Psychological Wellbeing of Polish Migrants: What is the Role of the NHS?

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June 2020

A thesis submitted in partial fulfilment of the requirements
of the University of East London for the Professional Doctorate in
Clinical Psychology

Word Count: 23 125

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ACKNOWLEDGMENTS

To all the survey respondents thank you for taking the time to contribute to this project, and thank you for sharing your personal experiences of your mental wellbeing, your contributions are invaluable.

To all the FOI officers who responded to my email, thank you for your time and for accepting my invitation to think about the mental health of Polish migrants.

To Professor John Read, my Director of Studies, thank you for your guidance, patience and compassion. This project would not have existed without you.

To my loved ones, my family and friends, we have made it! Thank you for your continuous support and encouragement. To my sister Paulina for a constant supply of laughs, recipes and memes. To Hanna and Miriam, my best people. To the GU gang for the escapism.

Last but not least, a special thank you to my parents. To my mum, my number one fan and role model.

ABSTRACT

Aim: Polish migrants are currently the largest immigrant population in the UK. This study aimed to explore what the NHS is currently doing for this population and what needs to change for the services to be more accessible to Polish migrants.

Method: Freedom of Information Act Requests (FOIRs) were sent to all 56 Mental Health Trusts to investigate whether the NHS is serving Polish migrants by monitoring access to services. An online survey of Polish migrants was used to address the research question “What might need to change in order to make mental health services accessible/used by Polish migrants in the UK?”. The survey participants were recruited online through Facebook groups and online Polish news media. Data was analysed using descriptive and inferential statistics.

Results: Forty six Trusts responded to the FOIRs. The results indicate that very few Trusts collect information on access to services by Polish migrants. No Trust reported having developed a race equality strategy that attempts to address the needs of Polish service users specifically. Six hundred and five Polish people completed the online survey. The majority of participants (76.5%) identified as female and the average age was 35. The results indicate that a high proportion of Polish migrants are likely to experience mental health difficulties. Identified causal factors included work stress, isolation and loneliness, family stress, relationship problems and migration. The current study found that out of the 369 participants who reported mental health problems 40.9% sought support for their difficulties through the NHS. Participants who sought help had, on average, lived longer in the UK ($p = 0.001$). Barriers to accessing help included language difficulties, lack of time, lack of belief in services and experiences of fear and shame. Self-help strategies and family support were listed as protective factors.

Recommendations: In line with developing culturally competent services the NHS should adopt a practical approach to engaging this community and focus on enhancing the relationship between Polish migrants and the GP, adopt community approaches and pay attention to the identified causal beliefs of distress which centre around psycho-social factors such as stressful work conditions and isolation.

CHAPTER 1: INTRODUCTION

1.1. Overview

The following chapter will situate the research topic in its socio-political context. It will present the current state of mental health services in the UK, consider the current debates regarding the provision of mental health services to ethnic minority groups, and outline the historical and political context of Polish presence in the UK. The chapter will then go on to present a narrative review of the psychological wellbeing of Polish migrants in the UK, before outlining the research rationale, aims and research questions.

1.2. Terminology

1.2.1. Black and Minority Ethnic Groups

The term ‘BME’, denoting Black and Minority Ethnic groups, is regularly used in the literature and policy looking at inequalities in health in the UK. However, the definition of the term is inconsistent and representative of very diverse communities. While some documents include white minority groups such as Irish or Eastern European, others specify it to only refer to individuals from African and Asian backgrounds. Some do not define it at all.

Wood and Patel (2001) suggest that the term BME can be seen as a social construct and conceptualized as “including all those who politically define themselves as ‘Black’ (oppressed on the basis of colour or assumed racial categories – including African and those of African heritage, Indian, Pakistani and Bangladeshi people) and those from minority ethnic groups in the UK context, who also suffer racism” (p.2.). The department of Health (2005) define BME to include individuals of Irish and Mediterranean origin and Eastern European migrants. This thesis will use this broader definition of BME.

1.3 Setting the Context

1.3.1. Mental Health Services in the NHS

Mental health services in the UK have a history of multiple transformations. Victorian asylums were replaced with Care in the Community alongside the enforcement of the Mental Health Act in 1959 (Bartlett & Sandland, 2007). The first revision of The Mental Health Act took place in 1983, and the notion of consent was introduced. This change meant that people could still be detained under The Mental Health Act if they were at risk of harm to themselves or others, however, a lot more people began to voluntarily seek help (Szmukler & Holloway, 2000). Successive governments have encouraged community-centred care for people with mental health difficulties.

In recent years, a new wave of transformation programmes emerged, with the intention of shifting mental health provision from a medicalised system to one that focuses on the principles of recovery, i.e. a person-centred approach to care which emphasizes all aspects of a person's life, where the person is seen beyond their diagnosis and efforts are made to reintegrate individuals back to society and a life meaningful to them (Gale and Marshall-Lucette, 2012; NIMHE, 2005).

Currently there are 56 mental health trusts in the UK, commissioned and funded by clinical commissioning groups. The most common way for service users to access the service is through their GP or via an admission to hospital. Most services provide care to people who live in the local region, although there are a few specialist services for the whole of the UK. Services provided by mental health trusts vary but typically include: courses (e.g. on how to deal with stress), resources (leaflets, books), psychotherapy, family support, community drug and alcohol clinics, community mental health houses, inpatient psychiatric hospitals, day hospitals and day centres.

Furthermore, with the Improving Access to Psychological Therapies (IAPT) programme which was launched in 2008, there is an emphasis on better access to psychological therapies (Layard et al., 2006). The aim of IAPT is to provide CBT based psychological therapies for people with common mental health difficulties, such as anxiety and depression. Over 560,000 people per year are being treated in IAPT (NHS Digital, 2019). The service offers a range of treatments including face-to-face therapy and digital therapy (i.e. apps and online programmes).

The recommendations set out in the NHS England Five Year Forward View for Mental Health (2017), set mental health as a priority and a commitment to a future that dissolved the funding inequalities between physical and mental health. In 2017 nearly £12 billion was spent on mental health services in England (NHS England, 2017). This marks considerable change from the early days of the NHS.

However, today’s NHS is not without its problems. A community mental health survey conducted by the Care Quality Commission, reports that 97% of participants said they did not know who to contact with mental health concerns (Care Quality Commission, 2017). The survey also highlights that 50% of people with mental health difficulties were not offered alternatives to medication even though a quarter of those said they would have liked an alternative form of treatment. Furthermore, the Five Year Forward View for Mental Health, reports that three quarters of people with mental health problems receive no support at all.

In his book ‘Madness: a brief history’, Roy Porter (2002) explores the rather faltering and inconsistent attempts, throughout history, at determining who is mad, why and what can be done about it. By drawing from ambient culture, expressed in poetry, philosophy or literature, Porter demonstrates the notions, ideologies and prejudices that moulded theories of madness and clinical responses to them. Porter’s book is a reminder to think critically about conceptualisations of ‘mental illness’ and the consequential treatments on offer. Indeed, in the last couple of decades psychiatric labels have shifted to include “milder” or “borderline” cases of psychological distress, arguably within the range of normal variability. Porter offers the role of the psychopharmacology industry as a driving force in the expansion in the number of mental health diagnoses and the lowering of the threshold of complaint.

1.3.2. Ethnic and Cultural Diversity in the UK

The UK continues to become increasingly diverse and so the needs of the population are changing. Ethnic inequalities in mental health continue to be one of the biggest challenges the NHS is facing today (e.g. Grey, Sewell, Shapiro, & Ashraf, 2013). In comparison to the white native population, BME communities continue to be disproportionally diagnosed with mental health conditions (The Race Disparity Audit, 2017), there are significant barriers to accessing culturally appropriate services, and limited efforts in including BME communities in service design and delivery (Dogra, Vostanis & Frake, 2007; Lee, Sulaiman-Hill & Thompson, 2014) .

According to the latest census data (Office for National Statistics, 2012) the proportion of the resident population of the UK that identifies as ‘White’, decreased from 87.4% in 2001 to 80% in 2011. It was reported that the reminder of the population identified as ‘Asian/Asian British’ (7.5%), followed by ‘Black/African/Caribbean/Black British’ (3.3%), ‘Mixed/Multiple ethnic groups 2.2%) and ‘Other’ ethnic groups (1%).

However, since the expansion of the European Union in 2004 there has been a significant increase in the number of people from other ‘White’ backgrounds residing in the UK. This has largely been attributed to the sizable migration rates to the UK from Eastern and Central Europe. Between 2001 and 2011 the number of individuals who identify as ‘White Other’ increased by over 1 million, constituting 4.4% of the UK population. This broad and imprecise category includes individuals who are most likely to be born outside of the UK referencing Eastern, Western and Central Europe, Israel, Ireland, America and Australia (ONS, 2018).

The migrant population in the UK continues to increase. In 2018, the population of non-British nationals reached 6.2 million and the non-UK born population reached 9.4 million and (ONS, 2018). The most common non-British nationality since 2007 is Polish. Poland also remains the most common country of birth for non-UK born residents. It is estimated that approximately 1 million Polish nationals lived in the UK in 2017, which equals 16% of the total non-British nationals. The second most common country of birth was India (829,000), following by Pakistan (522,000), Romania (390,000) and the Republic of Ireland (390,000).

1.3.3. Ethnic Inequalities in Mental Health Services

Institutional racism and the persistence of inequalities have been well documented within diverse societies with their effects spanning education, police and judicial services, as well as the general workforce and health services (Fernando and Keating, 2008). Before considering the causal factors for ethnic inequalities in mental health it is important to understand the nature of these inequalities.

Disparities in the diagnoses of mental health conditions between different ethnic groups have now been well documented. According to the latest Race Disparity Audit (2017), Black women are most likely to be diagnosed with depression or anxiety, while Black men are most likely to be diagnosed with a psychotic disorder. Furthermore, individuals from BME communities are far more likely to experience restrictive measures within the health system, including being detained under the Mental Health Act (e.g. Fatimilehin & Coleman, 1999; Fernando, Ndegwa & Wilson, 1998; Barnett et al., 2019). Despite this being the case, the group that is most likely to receive psychological support is the White British community. White individuals are also more likely to report better outcomes of psychological therapies compared to other BME groups (Cabinet Office, 2017)

Further evidence of this can be seen in the White Irish population who, despite being largely ignored in analyses of inequalities, are also reported to experience higher rates of mental health diagnoses compared to the native population and are at higher risk of suicide compared to other BME groups (Harding, & Balarajan, 2001).

Service use inequality in mental health is most prominent in the African Caribbean community. Consequently, analyses of possible causes of ethnic inequalities most frequently focus on the experience of African Caribbean people. The conclusions are sometimes erroneously applied generally to all BME groups in literature (Barnard, 2011).

1.3.4. Causal Factors for Inequalities in Mental Health

Fernando (2002), argues that a major contributing factor to inequalities in mental health is the over reliance on westernised and Eurocentric models of psychiatry in the UK. The author calls for greater cultural competence among mental health staff and stresses the importance of health professionals examining and reflecting on their own worldview and biases, particularly in the early assessment of mental health problems. Furthermore, the author highlights cultural differences in perceptions of 'disease', help seeking behaviors and engagement with services. Moreover, the increasing socioeconomic uncertainty and income inequality in BME communities can lead to people not prioritizing the need for early intervention and being reluctant to engage with services until they reach crisis point (Grey, Sewell, Shapiro & Ashraf, 2013). Factors such as stigma, shame and language barriers should also not be underestimated as barriers in seeking help (Fountain & Hicks, 2010).

Perhaps the most important, and mostly overlooked, factor contributing to the failures and inadequacies of mental health services in providing adequate care to BME communities, is the focus on the problem in the communities themselves rather than on the systems that reinforce inequalities. The policy by the Department of Health (2011), No Health Without Mental Health, highlights the importance of addressing the wider determinants that affect physical and mental well-being. Socioeconomic factors are key determinants of mental well-being and the income equality gap between BME communities and the native white population is widening (ONS, 2018). There are several examples of social inequalities and vulnerability to mental health problems by different ethnic groups. A prominent example is the systemic discrimination against Black men who are more likely to be excluded from school, experience economic and social hardship, be exposed to criminal practices and subjected to racial abuse (Keating, 2007). Unfortunately, research looking at other ethnic groups, specifically Eastern Europeans, Roma, Gypsy and Traveler communities remains limited. It is important that research at local and national levels be undertaken to address this knowledge gap.

1.3.5. Striving for Equality

The Department of Health launched the Delivering Race Equality in Mental Health (DRE) 5-year action plan in 2005. It was created as an ambitious strategy to eliminate discrimination and address mental health inequalities experienced by minority ethnic groups (including people of Irish, Mediterranean, and East European origin). DRE was based on an earlier strategy, “Inside Outside” (Department of Health, 2003). The recommendations from “Inside Outside” are still relevant today and call for: a culturally competent workforce, elimination of race discrimination, and a focus on the wider determinants, such as poverty and race discrimination, within services and within wider society.

The DRE initiative also emphasized the importance of psychological therapies as an intervention in promoting mental wellbeing. The plan set out to ensure that BME communities have access to a greater range of psychotherapy and culturally appropriate therapeutic interventions. To improve mental health services, it was made clear that the BME community needs to be actively involved in service design, training and policy development.

More recent documents such as the NHS England Equalities ‘Toolkit’ (DoH, 2013) conceptualise race as a ‘protected characteristic’ within the Equality Act (2010) and advocate for ‘culturally competent’ services. However, while numerous of these initiatives have aimed to improve access, experience and outcomes for BME communities, there is very little evidence to show much improvement (Sewell and Waterhouse, 2012).

1.3.5.1. The Equality Diversity System

The Equality Delivery System (EDS) was first launched in 2011. The purpose of the system is to help local NHS organisations review and improve the performance for people with characteristics protected by the Equality Act 2010. EDS was commissioned by the NHS Equality and Diversity Council, and was developed in consultation with local partners and people. The goals of EDS were to better health outcomes for all, improve patient access and experience, empower and include staff and create inclusive leadership.

An independent review of the system highlighted that the collection was challenging for many mental health trusts and, that issues regarding staff resources and competing priorities placed an enormous amount of pressure on organisations (Shared Intelligence, 2012). In 2013, EDS was refreshed and replaced by The

Equality Delivery System2 (EDS2). EDS2 remains aligned to the NHS England's commitment to an inclusive NHS that is accessible and fair to all.

However, evaluative reports of the EDS and EDS2 demonstrated a lack of consistency between Trusts in terms of how they presented, evaluated and responded to their performance across different domains. Furthermore, the development of this equality and diversity remit, that aims to provide more inclusive and accessible service to all, is inevitably a step back away from specific racial initiatives. Indeed, the latest Race Disparity Audit (2018) demonstrates that BME people are not benefiting from NHS mental health services to the same degree as the local white population.

1.3.5.2. Workforce Race Equality Standard WRES (2014)

The Workforce Race Equality Standard (WRES) was established in 2014 by the NHS Equality and Diversity Council to ensure employees from BME backgrounds have equal access to carer opportunities, and receive fair treatment in the workplace. WRES is a tool that identifies gaps between experiences of BME and white staff in the NHS. The latest WRES report, providing a summary of data for the year 2019, demonstrates improvements across key indicators, particularly in areas such as representation within senior roles and on Trust boards. The report also highlights many areas for development, particularly prominent is the lack of improvement over the years in BME staff experience of harassment, bullying or abuse from colleagues.

