

## 4

# Unemployment and health: the development of the use of PRA in identified communities in Staveley, North Derbyshire

Teresa Cresswell

### • Aims

This study aimed to meet with unemployed workers in the Staveley area of North Derbyshire. Staveley is an urban area, where unemployment rates are 40% higher than the National UK Average. The study aimed to:

- identify personal risk factors for cardiovascular diseases, and enable people to address those factors to reduce the risk;
- enable unemployed workers to discuss health difficulties specific to unemployment and low income; and,
- promote a greater understanding of the specific health needs of unemployed people and people on a low income.

It was clear that health services were not meeting the needs of unemployed workers. Thus the study was geared towards trying to match needs and services more effectively.

Our greatest resource is human beings. But we do not work with people, we work on people. Why do people not use the services which are available? What do they really want? We provide structures of health services, but take away the ability to communicate.

### • Methodology

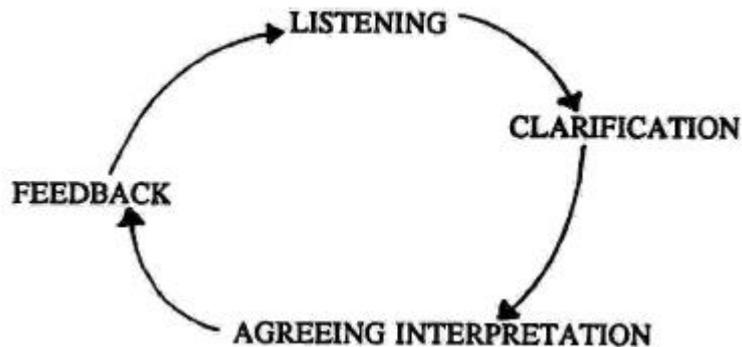
My approach was to break the community down into 'manageable patches'. I asked key people to help me identify the different sections and needs of the community. This was done on the basis of deprivation levels, such as levels of

unemployment; single parenthood; uptake of health services; car ownership; housing; child abuse/family difficulties. These were a combination of criteria based on deprivation levels and on the community's own perceptions.

Key people whom I identified included professionals in education, health, social services (including home helps), police (who had a very narrow perspective), clergy (who were excellent), and the housing sector. Key people from the community also were included, such as elected councillors (excellent), shopkeepers (again very good, because they knew who was buying what kind of food), other people of influence and community leaders. Finally the community themselves were divided into the elderly, middle aged, parents, children, group members, disabled, males, females. This was in recognition of the different needs of all these different groups.

When I first met with managers in the health authority, education, social services and so on, they wanted me to ask a long list of questions. They wanted immunisation rates, statistical data, disposable incomes and so on. I had to persuade them that statistics were irrelevant to the study and that disposable income could not be found out in any case, because of the black economy in the area. I managed to focus the study onto questions based on the differences between perceptions of the community and those of the professionals about the health problems of the area.

In each interview, I spent one hour approximately on the following:



I also used video, although it does make people a bit nervous because they feel they have to put on their best frocks and look smart. But it is a very good medium for taking back to the board room. I have also used tape recordings, although those can also be a bit difficult. Photos are good at prompting discussion. Maps too have been useful, to help people point out problems around the estate.

Those involved in the study also had an opportunity to test their own health by filling in a health profile questionnaire. This covered areas such as personal health, stress symptoms and a diet check. They could also have their blood pressure checked.

- **Different perceptions of the problems**

Whilst professional perceptions of the problems were based on overall disadvantage, community perceptions were based on splits between different factions of the community. One example of such splits concerns housing. Housing in the area was originally built for coal-board employees. However there have been mass job losses in the neighbourhood. Thus the estates now largely house unemployed people. Whilst previously, when everyone was at work in the mines, there was work-mate peer group pressure to maintain the general upkeep and behaviour on the estate, nowadays all that has changed.

Nowadays the borough council is in charge of the estate. The new people who have moved onto the estate are unemployed and are

therefore looked down on by others. The elderly dwellers put all the blame of the present problems of the estate on these newcomers. They say they are unmarried, have wild children who create havoc and that they have brought the estate a bad name.

Thus whilst the professionals go on about general deprivation in the community, causing stress and so on, the estate dwellers themselves point out the immediate practical problems which they face, such as no phone boxes, inadequate street lighting and no community centre. When I asked "*If you could, how would you...?*" some very good answers came up.

