals communicate using various degrees of bilingualism (English-French). In fact, they represent an average 8% of the population (Floch & Warnke, 2004). The Eastern Townships' area is not a region of extremely active immigration; therefore the non-English speaking population is quite homogeneously made of French speakers. Institutions offering general or mental health care are, for the most part, operated by French speakers and there is no identified "English-speaking" health institution like we can see in Montreal (Office of the Commissioner of Official Languages, 2008). A survey conducted in 2010 for the Community Health and Social Service Network (CROP Inc., 2010) showed that 87.2% of Anglophones believed that it was important for them to receive health services in English, and that there was a serious lack of services offered in our region, especially in the public sector[1]. An expected consequence of this was that only 36.8% of the Anglophones of our region said that they were satisfied with the services offered, while the provincial average is of 45.9% (Stout, Charpentier, Chiasson, & Fillion, 2009). A second particularity in our region is that the elderly (65+ year-old) represent a large portion of the English community[1] (CROP Inc., 2010). Ageing, having a generally lower level of education, lower income and more frequently relying on governmental aid, people belonging to the English community are, therefore, more exposed than others to health problems and may require more specific health services. Thus, it is important to keep in mind the specificities of the studied region and that all the barriers or solutions identified may not apply to another kind of situation.

Our study had three main goals: 1- Establish a portrait of the services offered in English 5 years after the study of 2007; 2- We also wanted to identify potential linguistic and communication barriers between users and practitioners and 3- Determine if communication barriers had an

[1] On 3195 participants, health services were available in English in private clinics (76.6%), CSSS (63.6%), 811 (38.3%), Emergency rooms and walk-in clinics (512.3%), hospital stay (62%).

influence on the level of stress in the English-speaking population. We can first state that we identified communication barriers at all levels of this study, namely barriers between researchers and the community (users), barriers between researchers and health practitioners and barriers between the community and health practitioners. We will treat these barriers in order and present some possible solutions.

Barriers between researchers and health care users

The first unexpected barrier that we faced when the study started was largely based on a misconception of our role as researcher. While some users were very delusional about our roles and saw us a bit like saviors, others would, in contrast, project their dissatisfaction and disenchantment on the researchers. In the first case, we had to deal with people thinking that we would help them find a family doctor or obtain a quicker appointment /place in an institution. In the second case, we found health care users who took our research as a mean to express their frustrations towards the health care system. Our communication strategy had to be adjusted accordingly in order to overcome this barrier. First, we clarified the role of independent researches and the historical benefits that have been made possible thanks to previous studies. Secondly, we obtained a better collaboration of health care users when we gave them information or oriented them to the right resources (explained procedures to find a family doctor, provided phone numbers that were often easy to find on Internet but not known by these users). Last but not least, we started to work a lot with local associations (Townshippers, Reading groups, etc.) who are very active and brought forth the benefit of trust from the English-speaking population in our region.

The other kind of barrier we had to overcome was a political one. Part of our study involved both French and English speakers. The recruitment of French-speaking participants wasn't always easy in a context where language is a sensitive matter. French-speakers expressed the fact that they saw no need to specifically study access to health care in English in a francophone province. People also expressed the fact that we should first seek to fix this universal problem (access to health care) for the majority before "losing our time and money" for a minority. We had to build a good communication plan with interventions (in French) on local radios and newspapers. Overall, the level of participation increased, but recruitment remained a big issue for our study. We managed to obtain 600 participants in total, with almost 50% of Francophones.

Barriers between researchers and health practitioners

This kind of barrier was rather administrative and political. It has been extremely difficult to reach employees of institutions providing health care. A previous study conducted by researchers of our team showed that institutions offering mental health care tended to rate their offerings in term of linguistically adapted health care at a much higher level than what users rated them. We felt that there was some resistance to allow researchers to evaluate their offerings.

Barriers between health care users and providers

In our study, we were able to identify some specific barriers between the English-speaking users and the health practitioners. While the first difficulty cited to access health care was waiting time for both Francophones (54%) and Anglophones (75%), the language barrier came second (31.8%) for English-speakers, before the non-availability of the service (25% for English-speakers *vs* 50.9% for French-speakers). Several questions in our questionnaire were particularly

informative about the nature of the barrier. In particular, English-speakers expressed a fear of having to speak in another language with the practitioner and the fear of being judged because of their language. Compared to French-speakers, English-speakers expressed more difficulties to obtain information about health services, to request and obtain an appointment with a physician or a mental health specialist in their mother language. A lot of analysis remains to be performed with the data collected, but we were at least able to identify some of the barriers between the health system and its users.

Next, a section of our questionnaire was meant to permit the participant to propose one or several avenues that may, in their opinion, improve the system and help overcoming these barriers. Surprisingly and interestingly enough, the possible solutions proposed by English and French-speakers were different. For instance, the second most cited solution cited by French-speakers was the use of "ad hoc" interpreters (relatives or friends who can accompany the user and translate – 34%), a solution that appears satisfactory enough at low cost. The use of official interpreters was cited by 24% of the French-speakers. For the English-speaking health care users thought this kind of avenue was cited in only 6% (ad hoc interpreter) and 10% (official interpreter) of the cases and did not appear as a satisfactory solution. The recruitment of English-speaking practitioners or the training of health professionals in English was by far the preferred solution of English-speaking health care users (56% and 73% respectively) compared to French-speaking participants (12% and 56% respectively). Interestingly, the ASSSE, who establishes policies and practices, is mostly composed of French-speakers but consults English-speaking health care users regarding this specific problematic (Agence de la Santé et des Services Sociaux de l'Estrie, 2011); our observation highlights the critical role of such consultations.

In conclusion, our study of access to health services for linguistic minorities in an official language led us to discover unexpected barriers between researchers, practitioners and health care users. These barriers are likely detrimental to the functions of the health system and may well have a significant impact on the level of health in these minorities. This aspect will be explored with further analysis of the data collected. On a more positive note, it seems that a lot of these barriers are due to misconceptions and defective communication, and may therefore be relatively easily overcome.

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