1.3.6 Culturally Competent Services

Defining 'cultural competence' is difficult. Sue (1998) argues that cultural competence is contextually based rather than technique specific. He postulates that a therapist is culturally competent when they familiarize themselves with the cultural knowledge and skills of a particular culture well enough to deliver interventions to members of that culture. According to Sue, there are three distinct interrelated components of cultural competence: awareness of the therapists' own cultural assumptions, knowledge of the worldviews and values of culturally diverse populations and specific skills for intervention with these populations (Sue et al., 1982). Furthermore, it is equally important to know when to generalize, and apply the knowledge of a specific culture, and when to individualize. A therapist needs to be able to recognize when, and how, cultural values may be relevant to the service users' difficulties, at the same time as resisting stereotyping and remaining in tune with the person's individual needs.

Cultural competence can be contrasted with the unintentional ethnocentrism that might take place when therapists are unable to reflect on their own culture and how it may affect their interpretations of, and their response to, the content their clients may bring (Jim & Pistrang, 2007; Pedersen, Draguns, Lonner & Trimble, 2002).

Other definitions of cultural competence place more emphasis on the way the services are provided. Halsey and Patel (2003) suggested that "the overall aim is not to form a body of experts in the field of race and culture, but to develop a service which can actively engage in a reflective process of the models adopted and think creatively about the service delivered to diverse populations" (p.32). Therefore, delivering appropriate services to all individuals of BME backgrounds should be embedded within an educational ad political framework (Dogra et al., 2007).

1.3.7. The Challenges of Cultural Competence

Cultural competence in mental health, particularly in psychological therapy, tends to be discussed only when there are noticeable differences between the mental health worker and the service user, i.e. the focus tends to be on the white therapist to work with 'difference' (Fatimilehin & Coleman, 1999). The over emphasis in literature on the perspectives of the white clinicians, not only obscures the experiences of therapists from BME backgrounds, but also constructs 'Whiteness' as homogenous.

Every individual has a different internalised construction of their own culture that needs to be considered in a therapeutic setting (Sue et al., 2009; Wohl, 1989). Cultural competence needs therefore to be considered in all therapist-client relationships, and not only when working therapeutically with individuals of minority ethnic backgrounds or with immigrants.

Furthermore, it can be argued that the current discourses regarding the needs of BME populations in the UK, and the over emphasis on visible difference, is obscuring the hidden minority populations such as ‘White Other’. This category is problematic as it groups people belonging to a number of different cultures. Culturally competent services for a person from Australia might be very different to culturally relevant services for a person from Poland.

1.3.8. Race, Culture, Ethnicity and Institutional Racism

When discussing the experiences of minority populations in the UK it is important to consider, and establish the right definitions of the pertinent topics of race, culture, ethnicity and how they relate to experiences of institutional racism.

While categorising human beings into ‘races’ based on skin colour has long been discredited (Cornell & Hartmann, 1998), the notion of ‘race’ persists in modern society, partly through the existence of racism (Fernando & Keating, 2008). One of the commonly used arguments to support the idea that anti-immigrant rhetoric has nothing to do with racism is that Eastern Europeans are white. However, it can be argued that racist discourses have shifted to culture and ethnicity, giving rise to new forms of racism. According to Anthias and Yuval-Davis (1983, p. 67): “racist discourse posits an essential biological determination to culture but its referent may be any group that has been ‘socially’ constructed as having different ‘origin’, whether cultural, biological or historical. It can be ‘Jewish’, ‘black’, ‘foreign’, ‘migrant’, ‘minority’. In other words any group that has been located in ethnic terms can be subject to ‘racism’ as a form of exclusion”. It can therefore be argued that, while traditionally racism was understood to position ‘other races as inferior, through the process of racialization the same discourses extend to ‘other’ nationalities, cultures, ethnic communities, faiths or kinds of people, which are conceptualised in the same way as ‘races’ (Fernando & Keating, 2008).

Consequently, it ca be argued that different groups of people can become ‘racialised’ irrespective of their skin colour, and that racism no longer operates solely on the Black – White binary (Gillborn, 2006; 2009; 2015). The term racism has been used to denote the experiences of racialised white minority migrant groups in a number of publications (e.g. Fox, 2013; Rzepnikowska, 2018). An example of how racism has been perpetuated against religious groups can be seen in the dominant anti-Semitic or anti- Islamic attitudes and behaviours (Fernando & Keating, 2008). Similarly, it can be argued that white immigrant communities, such as Polish or Irish, have become ‘racialised’ in the UK and therefore disadvantaged and victimised (McDowall, 2009), see section 1.4.4..

The MacPherson Report (1999) defined institutional racism as *“the collective failure of an organization to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudices, ignorance, thoughtlessness and racist stereotyping, which disadvantages minority ethnic groups”* (p.28). Patel et al (2000) further defines it as “*the reproduction within institutions of practices of power, which discriminate against persons on the grounds of perceived ‘race’. These practices maintain the status quo in institutions and can be practiced in the commission of racist acts…”* (p.31). Linking these definitions to those of racism it can be inferred that Polish migrants are vulnerable to experiences of institutional racism on the grounds of their minority status, ethnic and cultural differences.

Research suggests that experiencing racism can have a negative effect on overall health and mental health (e.g. Williams & Williams-Morris, 2000; Gibbons, O’Hara, Stock, et al. 2012; Williams, 2018). There is a growing body of research to suggest that those exposed to racism may be more likely to experience mental health problems such as psychosis and depression (Wallace, Nazroo & Becares, 2016; Bhui, Nazroo, Francis et al. 2018). This point further highlights the need for cultural competence training in the NHS.

1.4. Polish Migrants in the United Kingdom

1.4.1. Historical Context of Polish Migration

The enlargement of the European union since 2004 has led to an increase in the number of Eastern European migrants living in the UK. To date, Polish migrants are by far the biggest migrant group in the UK (ONS, 2018). In order to understand the position of Polish migrants in the country, especially considering the current political climate, it is important to be aware of, and reflect on, the historical context of emigration from Poland.

Poland, similarly to Ireland and Italy, is a country where emigration, be it long term migration to America in the nineteenth century, or short-term seasonal movement to Germany, is seen as a normal course of action. It is culturally embedded and economically pragmatic. Moreover, there is a longstanding political tradition of exile, dating back to the 18th century when Poland did not exist on the map of Europe (Ascher et al., 2002). This is an important historical fact which posits Polishness as something which exists outside of the country itself. This sentiment is reflected in a lot of Polish literature, which forms part of the cultural narrative and the idea of "longing for the Polish homeland from afar" (Mickiewicz, 1826). Mobility and diaspora are therefore not strange ideas or distant experiences for Poles, and when we think of people leaving Poland in the twenty-first century to work, it can be postulated that strong historical precedents are being re-enacted, whether consciously or not (Burrell & Schweyher, 2019).

Furthermore, there are several important historical precedents to Polish migration to the UK. During the Second World War for example, Polish troops became part of the Allied forces, the Polish government-in-exile was established in London, and ultimately, with the war ending, over 150,000 ex-servicemen and their families, along with displaced refugees from eastern Europe, resettled in the UK (Kacewicz, 2012).

The Second World War affected every Polish family. Many Polish nationals have been caught up in deportation, sent to Siberia by the Soviet troops and fought in the forces, millions of Poles died in the Holocaust and the Polish uprising. Memories of war trauma, loss of homeland, families and friends, and the struggle to adapt and cope in a post-war environment have affected everyday lives from the initial period of settlement until the present day (Winslow, 2001).

Since the Second World War there has been a small number of Polish professionals, doctors and academics, accepting invitations to work in the UK. These were often people escaping uncertainty and sometimes persecutions during the Solidarity movement in the 1980s. During this time the Polish government-in-exile remained in London, further strengthening the link between Poland and the UK (Kacewicz, 2012). After 1989 however, when the Socialist regime fell and mobility restrictions were removed, migration to the UK, and the rest of Europe, reconfigured again. The Seasonal Agricultural Workers Scheme, for example, employing Polish migrants in key agricultural sectors, set an important precedent for post-2004 movements, bringing in workers to fill labour gaps and strengthening migratory links between the two countries (Burrell & Schweyher, 2019). Professional and student migration increased too, alongside this (Rzepnikowska, 2018).

The era between 1989 and 2004 is particularly relevant in better understanding the experiences of Polish migrants living in the UK today. With Brexit looming over the UK the experiences people had in the 1990s have a real resonance. At that time Polish migrants required an appropriate visa to work in the UK – often accompanied by intrusive questioning and discriminatory experiences on the British border. Dr Kathy Burrell, a researcher from the University of Liverpool specialising in Polish migration, talks about the importance of migrants' experiences at the border, and their role in evoking feelings of being a second hand citizen and the wider asymmetry of privilege and status (Burrell & Schweyher, 2019. This of course is far from unique to Polish migrants and we are witnessing extreme examples of this with the 'Muslim ban' in the US, underlying further the difficult and often traumatic emotional responses which are tied up in the crossing of borders.

Furthermore, the collapse of the Socialist regime in the early 1990s is another important historical context to be considered. It is often described in the literature as a period of 'crisis', where the shift from a planned to a market economy had a huge impact on the population. The unemployment rates were at an all-time high and there was a significant loss of social security and safety nets (Winslow, 2001). Alongside the economic uncertainty came a new psychological anxiety about what the future would hold. Interviews with Polish migrants highlight a strong sense of disorientation, of suddenly not knowing what the new rules were and of the people who would usually be relied upon to offer guidance (such as parents or grandparents) not knowing either (Burrell & Schweyher, 2019). This transition, of

Poland 'becoming westernised', lasted well beyond the 1990s. On the eve of the EU enlargement youth unemployment was around 40%, wages were low and emigration offered the promise of a better life (Eade, Drinkwater & Garapich, 2006).

1.4.2. Post-2004 Migration

Since the accession of eight new Eastern European countries (A8 - Lithuania, Latvia, Estonia, Poland, Czech Republic, Slovakia, Slovenia and Hungary) to the European Union (EU) in 2004, migration rates have significantly increased across Europe. Severe labour shortages in low-wage and low-skilled jobs led the UK to grant free access to the labour market to all A8 nationals. These new job opportunities and the right to freedom of movement, attracted many young Polish people, who have been particularly affected by high rates of unemployment and low pay in Poland (White, 2013). Between 2003 and 2010, the Polish-born population of the UK increased from 75,000 to 532,000 (ONS, 2012). To date, it is estimated that 1 million Polish nationals are living in the UK, with Polish being the most commonly spoken language after English (ONS, 2018).

However, estimates of the number of Polish people in the UK are based solely on the number of people living in the UK who were born in Poland, and the number who are nationals of Poland. Many Polish migrants may have a registered country of birth outside of Poland, or an alternative nationality, therefore neither of these measures fully captures what might be considered the Polish population of the UK (Hawkins & Moses, 2016) . Furthermore, Poles are not separately identified in the ethnic classification that is used for official statistics in the UK, often belonging to the category "white other". For this reason, the Polish population in the UK is potentially much larger than what is currently being captured.

1.4.3. Life in the UK; Diversity of Polish Migrants

Polish migration to the UK after 2004 has become one of the most significant movements in UK migration history. The Polish settlement has been particularly widespread with most cities and towns having a Polish presence. It is probably the least London-centric migration movement the UK has seen. It also means that Poles have become part of the social fabric of these localities in many ways. The airline landscape has changed, with very cheap flights flying to all parts of Poland from most British airports. Polish shops are present in most towns, even big chains such as Tesco or Sainsbury’s have shelves dedicated to Polish products - a good example of local interactions and increased Polish visibility in the public space.

Furthermore, the Polish population of the UK is far more diverse than what is being presented in the media. It is for example, untrue that most Poles are ‘low skilled’ migrants. Research reports that UK attracted the most qualified young people from Poland and that many feel de-skilled, experiencing ‘brain waste’, due to not being able to use their degrees and practice in their chosen professions. The age range of this population is also more varied than initially reported. Even though the largest section of Polish migrants came to the UK in their twenties or early thirties, there has been an increase in people over 40s escaping the limited labour market or, in many cases, coming over to help family look after children. An important point here is that there is no ‘typical’ Polish migrant, the population consists of individuals of diverse social, and occupational backgrounds, different levels of income and education and different attitudes toward integration into British society (Fomina, 2009).

For many years, Polish mobility to the UK has been seen as temporary and economic in nature. However, many Poles have made UK their home and large parts of the community are here to stay. To this point, a study by Garapich (2013) highlights the lack of initiatives in integrating the interests of this population, particularly the lack of Polish representatives, in comparison to other ethnic groups, in local British authorities. It is an interesting point because it indicates that local British policy, is often favouring ethnic blocs as interest groups (Garapich 2013). It is however, only one way of conceptualizing the political interests of Poles in the UK as they can also be framed in terms of class interests. The interviewees in Garapich’s study for example, identify themselves either as Poles or as workers/migrants (2013). The increasing class differentiation of Polish migrant groups, diversity of interests, the emergence of multiple ideological conflicts between Polish citizens, lack of political representation and the desire to fill these gaps – all those processes are linked to the generation replacement in the existing Polish diaspora (Kordasiewicz & Sadura, 2016).

1.4.4. Media Representations and the Racialisation of Polish Migrants

The initial media reporting of Polish migration tended to be positive. The focus was on Polish migrants' positive work ethics, on their being hardworking, value for money and diligent. Polish migrants were considered 'desirable' and 'invisible' due to their whiteness. However, around the time of the economic crisis in 2008 this rhetoric shifted (Rzepnikowska, 2018). The media framed Polish migrants to be an economic threat, responsible for society's malaise: job shortages, unemployment, and strain on social services.In the lead up, and ever since, the EU referendum in 2016, open hostility has increased towards Polish migrants, and to 'foreigners' generally. There have been horrific stories of children being targeted at schools, of POSK the Polish culture centre in London being vandalised with racist graffiti. A Polish man was murdered in Harlow, Essex, just for being Polish (Burnett 2017). In the run up to the Brexit vote, the reporting of immigration in the media more than tripled, and the coverage of the effects of immigration was overwhelmingly negative (Moore and Ramsay, 2017). In fact, the media's slandering of Polish migrants became so severe that the European Commission against Racism and Intolerance (ECRI) (2016) criticised British tabloid newspapers, for 'offensive, discriminatory and provocative terminology'.

Furthermore, studies on British cultural stereotypes of Polish people reveal noticeable markers of Polish people. Polish names, different letters and pronunciation constitute visible and audible markers of difference (Rzepnikowska, 2018). In a study on racialisation of Eastern European migrants in Herefordshire, Dawney's (2008) revealed some references to the clothes worn by these migrants considered as unfashionable, and therefore noticeable. Moreover, while some respondents in Ryan's (2010) study on Polish migrants in London claimed that Poles can blend into British society, presumably due to their whiteness, others thought that Poles can be recognised by facial features.

Indication of popular discourses on the inferiority of Eastern Europeans can be found in the etymology of the word 'Slavic' (referring to large parts of the inhabitants of Easter Europe, including the Poles). Many modern western scholars believe there's a clear connection between "Slavs" and "slaves" in English and other contemporary European languages. If one looks at the BBC's webpage about the roots of slavery, there's a statement that "the term 'slave' has its origins in the word 'Slav'" This however is still a topic of discussion and no clear consensus about the true origin of the word has been reached in the field of etymology.

Anti-Polish rhetoric offers an important reminder that being white, even with all the privilege it does confer, can sometimes offer only limited protection against anti-immigrant agitation and migration regime insecurity. This raises new questions about how we might engage with the concept of whiteness, its interplay with class, and the role of the British media in the racialisation of Polish migrants (Rzepnikowska, 2018). More research should be done to understand where this hostility and discomfort comes from, where Polish migrants fit into the wider contexts of diversity and migration, and how they are being othered in the UK.