- **Different perceptions of solutions**

Having established the difference between perceptions of the problems, I went on to find out about different perceptions of possible solutions. I began by asking professionals how they think they might improve upon their present working methods. The curious thing was that, while the professionals are really committed to working with the community, they are never asked how they might change to improve this. As far as the community were concerned, they said they did not know the professionals at all. They saw them as being intrusive, unhelpful watchdogs rather than as supporters.

Again it became clear that to learn about people's problems, you have to talk to them themselves. For instance even amongst the community themselves, differences arose

between general community beliefs and the thoughts of those about whom the belief was held.

Unemployed single parents, for instance, whose families had broken up, were identified by community members as people with special problems. However when I spoke with them, they explained: *"Since the community see us as a problem, that is how we act. Yet, our needs for resources, such as child care, really don't need much input to solve"*.

Similarly children had a different view of things. Whilst the community at large declared that *"kids are a problem"*, I identified 200 children through school. Their parents said they needed youth clubs. But the children themselves said *"we want people to talk to us, such as counsellors and young youth leaders. We want structured activities, with different age groups, to stop bullying and pressure from the older ones"*. They knew quite clearly what they wanted, but no one had ever asked them.

### • The interview experience

The community were really surprised by the study. They said they had never been asked anything before. At first, they said they did not know anything, but then a real wealth of information began to flow out of them. A real sense of empowerment emerged out of the process. The children particularly were glad that they had been included.

### • Validity and follow-up

The next question is the extent to which the authorities were prepared to believe the information which I produced and to act on it. I checked all the information which I was told by informants by repeating it back to them and asking them to check and change it if they wanted to. In that sense, therefore, I have worked as a catalyst for their ideas: they have done the thinking. I feel pretty confident that the councillors will act on the information collected. Their initial reactions have been very positive and big new resources are not necessary to meet many of the needs identified.

### • Conclusions of the study

'Good Health' in any community group is difficult to achieve, but perhaps more so in community groups that are disadvantaged through unemployment and poverty. This study illustrated the complex interaction between unemployment, poverty, family influence, age, housing, and the many other social factors which considerably affect and restrict an individual's ability to make a 'health choice'.

The opportunity to utilise the health check was taken advantage of, which in part dispelled the myth that unemployed people were not interested in their health. The response of the participants indicated that they valued the time given to talk, and the individual attention. The blood pressure check was seen as something constructive to work from. The extended use of the health profile formed the basis for the easy exchange of information, which was productive, and enabled people to identify with the many complex social, emotional and financial problems that affected their health. The participants also valued the opportunity to return for the re-checking of blood pressure, health information or counselling.

Men were more receptive to asking and learning about health issues than previously thought; more importantly, they were prepared to make health changes based on the information given.

The level of health knowledge was generally poor, as it is with most other community groups. People who had diagnosed illnesses appeared to have little health knowledge about their specific condition. This was not a reflection of the individual's ability to absorb the information given, but it appeared to be due to the information not always having been given in a form which they could readily understand.

The high number of referrals to health and other agencies demonstrated that there were many health associated problems that required specific help. It also identified the general lack of awareness of resources, existing services, and the benefit system.

Unemployment did put pressure on families; many families in the study were estranged and

divorced. Tension in the home was known to cause problems for the children, both emotionally and physically through impoverishment. Clearly the parents interviewed did care about the effects poverty had on their children, but felt unable to combat these effects. The unemployed people interviewed were very sensitive about their position. People usually became unemployed because of factors beyond their control. It is the unemployed status - more specifically, the way status provoked discrimination - which appeared to add to the health problems. I found it important to disregard the 'unemployed status' and concentrate on the individual knowledge and skills that people had. These were from a wide range of backgrounds, and all had something to contribute during the interviews. It is also very important to acknowledge that unemployed people are not a separate community group. They are the community, and experience the same health problems as other members of the community. But they may have additional health problems because of unemployment and associated poverty.

available from Teresa at the above address.)

The study identified that there is a need to improve the health and associated care for individuals and families that are disadvantaged through unemployment. It showed that people were willing and able to make effective use of such a facility. It also highlighted the need for an informed, integrated, inter-agency approach with the involvement of unemployed people in order to be able to respond effectively to the problems of unemployment. There clearly is a need for initiatives to take place which combat the health effects of unemployment and poverty. Initially this could be best achieved through improved professional training and joint work using the skills and expertise of unemployed people.

- **Teresa Cresswell**, Programme Manager (Community Development Projects), North Derbyshire Health Promotion Service Scarsdale Hospital, Newbold Road, Chesterfield S41 7PF, UK.

#### NOTE

The article produced here is compiled from reports by Teresa Cresswell and additional comments made by her at the IDS meeting, November 1991. Full reports of the project are