1.5. Psychological Wellbeing of Polish Migrants in the UK: a Review of the Literature.

1.5.1. Review Strategy

Historically much of the research on the experience and use of health services among migrants and ethnic minorities in the UK has focused on the longer established black and minority ethnic (BME) communities (Jayaweera, 2010). Identifying the most relevant literature is therefore challenging, as few research studies have focused specifically on Polish migrants.

In order to conduct a systematic review of the most relevant literature pertaining to the mental health of Polish migrants in the UK, studies involving other migrant groups would have to be included. However, this approach would be inevitably challenging and produce an overwhelming amount of literature. Furthermore, generalising these findings to the Polish population might prove problematic. For these reasons, a narrative literature review seems more appropriate.

A narrative review aims to identify and summarise previously published studies on a given topic, providing a meaningful synthesis of diverse research. Narrative reviews are often criticised for their subjectivity and proneness to bias. However, the quality of the review may be improved by borrowing from the systematic review methodologies i.e. by employing a methodical search strategy and by using clearly defined research terms (Ferrari, 2015). Furthermore, the inclusion of previous systematic literature reviews can help to counterbalance any potential bias.

The search strategy involved reviewing the following three electronic databases: Psychinfo, CINHAL and Academic Search Complete. Papers, books and relevant articles were filtered through an initial reading of abstracts. The searches were conducted in October 2018, November 2019 and April 2020. The same search terms were entered into each of the search engines in the following order: ‘mental health’ or ‘mental health services’ and ‘Polish’ and ‘United Kingdom’ or ‘UK’ or ‘Britain’ or ‘England’ or ‘Scotland’ or ‘Wales’ or ‘Northern Ireland’. After looking through abstracts to identify relevant studies, and removing duplicates, seven studies looking at the mental health of Polish migrants in the UK were identified, see Figure 1 for search strategy. References and citations were also reviewed to identify additional sources, related books and additional sources recommended by top researchers in the field were also reviewed for key themes. No additional studies were identified.

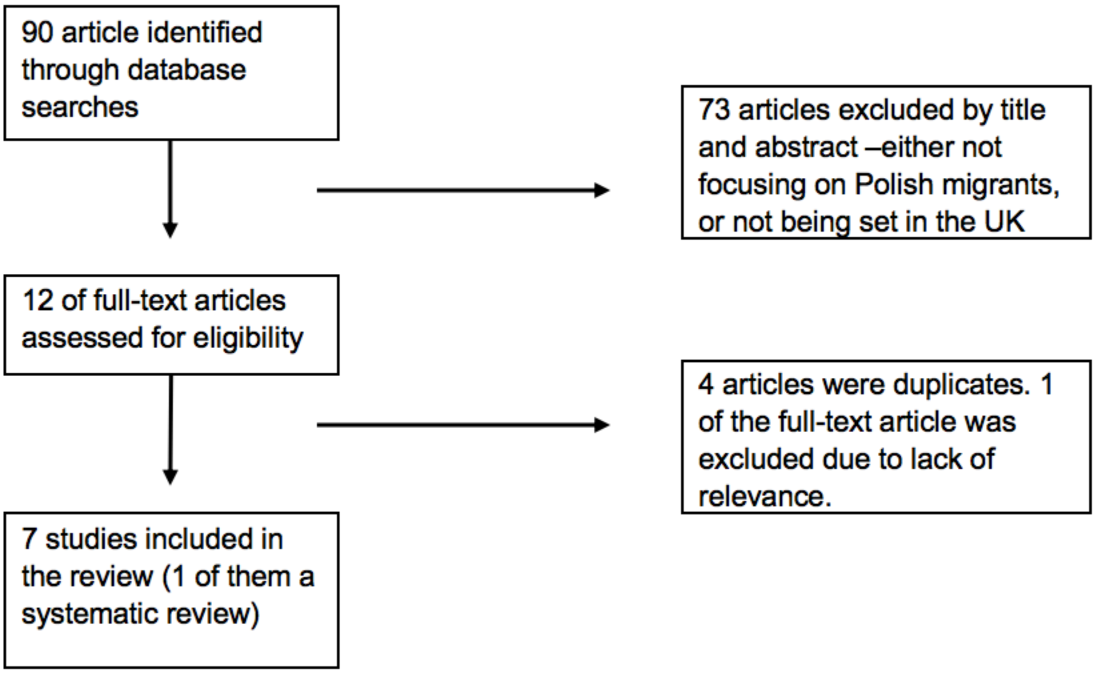


Figure 1. Summary of search strategy and research extraction.

1.5.2. Impact of Migration on Psychological Wellbeing

Some evidence from older reports from around the world on the experience of Polish migrants shows higher suicide rates compared to the home population (Johnasson et al., 1997), high rates of hospitalization due to diagnoses of Schizophrenia (Chochrane & Bal, 1987), as well as feelings of disruption, grief and loss (Aroian, 1990). Furthermore, Polish migrants have been found to be at higher risk of depression, substance abuse and suicide compared with other migrant groups in the UK (Belfast Health and Social Care Trust, 2011). Indeed, excessive alcohol drinking in this community has been linked to both causal and consequential factors of increased experiences of depression (Garapich, 2010). Moreover, Polish nationals in the UK, together with other Eastern Europeans, make up the biggest proportion of homeless individuals in the country, a significant statistic considering the links between homelessness, substance misuse and mental health problems (Fazel et al., 2008).

As summarised above, there is an increasing recognition that migration acts as a risk factor for a range of mental health difficulties. Despite there being a clear consensus that the majority of migrants are motivated to emigrate by the perceived lack of prospects in their home country, researchers have drawn a line between forced and voluntary migration. Although Polish post-accession migrants have been identified as those representing the voluntary migrant wave, White (2013) argues that they frequently feel forced to migrate by the current economic situation and a high unemployment rate in Poland, often severely threatening to the quality of life. Therefore, despite voluntary migration being associated with less severe psychological reactions, it has nevertheless been associated with multiple stresses, depression and feelings of isolation (Lakasing and Mirza, 2009), and the psycho-social process of loss and change accompanying abandonment of one's homeland has been recognized in the psychiatry of migration as a grief process and a distressing experience (Carta et al., 2005) Such observations inform us of the potential vulnerability of migrant groups as well as identify a probable requirement for intervention from the mental health services.

1.5.3. Mental Health of Polish Migrants in the UK

There is a very limited body of research looking at the mental health of, and help-seeking by, Polish migrants in the UK. The review strategy identified 6 studies and one systematic review. All studies were small scale, mainly qualitative and often published in a non-peer reviewed format – making it difficult to determine their quality. The available evidence suggests that mental health in this population is affected by high levels of stress, feelings of alienation, poverty, exploitation, loneliness and poor physical health (Bhatkal & Shah, 2004; Weishaar, 2008; Selkirk, Quayle & Rothwell, 2012; O'Brien & Tribe, 2013; Madden, Harris, Blickem, Harrison & Timpson, 2017; Godonek & Kirkbride, 2018). These experiences can be linked to the literature on the overall impact of migration, where it has been asserted that symptoms of mental health difficulties are of lesser importance to migrants who are concerned with other problems, such as grief or anger over past injustices or a myriad of difficulties associated with the migration process (Van der Veer, 1998).

One of the studies identified in the search was a recent systematic review conducted in 2018, examining what is currently known about the mental health needs of Polish post-accession migrants in the UK (Maciagowska & Hanley, 2018). Macigowska and Hanley identified eight qualitative studies, only three of them overlapped with the search strategy used by this paper. This is due to Macigowska and Hanley using broader search terms and including small scale papers that did not explicitly focus on mental health distress. They analysed the papers using a thematic synthesis.

Macigowska and Hanley reported that negative mental health aspects of migration were linked to feelings of frustration and stress, language difficulties, discrimination and isolation, financial hardship, unfamiliarity with the culture, stigma and shame. Most of the studies they reviewed, reported language difficulties to be the major contributing factor to migrant stress and frustration. The review links language barriers to a negative view of the self and identity loss whereby participants reported feeling 'dumb and stupid'. Furthermore, language barriers contributed to the phenomenon of 'talent loss' (Krahn, Derwing, Mulder, & Wilkinson, 2000), the fact that many skilled and educated Polish migrants occupy positions of manual workers, which further contributes to feelings of frustration, boredom, professional identity loss and, in some cases, low mood.

Financial hardship was also identified as one of the major themes contributing to stress and frustration in their study population. The inability to find a job, low income, lack of support from the government upon arrival, and long working hours were all perceived as a source of anxiety. Furthermore, participants reported feeling unsure of what they are entitled to, how to engage with the British society and where to seek support, which contributed to isolation and distress.

The authors linked these findings to the broader literature on ‘acculturative stress’ (Berry, 1997) and long-term social defeat, where it is argued that migrants’ increased risk of poor mental health outcomes can be understood as a consequence of obtaining an outsider status and a subordinate societal position (Selten & Cantor-Graae, 2007). Indeed, in recent years the public discourses on Polish migrants have turned very hostile, with narratives such as “stealing jobs”, putting a strain on public services and welfare becoming more prominent. Racial and xenophobic abuse, although always present, has become more prominent following the Brexit vote (Rzepnikowska, 2018). The othering of this particular migrant group contributes to the discrimination and oppression of Polish people living in the UK, and in turn their experiences of poor mental health and willingness to engage with services.

Mciogowska and Hanley also highlighted some positive aspects of migration. A number of participants reported that migrating to them symbolises freedom and liberation, as well as an opportunity for a better future. Furthermore, although immigration was predominantly associated with challenges, participants reported resourceful coping strategies, including social support and self-motivation (Weishaar, 2010).

Maciogowska and Hanley offered the first systematic exploration of the literature looking at mental health needs of this population. The review, comprehensive and informative in its analysis, highlighted the lack of research in this area. All studies identified were small scale and qualitative in nature. One study in particular focused exclusively on gay/bisexual Polish migrants, highlighting the intersectionality of this community while also making the findings less generalisable to the rest of this population. Moreover, the review focused solely on post-accession Polish migrants to the UK. However, as described in the previous section Polish emigration to the UK reaches further than the 2004 opening of borders. None of the reviewed studies consider length of stay in the UK and the effects of participants' mental health.

1.5.4. Community Resources

Three studies emphasized the role of support provided within the Polish community (Selkirk, et al., 2012; O'Brien & Tribe, 2013; Weishaar, 2008). Participants in the Selkirk and colleagues study reported that close family and friendship networks provided the first port of call for financial, practical and emotional support. The majority of participants, in Scotland, socialised mainly with other Polish people although this could largely be attributed to language barriers. O'Brien and Tribe (2013) argue that lack of deeper relationship building between Polish and British people could be explained by socio-cultural differences between Poland and the UK. Two other studies identified in the literature search make reference to the collectivist nature of Polish culture (Selkirk et al., 2012; Bak-Klimek et al., 2018). It is argued that, due to the political climate in Poland, and a lack of social security, there exists a greater psychosocial reliance on family and friends in Poland than in the UK (Hofstede, 2001). Furthermore, previous research has highlighted that migrants moving from a collectivist to an individualistic society may find it difficult to settle in and adjust to new cultural values Bhugra (2004).

The studies also mentioned a conflict of interest within groups of Polish migrants. Participants in Weishaar's (2008) study reported a general expectation to support fellow nationals upon arrival. Those who had been in the country for a while reported that new migrants often came with very high expectations, were demanding and took advantage of those who had been in the country for longer. Selkirk and colleagues (2012) on the other hand, reported a strong preference in their participants to seek help from informal sources within the community. They link their findings to Knab's (1986) discussion on cultural values shaping help-seeking beliefs in Polish culture, and describe Polish cultural beliefs to view suffering as a normal part of life; cultural emphasis on self-reliance; and concerns about brining shame upon family.

However, the studies did not offer much insight into the kind of support that Polish migrants would, in fact, engage with. This type of support has not been studied in much depth and is often referred to as ‘informal social networks’, ‘Polish churches’ or ‘private psychologists’. One such support network, which is seen as informal, yet is quite heavily relied upon, is the Polish Psychologist Association (PPA). The PPA is a volunteer group of psychologists, pedagogues and sociologists founded in 2006, it offers therapy, family counselling, telephone consultations, professional career coaching, training and workshops to Polish migrants living in the UK.

1.5.5. Access to Mental Health Services

Three studies reported that Polish migrants underutilise mental health services in the UK (Selkirk et al., 2012; Madden et al., 2017; Godonek & Kirkbride, 2018). Godonek and Kirkbride (2018) conducted a multivariate and linear regression to identify predictors of mental health help-seeking in this population. The study surveyed 536 Polish migrants and found that the participants included in the study had particularly poor mental health, whilst exhibiting low intentions of help-seeking. The study employed an online recruitment strategy and so it can be argued that a skewed sample of the population, of participants who had experience of poor mental health, were attracted to take part. Nevertheless, the study reports preliminary findings of older age, previous knowledge of the NHS and being single, or not having a partner in the UK, as predisposing and enabling factors to help-seeking in this population. Furthermore, length of stay in the UK predicted past help-seeking behaviour and can be linked to better understanding of services.

A survey conducted by the Polish Psychologist Association, of 450 Poles living in the UK, investigated patterns of accessing psychological support. It was reported that 55% of the respondents felt like they would have benefited from psychological support during their stay in the UK. However, only 24% felt able to access the help they needed. Out of the people who accessed help, 86% received it from a charitable organisation and only 30% from the National Health Services (NHS). 41% of all respondents were not aware that they could access psychological support through the NHS free of charge (Stefanicka, Erecinski & Kwiatwowska, 2016).

Cited reasons for underutilisation of services, in addition to limited knowledge of the NHS, include poor language skills, perceived cultural differences, previous negative experiences of services, mental health stigma and isolation (Kouvonen, Bell & Donnelly, 2014; Kozlowska, Sallah & Galasinki, 2008; Gondek & Kirkbride, 2018).

A recent study by Madden and colleagues (2017) looked at the health service experience of the Eastern European population in a town in North England. Three quarters of the participants in this study (n=28) were Polish. It was reported that this population had a good understanding of the UK health service structure and high registration and use of practice/primary care services. However, overall, there were high levels of dissatisfaction, frustration and distrust in General Practitioners (GP). The majority of participants viewed the GP as unhelpful and dismissive; a barrier to secondary/acute care; reluctant to prescribe antibiotics; and that GPs too often advise them to take paracetamol and rest. This is a significant finding, as GP's often act as gatekeepers to mental health services. Polish immigrants distrust in GPs could therefore be seen as a big barrier to accessing mental health care.

Other cited studies reported the pattern of Polish migrants' relationship with mental health services to mimic that of other BME communities where admissions to acute psychiatric services and suicide rates are high (Smolen, 2013), while the use of psychological services and primary care seems to be low (Selkirk, Quayle & Rothwell, 2012)

1.5.6. Relationship with Services

A recent study by Pleitgen (2018) explores Polish migrants' engagement with mental health services in the UK at a systemic level. By interviewing Polish migrants who accessed psychological therapy in the UK as well as Clinical Psychologists and Polish professionals who have experience of working with this community, the author offers a unique perspective on the experiences of both those who are seeking help and those offering it.

Seventy nine psychologists completed an online survey where they were asked about what in their opinion affects the psychological wellbeing of Polish migrants.

Respondents acknowledged the impact of migration-related, *so*cio-economic and cultural factors on the wellbeing of Polish clients. In considering access to services, the majority of responses located the barriers within the Polish community (e.g. help-seeking attitudes).

Interviews with Polish migrants were analysed using thematic analysis. The analysis identified three main themes: 'occupying dichotomous positions', 'help through Polish cultural lens' and 'understanding beyond language'.

An overarching theme, present across all interviews, was the sense that the participants were seeing themselves and other Polish immigrants as occupying dichotomous positions within realms of time, place and identity. Participants spoke about the impact that Poland's past historical and cultural context and traditions had on their current functioning: linking the collective past of the nation to their collective present. Participants also made references to immigrants living with *"one leg in Poland, one leg in the UK"*. Many of the participants made references to a double identity of Poles in the UK, which oscillated between feeling (and being positioned as) 'the same' and 'different' to the host community. Interestingly, many participants also talked about the different forms of current and historical oppression experienced by Poles as a nation, and on the racism and discrimination displayed by Poles towards other nations, positioning them as perpetrators of oppression.

The second theme 'Help through Polish cultural lenses' contains sub-themes conceptualising therapy as culturally unfamiliar, seeking help as connected to aspects of pride and shame, and a perception of services as unwilling to help. The final theme, 'understanding beyond language', conveys the importance of understanding the historical, political and cultural context as well as appropriately addressing language barriers in therapy.

The author concludes that there is a clear need to improve the understanding of the Polish community within mainstream psychology services, and efforts should be made to improve the relationship between Polish community and the NHS.

1.6. Rationale and Research Questions

Poles are currently the largest immigrant population in this country and the summarised research highlights the psychological needs of this population. Despite the increased risk of poor mental health and adverse experiences, Poles seem to be reluctant to seek help and are known to underutilise NHS services. Indeed, the majority of the identified literature seems to be concerned with “what is it about the Polish that makes them reluctant to seek psychological help?” rather than to also explore whether the kind of services provided, and how they are provided, are in line with the needs, values and beliefs of the community. The study by Pleitgen was the only study to focus in more depth on the experiences of Polish migrants who have accessed psychological help in the UK.

While the aforementioned studies focus on the perspectives of Poles as a minority, they appear to assume that both majority and minority groups in this context are in a balanced relation of status and power. The answers given by research participants are seen as their “preferences” chosen within a free choice scenario, and they tend to ignore the political, social and economic power inequalities (Paloma, García-Ramírez, Camacho, & Olmedo, 2016). More active effort ought to be made to reach out to these individuals. In order to do that, this study aims to explore what the NHS is currently doing for this population and what needs to change for the services to be more accessible to Polish migrants. This study will therefore aim to answer the following research questions:

- How well is the NHS monitoring how much Polish people access mental health services?
- How frequently are Polish people using mental health services compared to other groups of people living in the UK?
- What might need to change to make mental health services accessible/used by Polish people?

The study will focus on adult mental health services.

CHAPTER 2: METHOD

2.1. Overview

This chapter will offer a summary of the epistemological position underpinning the present study, offer a reflection of my own position as a researcher conducting this study. It then describes the consultation process in developing the study materials, followed by a description of the research design. The two studies will be outlined in detail, the recruitment strategy, materials and procedures and analytic strategy applied to the data will be considered.

2.2. Epistemological Position

The current study adopted a critical-realist epistemology which postulates that even though we can assume that an independent reality exists, we are not committed to the view that absolute knowledge of the way it works is possible (Scott, 2005). It is assumed that reality cannot be accessed independently of perception and thinking and can therefore be understood from multiple perspectives (Harper and Thompson, 2012). Furthermore, the critical realist position emphasizes the replicability of research (Popper, 1995) and that a topic of research should be approached using different methods, with complementary strengths and weaknesses, i.e. the strategy of triangulation (Creswell, 2003; Tashakkori & Teddlie, 1998).

The current study aims to develop a better understanding of Polish migrants' needs in relation to psychological help in the UK, as well as insight into what NHS mental health services are doing to tailor service provision to this population. From this perspective the researcher takes the position that there is an ontological reality to the provision of mental health services to migrant populations in the UK as well as to the act of emigrating from one country to another. The implication here is that these realities exist beyond the participants' accounts and the researcher's interpretations of them. However, the nature of the impact of emigration and particular experiences of seeking and receiving help for emotional problems in a foreign country, as well as the way this impact is constructed might be affected by multiple factors. These include service structures and data monitoring practices as well as individuals' experiences and beliefs, their meaning making systems, their language and societal discourses.

Furthermore, regardless of the researcher's own perceptions of discrimination and ethnicity, informed by their own experience of being a migrant, ethnic disparities in service provision still exist. Therefore, using Freedom of Information Requests (FOIRs) and a survey, facilitates the gathering of data from both mental health services and the population in question. Consequently, it was hoped that this strategy would provide valuable evidence concerning the mechanisms that underpin observed service disparities. By adopting a mixed-method design, the study deploys the strategy of triangulation, and thereby offers a new perspective into this topic and complements the current research base.

2.3. Reflexivity

The choice of research questions and the methodology used have all been influenced by my theoretical orientation, experiences, position in society as well as my ethical considerations and commitments.

I am a 28 year old white woman. My parents are Polish migrants who emigrated to Sweden where I grew up. I identify as both Polish and Swedish, and I speak both languages. I moved to the UK approximately 10 years ago. When people ask me where I am from I noticed that the reactions are different whether I respond that I am Swedish or Polish. The two counties seem to carry with them different connotations and constructs of the 'type of migrant'. My subjective experience has been that migrants from Sweden, due to the economic status of Sweden, are favoured over those from Poland, who are often seen as 'low-skilled workers', a construct that carries with it the weight of political and media representations of Poles in the UK (Rzepnikowska, 2018). My experience influenced my interest in the 'racialization' of Polish migrants and the constructs of whiteness.

Furthermore, I am a Trainee Clinical Psychologist at the University of East London. The ethos of the university, which privileges the role of social context in understanding distress, is a further influence on my personal stance. Moreover, being employed by the NHS means that I am immersed in the context that I am researching. Throughout the conduct of this thesis I have been on a number of placements in the NHS. My work has confirmed my belief that there is little talk of Polish migrants in the various teams. Despite an acknowledgement that most professionals have worked with Polish service users, little consideration has been paid to Polish service users as a community with distinct cultural needs.

2.4. Consultations

2.4.1. Dr Michal Garapich

I set up a meeting with Dr Michal Garapich, senior lecturer at the Department of Social Sciences, University of Roehampton, specialising in the issues of migration, ethnicity, nationalism, multiculturalism, substance misuse, homelessness and migration from Poland. He advised me on the make-up of the Polish population of the UK; different waves of groups of Polish migrants in the UK, intersectionality of Polish migrants, power relations within diasporic/ethnic associations and negotiations of ethnicity and whiteness. Information gathered from this meeting informed this study's rationale and aims.

2.4.2. Karina Pleitgen

Karina, a former Trainee Clinical Psychologist at the University of East London, completed her thesis in 2018 looking at factors affecting psychological wellbeing of Polish migrants in the UK, their access to services and their experience of accessing them. She also interviewed psychologists in the UK on their experience of working with this client group. Details of Karina's study are outlined in the literature review section of this thesis.

The meeting with Karina helped identify current research gaps and informed this study's methodology. Karina's study helped inform the development of the survey – particularly questions around Polish migrants' expectations of therapy and appropriateness of the care provided by NHS mental health services.

2.5. Design

The current project adopted a mixed method design and consists of two studies:

- **Study 1:** Looking at how well the NHS is monitoring how much Polish people access mental health services, how frequently Polish people are using mental health services compared to other groups of people living in the UK and whether mental health services have developed an equality strategy that addresses the needs of Polish service users.

- **Study 2:** Looking at what might need to change in order to make mental health services accessible/used by Polish people.

2.6. Study 1: Freedom of Information Requests

The study employed a Freedom of Information (FOI) Act methodology in order to answer the first two research questions:

- How well is the NHS monitoring how much Polish people access mental health services?
- How frequently are Polish people using mental health services compared to other groups of people living in the UK?

The Freedom of Information Act 2000 provides public access to information held by public authorities. Under the Act, any member of the public is entitled to request information from authorities. If the authority possesses the requested information, they are obliged to share it. If however, the public authority is not in possession of the information, or if the request exceeds 18 hours to collate, which is equivalent to a cost of £450 (calculated at a rate of £25/hour), the requestor is entitled to a notice of denial or exception (Savage & Hyde, 2014). Under the FOI, the public authority is required to respond within 21 working days, and should notify the requestor of receipt and/or any reason they are unable to fulfil the request (Information Commissioners Office (ICO), 2002).

FOI methodology is becoming increasingly popular in the field of social science, including studies of mental health provision (e.g. Bennion, Hardy, Moore & Millings, 2017; Harrop, Read, Geekie & Renton, 2018; Read, Harrop, Geekie & Renton 2018). FOIRs are a powerful tool, that can provide significant amounts of meaningful data and, due to their low costs, enable researchers to undertake projects that have previously been the domain of large financial investments. Consequently, the added benefit of this methodology, is its flexibility, allowing researchers to analyse and report their own findings based on large scale data, while remaining true to their aims and epistemological and ontological positions (Savage & Hyde, 2014).

2.6.1. Ethical Approval

No ethical approval was required for this part of the study as any member of the public is entitled to request information from public authorities and no individuals were contacted in any way as a result of the FOIRs.

2.6.2. Data Gathering

In April, 2019, FOIR were piloted on 4 Trusts (Black Country Partnership, Coventry and Warwickshire, North East London, South West London). The request consisted of 11 questions, developed specifically for this study to address the research questions (see below).

One Trust did not respond to the request, even after a reminder was sent (South West London). One Trust reported collecting no Polish ethnicity, nationality or country of birth data (Black Country Partnership NHS Foundation). One Trust reported collecting information on the number of Polish people (Coventry and Warwickshire). One Trust reported collecting nationality data (North East London). Due to the variability in responses it was deemed important to keep all the questions, therefore no amendments to the requests were performed.

In June, 2019, a FOIR was sent to FOI Officers in all of the 56 NHS mental health trusts across England. For the full request please see Appendix A.

1) The number of people seen by adult Mental Health Services in the latest year for which you have complete data, by ethnicity (specify which year please). If possible, please break this down further by gender and age.

2) The number of people seen by adult Mental Health Services in the latest year for which you have complete data, by nationality. If possible, please break this down by gender and age.

3) The number of people seen by adult Mental Health Services in the latest year for which you have complete data, by country of birth. If possible, please break this down by gender and age.

4) [If not provided an answers to Qs 1-3] the number of times Polish people used your Adult Mental Health Services in the latest year for which you have data? If possible, please break this down by gender and age.

5) The number of times a Polish interpreter was used within adult mental health services in the past year

6) The number of people for whom the Mental Health Act was used in the past year, broken down by Ethnicity, Nationality and/or Country of Birth

7) The number of times the four most frequently used psychiatric diagnoses were used in the past year, broken down by Ethnicity, Nationality and/or Country of Birth

8) The number of people that received psychological therapies in the past year, broken down by Ethnicity, Nationality and/or Country of Birth

9) Does your trust have a policy, programme or initiative that focuses on ethnicity/diversity/cultural competence/race inequality relating to:
a. The provision of adult mental health services?
b. Operational aspects of mental health services e.g. staffing / recruitment / support?

*If yes, please include the policy/policies in your response.**

10) What number of adult Polish people are in your catchment area?

11) What is the adult population of your catchment area?

After the initial FOIR response deadline of 21 working days had elapsed, a follow up email was sent to 14 Trusts that did not respond (see Appendix B).

4.6.3. Analysis

This data was analysed using descriptive statistics.

2.7. Study 2

In order to address the question 'What might need to change to make mental health services accessible/used by Polish people?' an online survey was conducted with Polish migrants living in the UK. The survey included questions relating to people's experience of mental health difficulties as well as their experience of seeking support, or not seeking support, for any mental health problems while living in the UK. The full survey is attached in Appendix C.

2.7.1. Survey Design

The survey was developed by the researcher in consultation with the research supervisor, and the consultations outlined above. Questions referring to causal beliefs of mental health difficulties were based on a previous study by Read, Cartwright, Gibson, Shiels and Haslam (2014). Two trainee clinical psychologists, two members of the public, and three Polish speakers, took part in piloting the survey. They were asked to comment on the coherence and clarity of the questions, completion time and ease of use. The survey was amended based on the feedback provided, e.g. use of language (consistency of use of 'distress' and 'problem'), section flow and division of survey, inclusion of questions around the help respondents would have liked to receive.

2.7.2. Materials

The survey, developed using the Qualtrics tool (https://www.qualtrics.com), was available in English and Polish. The researcher, who is fluent in Polish, translated the survey using back-translation based on established guidelines. The survey was given to two native Polish speakers to check for discrepancies.

2.7.3. Ethics

Ethical approval for this study was gained from University of East London's Ethics Committee, see Appendix D. One minor amendment was requested related to the study title, the additional approval is included in Appendix D.

2.7.3.1. Informed consent

The advertisements for potential survey participants included the aims of the study. The front page of the survey on Qualtrics included a full information sheet, explaining the purpose of the survey and the researcher's contact details, information about anonymity, etc. (See Appendix E).

An informed consent measure, tailored towards an online study, was used. The form was broken down into statements with a check box next to each statement. Participants were asked to tick each respective box to signal consent (See Appendix F).

The right to withdraw at any time (before, during and after) was clearly stated on the consent form, invitation letter and online measures. Failure to tick all boxes to indicate informed consent prevented the participant from continuing with the online survey and they were subsequently taken to the debrief form.

2.7.3.2. Right to withdrawal

Participants were advised that they were free to withdraw from the research study without explanation, disadvantage or consequence. Participants just had to exit from the online survey if they so wished, at any time. Exiting from the survey still allowed data up until that point to be stored, and participants were notified of this. If the participant wanted to withdraw their data from the study entirely they were asked to request this by contacting the researcher via email (listed on the invitation page) providing their participant code (generated and indicated by Qualtrics).

Participants were reminded about their right to withdrawal up until the point of the data being analysed, which took place a month after their participation. If they withdrew after that time period, the researcher reserved the right to use their anonymous data after analysis of the data had begun. This was made clear on the information sheets and consent forms.

2.7.3.3. Confidentiality

Participants privacy and safety was respected at all times. The survey was completely anonymised.

The online version of the questionnaire had been constructed as an anonymous survey, meaning no emails or IP addresses were identified in the responses. HTTPS survey links (also known as secure survey links) had been used, giving Secure Sockets Layer (SSL) Encryption while the questionnaire was being completed. During the study, data collected online was stored on an EU-based server and was subject to EU Data Protection acts. All online data was completely destroyed following completion of data collection.

2.7.3.4. Debriefing

All participants were informed about the true nature of the research before they agreed to participate. A de-brief letter was presented at the end of the survey to re-iterate the information given on the information sheet and to thank participants for their time (See Appendix G).

2.7.3.5. Consideration of distress

It is possible that some respondents may have experienced some distress when recalling their mental health difficulties or an absence of support for those difficulties.

The Debrief Sheet included the following statement:

If you need support with any distress you may experience from completing the survey, please consider letting a trusted friend or relative know how you are feeling, contacting your GP, or ringing Samaritans on 116 123.

2.7.4. Participants

The population of interest were Polish adults living in the UK, estimated to be one million. Recruitment took place from June 2019 to February 2020, using a combination of convenience and snowball sampling strategies. All participants were recruited online through Facebook and online Polish news media (Polish Express).

2.7.5. Sampling Procedures

All Facebook groups were identified by entering key words into Facebook ‘search’ for the people living in the same area e.g. ‘Polish people in’ and the name of cities in the UK (e.g., London, Glasgow). In addition, Facebook automatically recommended other potentially relevant groups based on the searches. After obtaining membership to those groups, the researcher was able to access 14 groups. The groups included 167,740 members. However, this number fluctuated during data collection. In addition, it is unclear how many members were active users and how many individuals were members of more than one group. The survey was posted in each group twice between September 2019 and February 2020.

The link to the survey, together with brief information, in Polish, explaining the purpose of the study was posted on the groups’ home page. A translated version of the information can be found in Appendix H. The survey was also posted on Polish Express, a Polish online news service. The website asked for a brief article contextualising the need for this research to be posted alongside with the survey link. The article was co-written with the news editor. A translated version of the article can be found in Appendix I.

2.7.6. Data Analysis

For quantitative questions, the total number of responses were collated and presented using descriptive statistics and visual displays.

Statistical analysis were conducted to test for group differences between participants who sought help for their mental health difficulties and those who did not. Independent-samples t-tests and chi-square test for association were conducted to consider the impact of gender, age and length of stay in the UK.

Responses to open, qualitative questions were analysed using an inductive content analysis. All responses provided in Polish were translated into English by the researcher. The content analysis followed the procedure outline by Erlinsson and Bryciewich (2017). After thorough familiarisation with the transcribed data, the text was divided into meaning units. Because of the simplicity of the questions (which often required only one word answers) the meaning units were grouped into themes that formed the highest level of abstraction (e.g. post-natal depression). Each theme was then counted. Only themes that were reported by 3 or more participants were reported. For themes that required higher level interpretation at least three example quotes were provided (see Table 12).

2.7.6.1. Description of profession

Participants were asked an open ended question about their profession. Their responses were coded and grouped using the International Standard Classification on Occupations (ISCO). ISCO is an International Labour Organisation classification structure for organising information on labour and jobs. It is part of the international family of economic and social classifications of the United Nations. The current version, which was published in 2008, is known as the ISCO-8. The full classification structure can be found in Appendix J.

CHAPTER 3: RESULTS

3.1. Overview

This study has two parts. The first section is related to research question one : “What are Trusts in England doing to improve access to mental health services for Polish migrants?”. This section reports the findings from the FOIRs sent to all 56 Trusts in England. The second section is related to research question two: “What might need to change in order to make mental health services accessible/used by Polish migrants in the UK?”. This section reports the results of the survey using descriptive and inferential statistics.

3.2. Study 1: Analysis of Freedom of Information Act Requests (FOIRs)

In this section, Trust’s compliance rates, the current landscape of monitoring Polish ethnicity, nationality and country of birth, as well as race equality policies, are presented.

3.2.1. FOIRs Response Rates

Table 1 provides a breakdown of the NHS Trust’s response rate process. Of the 56 Trusts that were sent an FOIR, 46 responded, a response rate 82%.

Table 1. FOI Response Rates

	Number of Trusts	**Rate**
Trusts that were sent an FOI request	56	
Trusts that responded	46	82%
Trusts that required a reminder email	16	29%
Trusts that were unable to respond/did not hold data	2	4%
Trusts that did not respond to the request	8	14%

Of the 46 Trusts that responded, three raised “reasonable request” concerns, whereby they exercised their right to withhold or truncate responses to a question, if it exceeds 18 hours of time or £450 to calculate.

3.2.2. Monitoring Information

3.2.2.1. Ethnicity data

46 Trusts answered this question. Of these only 22% recorded ‘White Polish’ ethnicity. Other ethnicities, such as ‘White Irish’ were routinely recorded. See Table 2.

Table 2. Monitoring Ethnicity

	Number of Trusts	**Rate**
TOTAL RESPONSES	**46**	
Trusts monitoring ethnicity	44	95.7%
Trusts monitoring Polish ethnicity	10	21.7%
Trusts that do not monitor ethnicity	2	4.3%

3.2.2.2. Nationality data

43 Trusts answered this question. Of these, 22 (51.2%) collected nationality of service users. 12 out of the 22 Trusts had incomplete data, see Table 3.

Table 3. Monitoring Nationality

	Number of Trusts	**Rate**
TOTAL RESPONSES	**43**	
Trusts monitoring nationality of service users	22	51.2%
Trusts that do not monitor nationality of service users	21	48.8%

3.2.2.3. Country of birth data

As seen in Table 4, only six Trusts routinely collect data on patient country of birth. However due to the data that was provided being largely incomplete, this measure did not provide any insight into the proportion of Polish migrants being seen by the service. 37 of the Trusts, i.e. 86%, do not collect this information.

Table 4. Monitoring Country of Birth

	Number of Trusts	**Rate**
TOTAL RESPONSES	**43**	
Trusts monitoring country of birth of service users	6	14%
Trusts that do not monitor country of birth of service users	37	86%

3.2.2.4. Use of interpreter

Thirty two Trusts provided information on use of Polish interpreters. Two Trusts raised the “reasonable request” concern and did not provide any information to this question. Three Trusts were not able to provide information pertaining specifically to adult mental health services, only Trust wide use of interprets. One Trust did not have complete data for all the Trust boroughs.

Collated reports from the Trusts that provided this information indicate that interpreters were used at a range of 6 – 1,915 times over the span of a year per Trusts. These numbers include bookings of an interpreter repeatedly for the same service users.

3.2.3. Monitoring and the Mental Health Act

Table 5. Ethnicity, Nationality, Country of Birth and the Mental Health Act

	Number of Trusts	**Rate**
TOTAL RESPONSES	**43**	
Trusts monitoring ethnicity of service users	29	67.4%
Trusts monitoring Polish ethnicity	4	9.3%
Trusts monitoring nationality of service users	9	20.9%
Trusts monitoring country of birth of service users	1	2.3%
Trusts that do not hold this information	5	11.6%

43 Trusts answered the question on ethnicity monitoring of service users detained under the Mental Health Act, see Table 5. Of these 29 collected data on the ethnicity of service users who were detained under the Mental Health Act in the past year. Out of the 29 Trusts, 4 had available data for the category ‘White Polish’. Out of these 4 Trusts, only 2 had complete data for all service users detained in the past year.

Nine Trusts asked for service users’ nationality, however the data provided for the past year were mostly incomplete for all Trusts.

One Trust asked for service users country of birth, however their data for the past year was mostly incomplete.

3.2.4. Monitoring and Diagnoses

43 Trusts answered the question on ethnicity monitoring and diagnoses of service users, see Table 6. Of these, 20 collected data on ethnicity of service users in relation to their diagnosis. Out of these 20 Trusts only 3 had available data for the category ‘White Polish’.

Nine Trusts asked for service users nationality, however the data provided for the past year were mostly incomplete for all Trusts.

One Trust asked for service users country of birth, however their data for the past year were mostly incomplete.

Fifteen Trusts reported not holding this information.

Table 6. Ethnicity, Nationality, Country of Birth and Diagnosis

	Number of Trusts	**Rate**
TOTAL RESPONSES	**43**	
Trusts monitoring ethnicity of service users	20	46.5%
Trusts monitoring Polish ethnicity	3	6.9%
Trusts monitoring nationality of service users	9	20.9%
Trusts monitoring country of birth of service users	1	2.3%
Trusts that do not hold this information	15	34.8%

*note, some Trusts collect data for one or more of these categories

3.2.5. Ethnicity Monitoring and Talking Therapy

44 Trusts answered the question on ethnicity monitoring and access to psychological therapy (see Table 7). Out of these, 23 collected data on service users who received talking therapy and their ethnicity. Out of these 20 Trusts only three had available data for the category 'White Polish'.

Eight Trusts asked for service users nationality, however the data provided for the past year was mostly incomplete for all Trusts.

One Trust asked for service users country of birth, however their data for the past year was mostly incomplete.

Thirteen Trusts reported not holding this information.

Table 7. Ethnicity, Nationality, Country of Birth and Therapy

	Number of Trusts	**Rate**
TOTAL RESPONSES	**44**	
Trusts monitoring ethnicity of service users	23	52.2%
Trusts monitoring Polish ethnicity	3	6.8%
Trusts monitoring nationality of service users	8	18.2%
Trusts monitoring country of birth of service users	1	2.3%
Trusts that do not collect this information	13	30%

*note, some trusts collect data for one or more of these categories

3.2.6. Number of Polish Migrants in Catchment Area

Only two Trusts could provide information on the number of Polish people that live in their catchment area.

3.2.7. Race Equality Policies, Initiatives or Programmes

Table 8 shows that of the 46 Trusts that responded to the FOIRs, two of them had specific initiatives and/ or policies that focused on race equality at both workforce and service delivery levels. The majority of Trusts employed both the EDS2 and the WRES.

Table 8. Race Equality Policies

	Number of Trusts	**Rate**
TOTAL RESPONSES	**46**	
Trusts that reported having a race equality strategy	2	4.3%
Trusts using Equality Delivery System2	37	80.4%
Trusts using Workforce Race Equality Standard	40	86.9%
Trusts using both EDS2 and WRES	34	73.9%

3.3. Study 2: Online Survey of Polish Migrants in the UK

3.3.1. Summary

The following section will present the results of the online survey of Polish migrants living in the UK. It begins with an overview of participant demographic information before presenting findings on their experience of any mental health difficulties and perceptions of received care.

3.3.2. Demographic Information

A total of 646 people consented to taking part in the survey. Out of these participants 607 went on to answering the first question asking whether they were a Polish migrant living in the UK. 602 confirmed that they were in fact a Polish migrant living in the UK. Three people answered with the option ‘other’; two specified having lived in the UK but recently having moved back to Poland, one responded that they have now obtained a British citizenship. All three were included in the final sample of 605 participants.

Due to the design of the survey it was difficult to monitor attrition rates. However, based on the final sample that answered the last question presented to all participants 92 % of responders (559/605), made it through to the end of the survey.

3.3.3. Age and Gender

As summarised in Table 9, the average age of participants was 35 years of age (SD= 9.06). This is in accordance with the literature demonstrating that most Polish migrants in the UK are young adults of working age (Macigowska & Hanley, 2018).

The majority of participants (76.5%) identified as female.

Table 9 Age and Gender of Survey Participants

Age	**Count**
Range	18-65
Average	35.5
Median	35
Mode	33
Gender	**Number of participants**
Female	463 (76.5%)
Male	141 (23.2%)
Other	1 (0.2%) Identified with both genders
Total number of respondents: 605	

3.3.4. Profession

Table 10 summarises the professions of participants. See Appendix 7 for a thorough explanation of each category. A high proportion of the participants fell in the ‘Professionals’ category (19.2%), which included nursing, finance or engineering jobs and in the ‘Service and sales’ group, which included jobs such as waitering or child minding.

Table 10. Profession of Participants

Profession	**Count**
Professionals	106 (19.2%)
Service and sales workers	85 (15.4%)
Plant and machine operators and assemblers	71 (12.9%)
Elementary occupations	70 (12.7%)
Technicians, assistant professionals	55 (10%)
Craft and related trades workers	43 (7.8%)
Manager	42 (7.6%)
Student	25 (4.5%)
Clerical support workers	24 (4.3%)
Unemployed	22 (4%)
Answer not applicable	9 (1.6%)
Total number of respondents: 552	

3.3.5. Number of Years Living in the UK

A total of 600 participant answered this question. On average, participants have lived in the UK for 8.7 years (SD= 4.42), with a range from 0 to 23 years.

3.3.6. Experience of Mental Health Difficulties

A total of 601 participants answered the question ‘During your stay in the UK, have you experienced mental/psychological/emotional distress to the point that you thought you would need help from someone outside of your family?’. Table 11 summarises their responses. The majority of participants, 61%, reported having experienced mental health difficulties.

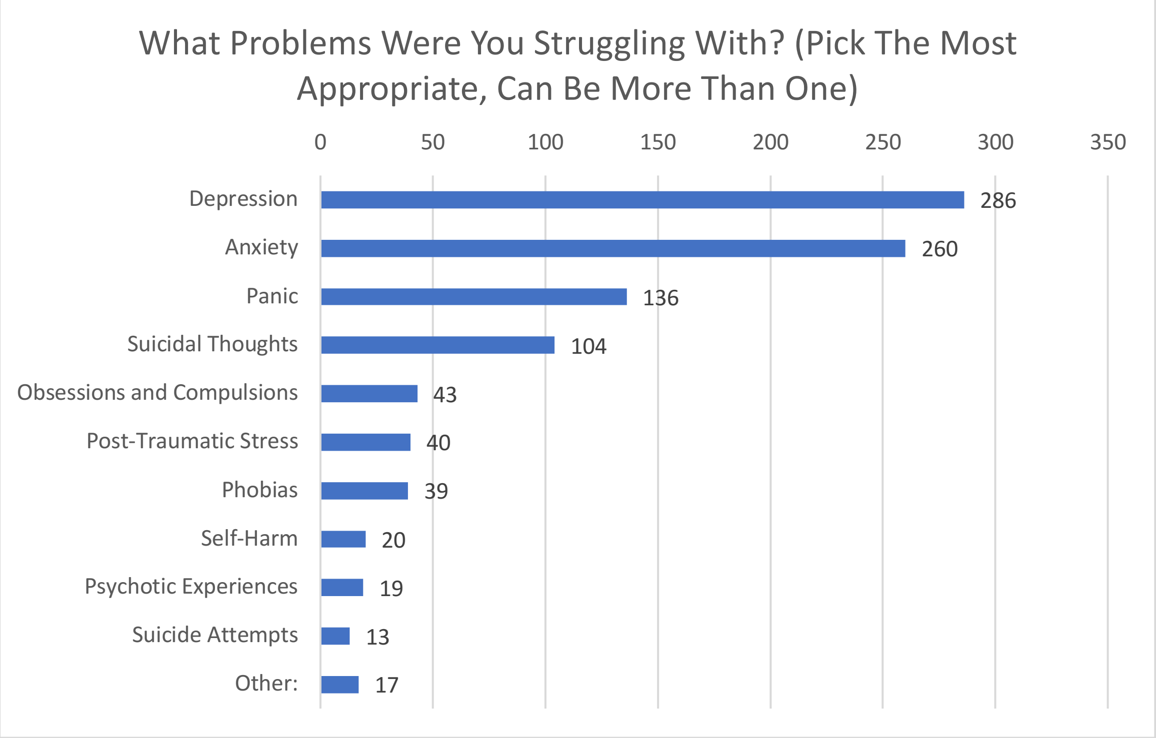
Table 11. Experience of Mental Health Difficulties

Experience of Mental Health Difficulties	**Count**
Yes	369 (61.4%)
No	204 (33.9%)
Don't Know	28 (4.7%)
Total number of respondents: 601	

Participants who answered 'Yes' or 'Don't know' were asked to continue with the survey (n=397). Participants who answered 'No' were taken to the end of the survey where they were asked whether they were aware that they are entitled to free mental health care via the NHS.

Figure 2 presents a bar graph of the different options participants chose from when categorising their mental health concerns. Participants could chose more than one option. A total of 397 participants were asked to answer this question.

Figure 2. Summary of Experienced Difficulties

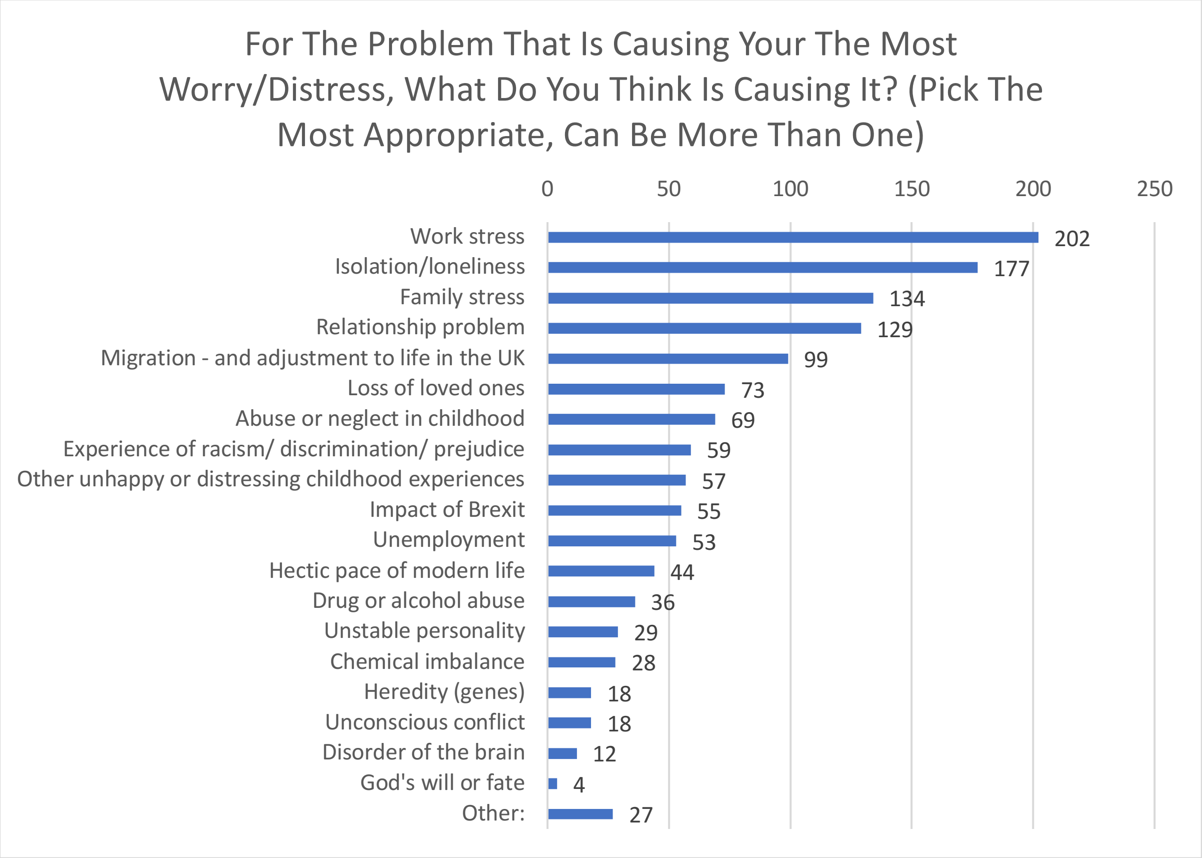


As seen in Figure 2, depression (72.0%) and anxiety (65.5%) were the most common problems reported. Panic (34.3%) and suicidal thoughts (26.2%) were also frequently reported.

Eight participants provided a response to the option ‘Other’. Post-natal depression was the most frequent (4 participants).

Participants were then given a series of options to choose from that best described what they believed to be the cause of their difficulties, see Figure 3. Participants could choose more than one option.

Figure 3. Believed Causal Factors of Mental Health Difficulties



Work stress (50.9%) and isolation/loneliness (44.6%) were the biggest perceived causes of mental health difficulties, closely followed by family (33.8%) and relationship difficulties (32.5%). Migration and adjustment to life in the UK (24.9%) was also a factor frequently selected. 55 participants (13.9%) answered that Brexit had an impact on their distress.

Twenty six participants provided 'other' causal factors. The most frequent were Physical health issues (5), sexual violence (4), domestic abuse (3) and caring responsibilities (3).

3.3.7. Seeking Help for Mental Health Difficulties

A total of 381 people answered the question "Did you seek support for any of the problems you were struggling with?". Less than half (159, 41.7%) responded that they did not seek help for their mental health difficulties. Table 12 summarises the their responses to the question 'What stopped you from seeking help?', 129 participants answered this question.

Table 12. Responses to "What stopped you from seeking help?"

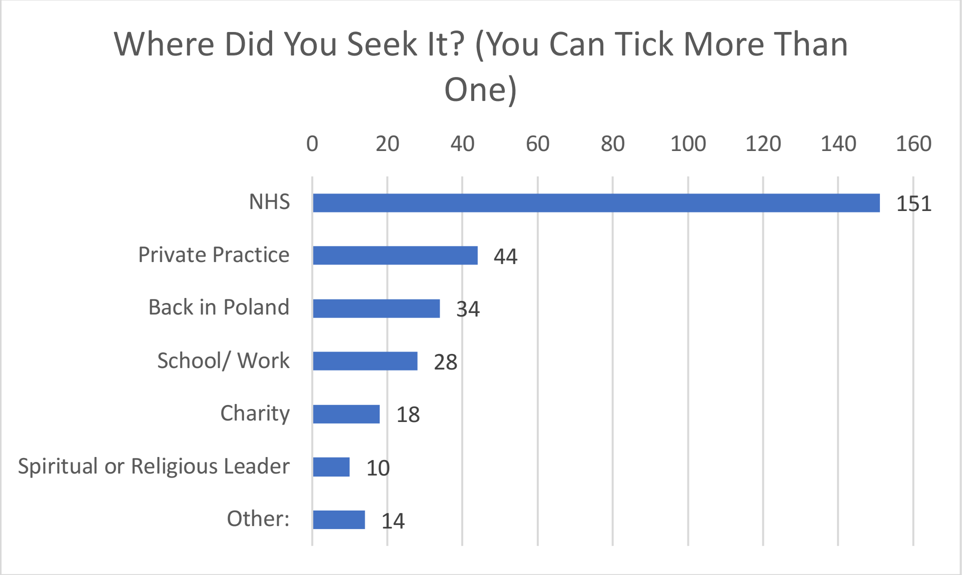
Theme	Count	Example Quote
Self-help, support from loved ones	22	"I can deal with everything myself", "Talking to friends"
Language barriers	19	"Lack of help in native language", "Insufficient language skills"
Lack of Time	18	"No time", "Time"
Lack of belief in services	16	"Previous experiences with NHS" "An incomprehensible and ineffective treatment system, fear of being misunderstood by an Englishman", "Lack of interest of healthcare professionals to help citizens of other countries", "Fear of being locked up in the hospital"

Shame	14	“Shame, shyness” “I did not want to share my problems with others”
Fear	13	“Fear”, “Fear, underestimating the problem”
Don’t know	12	“Don’t know”
Unaware of what is available	9	“Lack of knowledge where I can find this help”
Money	6	“Lack of money”, “Money”
A family member	5	“Family”, “Husband”
Did not feel motivated enough	4	“Myself”, “I couldn’t be bothered”
Fear of seeming like overreacting	3	“Telling myself that this is how it should be and other have it worse” “I am not sure if it is not my invention or my fault”

The most common factor was self-help and support from loved ones being sufficient. Language barriers were a frequent theme and will be explored further later in the survey. Lack of time and lack of belief in services also came up frequently. The theme of ‘Lack of Belief in Services’ often related to participants’ experience of being a migrant in the UK and fearing not being understood by a British clinician. Indeed, the themes of fear and shame were reported by many participants as a barrier to speaking about their difficulties. The 159 participants who answered this question were automatically taken to the next section of the survey where they were asked whether they were aware that free mental health care is available through the NHS.

The majority of participants (216, 56.7%) responded that they did seek help for their experiences of mental health difficulties. Six participants responded with the option ‘Other’. Figure 4 summarises participants’ responses to the question about where they sought support.

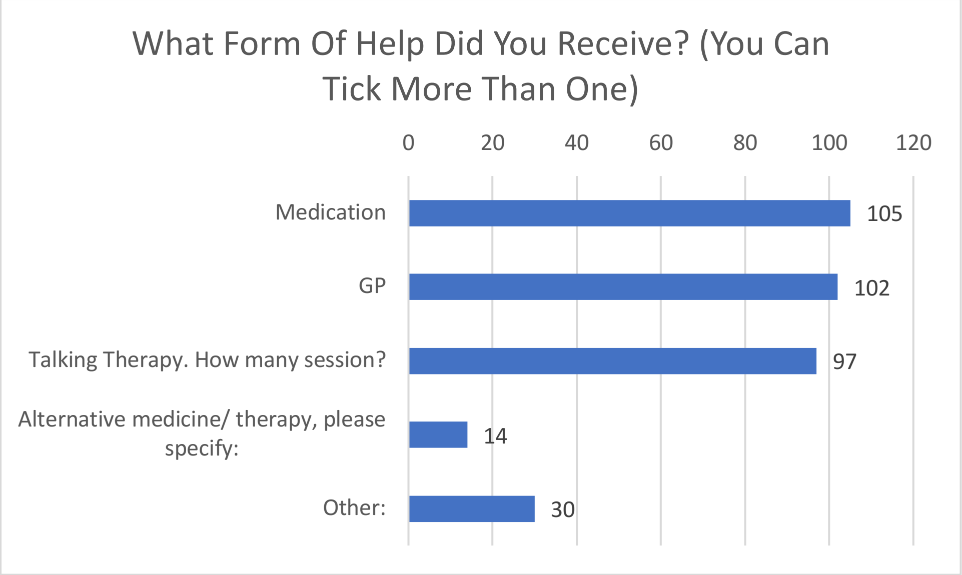
Figure 4. Summary of Where participants Sought Support



The majority of participants who sought help did so through the NHS (69.9%). The second most frequent option was private practice (20.4%) followed by seeking help back in Poland (15.7%). Responses to the option 'Other' included; private Polish psychologist (3), support from family and friends (2), other health care professionals (2) and community groups (2).

Participants were then asked to specify what form of help they received, see Figure 5.

Figure 5 Summary of the Help Participants Received



Almost half of the participants approached their GP (47.2%) for support. Furthermore, participants could choose more than one option and there was an equal balance between medication (48.6%) and talking therapy (44.9%) as the main treatment options on offer.

From the 97 participants who reported attending talking therapy, 63 specified how many sessions, four responded that the therapy was still ongoing and did not provide the number of sessions that they had attended so far, and 30 did not provide an answer. From the recorded responses, the range of sessions offered spanned from 0-25, with an average of 7.7 and a Mode of 10 sessions.

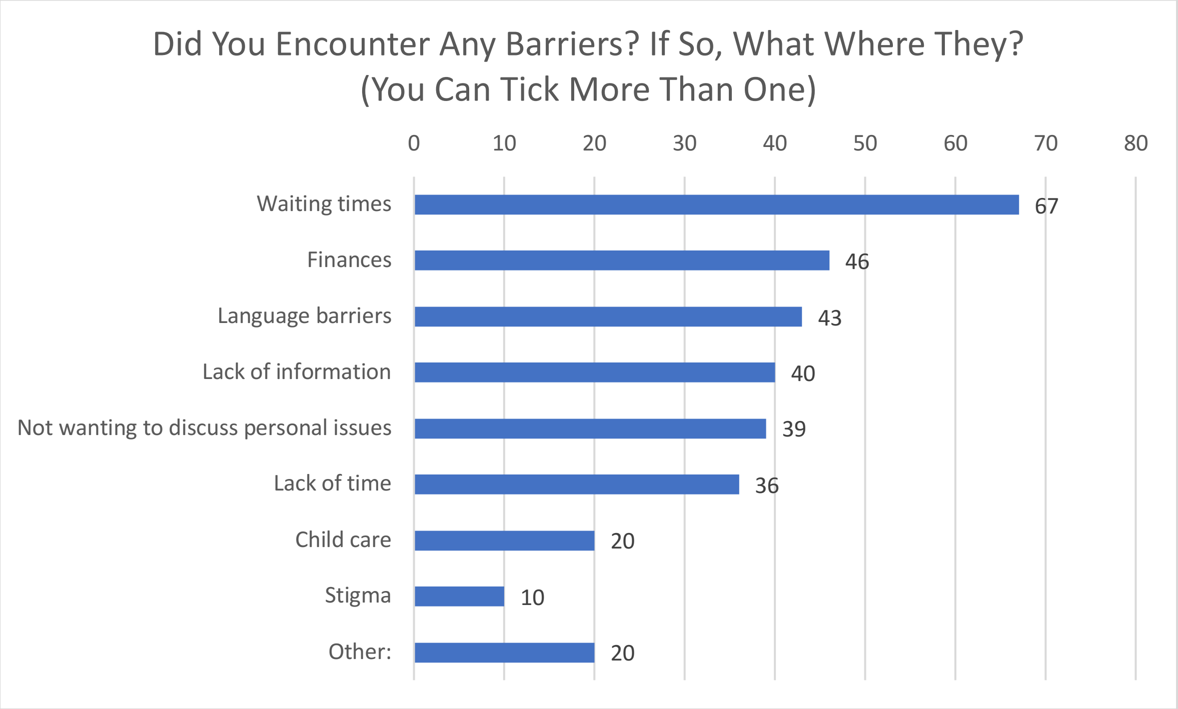
Responses to the option ‘Alternative medicine/therapy’ were very limited. Five participants used this option to specify the medication that they were taking, two reported using yoga and meditation.

16 responded to the question about ‘other’ treatments. Ten reported receiving no help at all, three reported engaging in community resources and support groups, and three reported engaging in group therapy/IAPT skills groups.

3.3.8. Barriers to Help Seeking

The 216 participant were then asked about barriers to obtaining help (see Figure 5). Waiting times (31%) were the most frequently reported barrier to seeking help. Lack of information about services (18.5%) and lack of finances (21.3%) were also reported to be big barriers, indicating that there is perhaps a belief that support needs to be paid for. A resistance to discussing personal issues was also a frequent barrier (18.1%). The barrier of language (19.9%) was further explored in the following questions.

Figure 6. Barriers to Getting Help



Content analysis conducted on the responses to the option ‘Other” revealed that ‘Inappropriate treatment’ (5) (e.g. ‘don’t agree with diagnosis’, ‘felt laughed at’) and ‘not being taken seriously by GP’ (4) were the most frequent themes.

Participants were subsequently asked about the help that they would have liked to receive. 140 participants provided an answer. Table 13 summarises their responses. Most participants responded that they would have liked to received talking therapies (46.4%) and help that was tailored to their particular needs (11.4%).

Table 14. Responses to the Question ‘What Help Would You Have Liked to Receive?’

Theme	Count
Psychology/ talking therapy	65
Support tailored to specific, individual needs	16
Medical check/ medication	10
More understanding and support from GP	9

Quicker help	8
None	6
Therapy in Polish	6
More options	5
Happy with the care provided	5
Don’t Know	4
Legal or financial advice	3

Table 15 summarises participants’ preference of language, a total of 183 participants answered this question. The majority of participants (82.0%) responded that they received care in English. When asked what language they would have preferred their care to be in, almost half of the participants (47.5%) responded with Polish. A big proportion of participants responded that they had no preference between Polish or English (30.60%).

Table 15. Responses to the Questions Regarding Language Preferences

What Language Did you Receive Care In?	**Count**
English	150 (82%)
Polish and English (with interpreter)	23 (12.6)
Does not matter	8 (4.4%)
Answer not applicable	2 (1.1%)
What language would you have liked to receive care in?	**Count**
English	39 (21.3%)
Polish	87 (47.5%)
Does not matter	56 (30.6%)

3.3.9. Talking Therapy and the NHS

When asked “Were you aware that you are entitled to free mental health care via the NHS?”, 72%, out of the 559 participant who answered this question responded yes. From the participants who responded with the option ‘other’, 5 responded that they were not sure if that was the case, 2 reported that they found out about it after they no longer needed mental health support, and 1 participant responded that they believed the care was only free until the age of 25. 26% of participants were not aware that they are entitled to free NHS mental health care.

When asked “Have you Received Talking Therapy Through the NHS?’, only 17% of participants responded that they had. When asked to describe what kind of therapy they received (see Table 19) the majority of participants responded with individual/face-to-face therapy. Thirteen participants specified that they received Cognitive Behavioural Therapy and some mentioned therapy for specific concerns (e.g. postnatal depression).

Table 19, Responses to the Question ‘Please give the name of, or describe in one sentence, the type of therapy you received’

Type of Therapy	Count
Talking therapy/individual/face-to-face	24
CBT	13
Consultation/ meeting with psychiatrist	7
Counselling	7
Specific concerns named (e.g. postnatal depression, psychosis, grief, addiction, domestic abuse x2)	7
Group therapy	5
Don’t remember	4
None/Did not attend	4
Telephone consultation	3

Participants were subsequently asked about how many sessions they were offered and how many they attended. Looking at the averages of their answers from Table 20, participants tended to attend fewer sessions than they were offered, the discrepancy being about 2 sessions.

Table 20. Number of Therapy Sessions

Question How Many NHS Therapy Sessions Were You Offered?	**Count**
Average	7.7
Range	0-30
Don't remember/not specified	25
How Many NHS Therapy Sessions Did you Attend?	**Count**
Average	5.8
Range	0-30
Don't remember/not specified	12
Total number of respondents: 85	

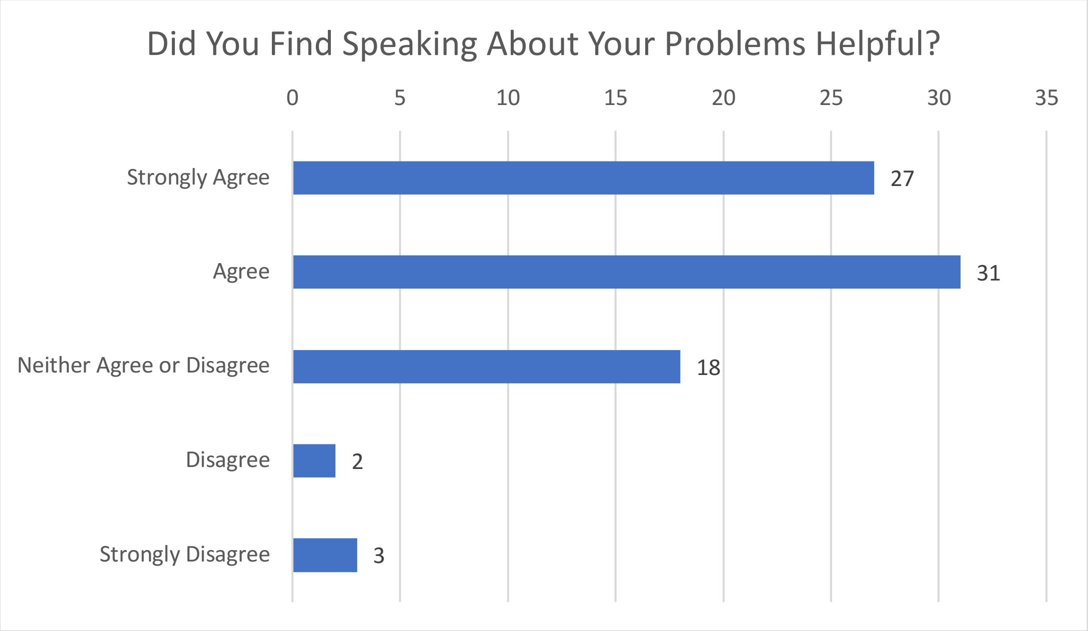
Participants were subsequently asked about their language preferences. As summarised in Tables 21, most participants received care in English. Their preferences indicate that the majority of participants preferred to either have therapy in Polish, or that they felt comfortable with either of the languages.

Table 21. Content Analysis of Responses to the Question 'What Language Did you Receive Care In?'

What Language Did you Receive Care In?	**Count**
English	58 (73.4%)
Polish and English (with interpreter)	20 (25.3%)
What language would you have liked to receive care in?	**Count**
English	15 (19%)
Polish	32 (40.5%)
Does not matter	32 (40.5%)
Total Responses: 79	

The survey went on to ask participants whether they found speaking about their problems helpful. A total of 81 participants answered this question. As summarised in Figure 6, the majority of participants found therapy to be helpful. The combined number of participants who answered “Agree’ and “Strongly Agree’ is 58 (71.6%).

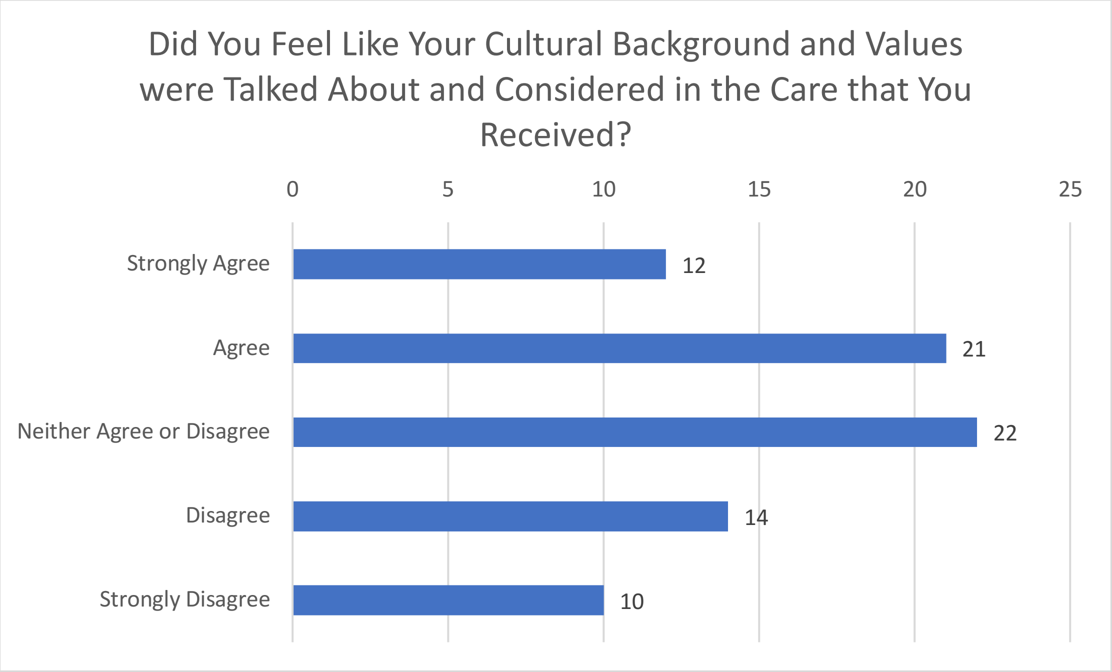
<u>Figure 7, Speaking About Problems</u>



The last part of the survey asked about cultural and religious considerations in the therapeutic work.

79 participants answered the question ‘Did you feel like your cultural background and values were talked about and considered in the care that you received?’. As seen in Figure 7 the combined number of participants who answered ‘Agree’ and ‘Strongly Agree’ is 33, which makes up for 41.77% of the sample. The most common answer was ‘Neither Agree or Disagree’ (27.85%).

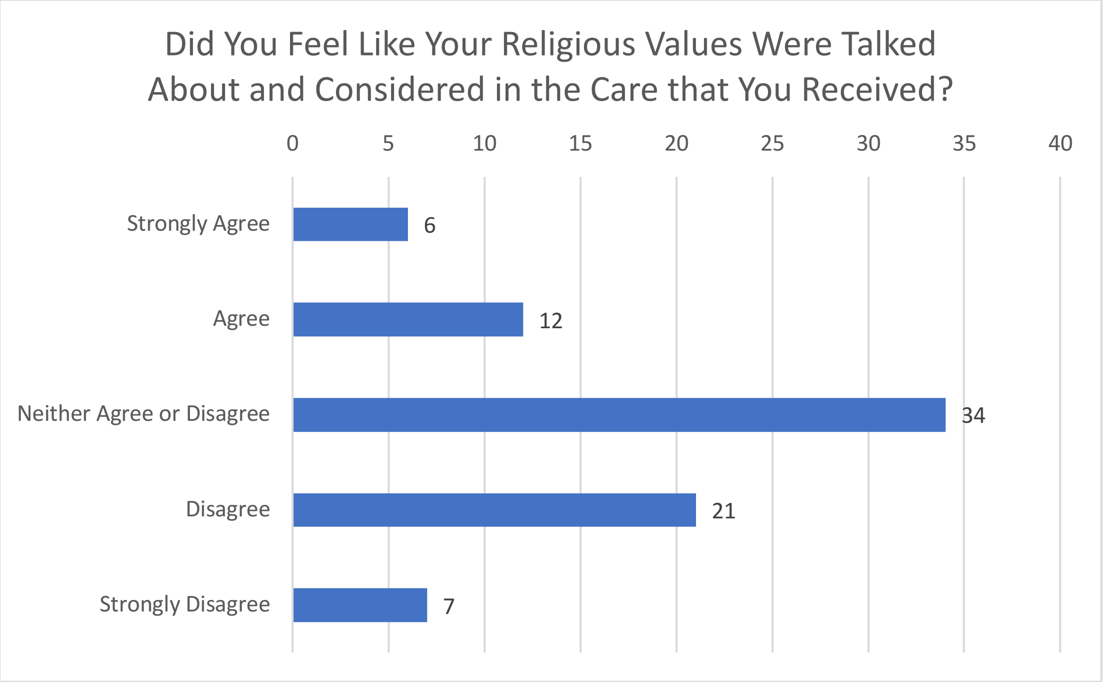
Figure 8. Considerations of Cultural Background and Values



When asked if they would have liked for their cultural values and beliefs to be considered in the care that they received, the majority of participants, 63.75% answered yes. A large number however, 31.25%, answered with ‘Don’t know’.

Lastly, participants were asked whether they felt like their religious values were considered in the care that they received, a total of 80 participants answered this question. The results for this questions are summarised in Figure 9. The majority of participants, 42.50%, responded that their neither agree or disagree with this statement. A big proportion answered that they disagree, 26.25%. However, when asked if they would have liked for their religious values to be considered in their care, participants gave a varied impression, the answers being almost equally distributed between the options ‘Yes’ (35.80%), ‘No’ (29.63%) and ‘Don’t know’ (34.57%).

Figure 9, Considerations of Religious Values



3.4. Group Differences in Help Seeking

Statistical analysis was conducted to test for group differences between participants who responded that they sought help for their mental health difficulties (n= 215) and those who did not (n=156).

3.4.1. Number of Years in The UK

An independent-samples t-test was run to determine if there were differences in number of years spent living in the UK between Polish migrants who sought help and those who did not. There were no outliers in the data, as assessed by inspection of a boxplot. Engagement scores for each level of time spent in the UK, were assessed by Shapiro-Wilk's test ($p > .05$), and homogeneity of variances, as assessed by Levene's test for equality of variances ($p = .055$). Participants who sought help had lived in the UK for longer (M = 9.81, SD= 4.5) than participants who did not (M = 8.29, SD= 4.06), a statistically significant difference, M = 1.51, 95% CI [0.621, 2.408], $t(369) = 3.333$, $p = 0.001$

3.4.2. Age

An independent-samples t-test was run to determine if there were differences in age between Polish migrants who sought help for their mental health difficulties and those who did not. There was no statistically significant difference, $M = 1.163$, 95% CI [-0.764, 3.09], $t(369) = 1.186$, $p = 0.236$.

3.4.3. Gender

A chi-square test for association was conducted between gender and help seeking behaviour. All expected cell frequencies were greater than five. There was no statistically significant association between gender and help seeking behaviour, $\chi 2(1) = 1.803$, $p = .179$

CHAPTER 4: DISCUSSION

4.1. Overview

This chapter will begin with a summary of the main research findings. A discussion of how these results compare to the general English public and previous research on the mental health of Polish migrants will follow. Some of the mentioned barriers to accessing help will be discussed in more detail. Implications for future research will be outlined before moving on to an evaluation of the current study.

4.2. Summary Of Findings

4.2.1. Main findings from the FOIR

This part of the study aimed to investigate what NHS mental health services are currently doing to facilitate access for Polish migrants.

The majority of Trusts reported recording ethnicity of service users in some capacity (95.7%). Only 10 Trusts (21.7%) reported having the option “White Polish” as an ethnic category. However, the meaningfulness of this data remains questionable. The majority of Trusts that provided their ethnicity data for the past year had missing data for a large proportion of service users. “White Polish” ethnicity data in relation to service user diagnosis, use of therapy and detainment under that Mental Health Act were only available from between two and four Trusts, and even then the data provided was poor and largely incomplete. Data on nationality and place of birth was even more scarce. Based on these results it appears that the NHS Trusts are not adequately capturing important information about the Polish migrant population. Because of lack of data on Polish service users it is impossible, for this researcher, the Trusts or the NHS, to assess how much Polish migrants are using mental health services compared to other migrant groups.

The failure to collect data on ethnicity is a longstanding problem in the NHS. A study from over twenty years ago looking at the reporting of ethnicity across inpatient services in the NHS, found high levels of invalid ethnicity coding in hospitals, the inconsistency of reporting rendered the data invalid (Gerrish, 2000). The study reported that over a third of NHS trusts felt there were other ethnic group categories for which data should have been collected, especially a subdivision of the white other group. More recent studies, while reporting an improvement over the past decade in the consistency of reporting, still report poor completeness by many services (Mathur et al., 2014; Afridi & Murji).

Out of the 46 Trusts that responded to the FOI, none had developed an equality strategy that specifically addresses the needs of Polish service users. The majority of Trusts reported relying on initiatives that had a broader focus i.e. the EDS2.

4.2.2. Main findings from the Survey

The survey was employed to address the question “What might need to change in order to make mental health services accessible/used by Polish migrants in the UK?”. This approach had two central objectives. Firstly, it aimed to contribute to the existing knowledge base regarding the factors influencing the psychological wellbeing of Polish migrants in the UK. Secondly, it sought to develop a better understanding of factors that affect Polish migrants’ access to mental health services and their experience of using them.

The results of the survey largely reflect the findings of the existing literature regarding factors affecting the mental health of Polish migrants in the UK (see 5.3 below). The majority of participants reported having experienced mental health difficulties during their time in the UK. Experiences of depression and anxiety were the most frequently reported concerns. Survey respondents reported psycho-social factors as the main cause for their distress, including work stress, isolation and loneliness, family stress, relationships problems and migration. Some of the other reported factors, such as isolation, and racism, might also be at least partly related to being a migrant.

More than half of the respondents sought support from mental health services for their distress. From the people who reported not seeking help, many reported that self-help and family support was enough. The main barriers included language difficulties, lack of time, lack of beliefs in services and experiences of fear and shame. Furthermore, participants who sought help had, on average, lived longer in the UK. It could be speculated that participants who have lived longer in the UK have a better understanding of the British healthcare system and a better proficiency of the English language, factors which would make seeking psychological help through the NHS easier.

Participants who sought help reported a number of barriers to pursuing further support. These included long waiting times, lack of finances, language barriers, lack of information, not wanting to disclose personal information and lack of time. Ten participants reported not having received any help despite seeking support. These responses were captured by a free text option and it is likely that the number is higher but due to a flaw in the survey design was not explicitly asked about.

Participants responded that their preferred form of support would be psychological talking therapy,17% reported having received talking therapy through the NHS. Importantly, the majority of participants who received talking therapy through the NHS reported having found it helpful. The general consensus was that their cultural values and believes were considered.

4.3. Comparison to Previous Research

4.3.1. Mental Health and Wellbeing in England

The most recent national survey looking at mental health and wellbeing of the population of England was published by NHS Digital in 2016 (The Adult Psychiatric Morbidity Survey - Survey of Mental Health and Wellbeing, England, 2014). According to the survey around one in six adults (17%) in England met the criteria for a diagnosis of common mental health difficulties. It was found that 37% of the respondents, who met the criteria for common mental health difficulties (examples given were Depression and Anxiety) were accessing mental health services. Of those who reported severe symptoms, 18% attended talking therapies.

Of the surveyed Polish migrants in this study 61.4% reported having experienced mental health difficulties (citing Depression and Anxiety as the most common concerns). This finding is significantly higher than the 17% of the general English population, although the NHS data includes only people who met diagnostic criteria. The current study found that out of the 369 participants who reported mental health problems 40.9% sought support for their difficulties through the NHS. This percentage is only slightly higher than the equivalent general population statistic (37%). Furthermore, 17% of the surveyed Polish migrants attended talking therapies through the NHS, a percentage very similar to that of the general English population (18%).

The following sections will begin by summarising participants causal beliefs of their mental health concerns in the hope of offering some explanations for the high proportions of reported difficulties. The remainder of the section will focus on discussing some of the reported barriers to accessing help. Even though the number of responses to perceived barriers are relatively small, they nevertheless offer important insights into better access to mental health support for this, particularly vulnerable, population.

4.3.2. Causal Beliefs

The most frequently cited cause of mental health difficulties was work stress. Most participants were working age adults. In their study on stress among Polish migrant workers in Scotland, Weishaar (2008) reported that participants complained of extremely high workloads and working hours. There is however, another layer to job dissatisfaction and it could be speculated to relate to what Macigowska and Hanley (2017) describe as ‘brain waste’, where they argue that many Polish migrants in the UK are in fact qualified young people who out of economic necessity are required to perform jobs that they feel overqualified for.

Isolation and loneliness, family and relationship difficulties, migration and adjustment to life in the UK were other factors frequently mentioned as causes for mental health difficulties. It has been argued in the literature that Poland adheres to collectivist cultural ideals (e.g. Hofstede, 2001). As such many Poles rely on close family and friendship networks for emotional support. It could therefore be speculated that feelings of loneliness and isolation are exacerbated by the differing values attached to the collective in the UK. Hence migrants moving from a collectivist to individual society may have difficulty settling in and finding the support that they are most familiar with (Bhugra, 2004). Difficulties with adjustment to life in the UK can be further linked to experiences of ‘othering’ and the literature on racism and its effects on mental health. There is a growing body of research to suggest that those exposed to racism may be more likely to experience mental health problems (Wallace, Nazroo & Becares, 2016; Bhui, Nazroo, Francis et al. 2018).

Furthermore, despite Polish migrants being described as voluntary migrants, many are forced to emigrate due to the economic situation and the high unemployment rate in Poland (White, 2013). Consequently, some of the processes associated with forced migration do still apply to this population. It could therefore be speculated that many Polish migrants in the UK were subjugated to the psycho-social process of loss and change accompanying abandonment of one’s homeland which has been recognized as a grief process and a distressing experience (Carta et al., 2005). Therefore the experience of grief for one’s homeland, adjustment from a collective to an individualistic society, work stress and forced migration due to economic hardship could be some of the processes that account for feelings of isolation and loneliness described by the majority of participants in this study. Furthermore, the results of this study demonstrated that participants who reported having lived longer in the UK were more likely to seek help for mental health difficulties. One explanation for this could relate to a better understanding of services and language proficiency that would enable help seeking. However, previous research on migrants in Italy (Pfarrwaller & Suris, 2012), Spain (Rivera, Casal, & Currais, 2015) and Canada (Lou & Beaujot, 2005) report a deterioration of mental health in long-term migrants when compared to newly arrived migrants. These findings could be suggestive of a link between the length of stay in the host country and severity of symptoms of distress, which could subsequently link with greater need for help seeking. More research should be done to investigate this link.

It is important to note that majority of the causal believes identified by the study population fell into psycho-social explanations of distress, rather than bio-genetic, which is consistent with studies in most other countries (Read et al., 2014). Participants attributed their distress to their circumstances rather than a belief that something was medically or genetically wrong with them.

4.3.3. Gender Differences

The current study found no gender differences between participants who sought help and, those who did not. This finding is in accordance with the study by Godonek and Kirkbride (2018) who also employed an online survey methodology of Polish migrants. Their objective was to identify predictors of mental health help-seeking in this population and their results indicate that gender was not a predictive factor. These findings are different from the broader literature on help seeking in mental health where it is reported that women are more likely to engage with mental health services than men (e.g. WHO, 2000; Oliver, Pearson, Coe, & Gunnell, 2005). A possible explanation of this disparity could be the use of online survey methodology. It is possible that men with a history of mental health difficulties and past help-seeking experience were disproportionately more likely to be attracted to take part in a survey looking at mental health, advertised on Polish online community groups.

4.3.4. Language Barriers

This study found that the most frequently mentioned barrier, by Polish migrants in the UK, to accessing mental health support, are language difficulties. This barrier was pointed out by participants who did not seek help for their experience of mental health difficulties, but also by participants who sought help but reported that language barriers prevented them from pursuing the support further.

Results from the FOI study indicate frequent use of Polish interpreters by the NHS. Other studies provide contradicting accounts regarding interpreter use with Polish service users. In the study by Pleitgen (2018), some of the surveyed mental health professionals complained of unavailability of interpreters while others commented that Polish service users are often unwilling to use interpreting services and prefer to use friends and family members instead. However, accounts from interviewed Polish

SU in Pleitgen's study indicate that many did not know that they were entitled to an interpreter and that they had never been offered this opportunity.

Other studies also found language to be the biggest barrier (e.g. Selkrik et al., 2012; Weishar, 2008). Indeed the reports all seem to indicate that while some Polish migrants are comfortable using interpreters, others feel that it is difficult to disclose personal information in the presence of an interpreter. These reports are in line with the broader literature on interpreter use, where migrants often report a preference for a family member to interpret due to feelings of trust towards them (e.g. Greenhalgh, Robb & Scambler, 2006).

Language can be an even more significant barrier when linked to lack of accessible information. Internet browsing is often the first step to seeking help. Participants in Pleitgen's (2018) study pointed out that when performing a Google search in Polish on phrases such as "psychological help in London" and "psychologist in London", no results related to help offered via the NHS came up. Most such searches yield results on private, Polish, psychological support.

4.3.5. Lack of Belief in Services

Lack of belief in services was another stated barrier to accessing mental health services. These reports are in line with previous literature. The study by Madden et al., (2017) reported Polish migrants being distrustful of their GP, viewing them as unhelpful and dismissive and as a barrier to secondary healthcare. In order to understand the relationship between Polish migrants and the British healthcare system it is important to consider the context of what healthcare provision is like in Poland.

The private healthcare sector is far more developed in Poland than it is in the UK. During the communist era in Poland healthcare provision suffered, and many doctors engaged in supplementary private practice to strengthen their income (Czupryniak, & Loba, 2004). At the end of the communist era the private practice expanded rapidly (Czupryniak, & Loba, 2004). Moreover, during that turbulent time the public sector was strewn with corruption and bribery, consequently pushing the Polish people to access private services without having to be referred by a GP (Millard, 1995). This has led to Polish people, who have experience of accessing healthcare in Poland, and who had the financial means to do so, becoming accustomed to being able to quickly access specialist care. Indeed, the study by Selkirk et al., (2012), of Polish migrants in Scotland, found that most felt disappointed in NHS services that fail to deliver in a similar manner to the private sector in Poland. Furthermore, many participants were dissatisfied at what they perceived as dismissive treatment on the part of Scottish GPs, especially when they did not receive medication or swift referrals to specialists. Consequently, participants who were dissatisfied with their contacts with the GP, tended to be distrustful of the support on offer and rejecting of psychological services as a helpful option to them.

These reports are not unique to the Polish population in the UK but have also been found in the experience of the native population. Research by Biddle et al (2006) has shown that young adults in the UK were reluctant to approach their GP for support with emotional difficulties due to a belief that they would be dismissive of their concerns and unable to offer appropriate help. Studies looking at other minority communities in the UK, particularly people from Black African and South Asian ethnic groups, found that in spite of relatively high GP attendance, and evidence to suggest that most people from the aforementioned backgrounds tend to seek access to care directly through their GP (Erens et al., 2001;Sashidharan, 2003), referrals of minority ethnic groups to clinical psychology services remain small (Williams, Turpin & Hardy, 2006). There are a number of explanations offered in the literature for this phenomenon, including variations in GPs recognition rates for detecting psychological distress in minority service users (Bhui, Bhugra, Goldenberg, Dunn & Desai, 2001), different use of language and conversations around distress (Lanzara, Scipioni, & Conti, 2019) , and more generally factors that relate to racial stereotyping and discrimination that result from services that fail to account for the needs of ethnic minorities (Williams, Turpin & Hardy, 2006).

Pleitgen (2018) interviewed mental health professionals on their views on what constituted barriers for Polish migrants to accessing psychological therapy in the UK. The respondents located most of the barriers within the Polish community, indicating that unhelpful help-seeking attitudes and beliefs were the biggest factors affecting referral rates, access and engagement with services. The participants believed that Polish migrants do not disclose their difficulties to the GP, or that they express their needs in a way that is difficult for GPs to recognise as a mental health need. Furthermore, participants reported attitudes indicative of stigma and a perception that Polish migrants prefer to seek help within the Polish community or go back for treatment in Poland. This view was not supported by the current study where it was found that 69.9% of the participants sough help for their mental health difficulties through the NHS, only 11% of the surveyed participants chose to go to Poland for mental health advice.

4.3.6. Feelings of Shame and Fear

Feelings of fear and shame were another barrier to seeking mental health support, whereas an unwillingness to disclose personal information was reported as a barrier by participants who sought support but did not want to pursue it further. Historically, there have been considerable social pressures to conform in Poland. Indeed, Polish history may have led to a perception of difference as being dangerous. Conditions during the Second World War, and later the communist regime, meant that standing out often had grave consequences. It is therefore very likely that intolerance of difference, which has been engraved in the social narrative for generations, continues to pervade Polish culture today, particularly in rural areas (Kerlin, 2005; Siemiensak & Domaradzka, 2009). Institutional and social discrimination towards the LGBT community, people with disabilities, single mothers and single women were described by many of the participants in the Selkirk et al., (2012) study. Furthermore, it is important to note that social services in Poland are underfunded, and that the organisation of the welfare system means that the majority of people are cared for by their families (Kerlin, 2005; Siemiensak & Domaradzka, 2009). Selkirk and colleagues (2012) found that reactions to other people's distress in the Polish community were determined by whether their behaviour was seen as understandable or abnormal. In general, participants attributed distress to life events such as divorce as reasonable. Although participants of that study expressed sympathy towards others experiencing difficulties, the authors argue that stigmatising attitudes were implicit in some accounts. This duality in attitudes is in accordance with many cultural attitudes towards mental health distress. Gilbert

(1992) argues that maintaining one’s social position within the community has a significant impact on emotional well-being. People may therefore avoid contact with mental health services, to avoid being stigmatised (Gilbert, 1992).

Furthermore, participants in Pleitgen’s (2018) study spoke of their concerns about the consequences of involvement with children’s social services. They described fearing that disclosure of mental health difficulties could lead to the removal of their children. In this context shame was linked to a feeling of failure and inability to cope with emotional difficulties. The fear of such consequences might prevent people from seeking assistance from services.

4.3.7 Lack of Time

Lack of time was the second most common barrier, reported both by participants who did not seek support and those who did but could not pursue it further. It could be speculated that this relates to factors such as stressful working conditions and lack of childcare due to reduced social networks, factors which have been described in more detail in the section 5.3.2.. This however, is conjecture and further research to explore Polish migrants’ experience of this barrier needs to be conducted.

4.3.8. Talking Therapy

When asked about the kind of support that they would have liked to receive for their mental health difficulties, many participants responded with talking therapies. Indeed, participants who reported having attended psychological therapies through the NHS responded that they had found the treatment helpful. This is in accordance with the results found by the Polish Psychologist Association (PPA) survey where 55% of the respondents felt like they would have benefited from psychological support during their stay in the UK. From the participants who reported that they sought help in the PPA survey, 30% received care from the NHS while many sought help privately or through charity (Stefanicka, Erecinski & Kwiatwowska, 2016). These findings are in accordance with the current study where the majority of participants reported a willingness to engage in psychological therapy. Barriers reported by the current study included long waiting times and lack of information, as well as lack of finances, the latter being indicative of a misconception that psychological help through the NHS needs to be paid for.

4.4. Clinical and Practical Implications

4.4.1. Ethnicity Monitoring

The results of the FOIRs indicate that very few Trusts collect information on access to services by Polish migrants. No Trust reported having developed a race equality strategy that attempts to address the needs of Polish service users specifically. This thesis has argued that while being the largest migrant group in the UK, Polish migrants are usually masked by their “whiteness” and lost in NHS statistics under the category “white other”. The FOIRs confirmed this to be the case.

Mental health Trusts have a responsibility to ensure their services do not discriminate against people on grounds of their race, mandated through the Equality Act (2010) and Public Sector Equality Duty (2011). As outlined in the first chapter of this thesis, Polish migrants have become a racialized group in the UK (e.g. Rzepnikowska, 2018), they have in recent years been increasingly exposed to discriminatory rhetoric in British politics and media, and so the interplay of this negative attention, of class and socioeconomic status, all play a role in making this group particularly vulnerable to emotional distress.

The WRES and/ or EDS2 should provide a set of standardised processes that support Trusts in their quest to deliver on those responsibilities. These initiatives require that Trusts demonstrate their commitment to non-discriminatory practices by monitoring and reporting their performance across several indicators. The first step to enabling Polish migrants equal access and care under the NHS should therefore be better monitoring of ethnicity data.

4.4.2. Building a Positive Relationship with the NHS

This study demonstrated that there is a need for, and a willingness from, the Polish community to engage with mental health services in the UK. However, distrust in the GP, lack of information and misconceptions around accessibility of services have been identified as barriers that exists between some Polish service users and the NHS. In line with developing culturally competent services (see 1.3.6 – 1.3.7.) the NHS should adopt a practical approach to engaging this community and focus on enhancing the relationship between Polish migrants and the GP, adopt community approaches that would be more relevant to the Polish community which is more aligned with a collectivist culture (e.g. community and narrative approaches, see Wood, 2012) and pay attention to the identified causal beliefs of distress which centre around psycho-social factors such as stressful work conditions and isolation. Migrants are frequently excluded from taking part in healthcare research, often due to language barriers and cultural differences, they are labelled as 'hard-to-reach' (Lee, Sulaiman-Hill & Thompson, 2014). However, in order to develop services that are adequately suitable to all populations, it is crucial that all stakeholders are considered. Therefore, including Polish service users in co-production initiatives is paramount to development of services that are better able to respond to the needs of this population.

Another aspect to developing partnership with the Polish community is through Polish organisations. Mental health trusts should cooperate with Polish organisations to facilitate outreach, demystify the NHS and develop a more positive relationship with the community. This in time could facilitate the involvement of Polish service users in research, consultation and co-production initiatives. Co-development of cultural competence training could make it more relevant and practice – rather than theory-driven.

Another useful strategy would be to focus on changing narratives around the accessibility of the NHS. As pointed out by Pleitgen (2018), community narratives on the unhelpfulness of the NHS and inaccessibility of psychological help persist through the telling and re-telling of stories of negative experiences within the Polish community. One way to strengthen positive narratives around the NHS is for Trusts to present accessible information about their services on platforms that are frequently visited by the Polish community. Examples might include online portals such as the ones used in this study. Publishing information on mental health trusts' websites about cooperation with Polish organisations and co-production with Polish service users, might also improve the reputation and credibility of NHS services.

4.4.3. Interpreters and Accessing Information

There is extensive international and national legislation that advocates for equality of access to healthcare services (e.g. Human Rights Act, 1998, Equality Act, 2010). Ensuring that trained interpreters are available within mental health services is a vital provision to uphold equality of access. Indeed many Trusts in this study reported the use of interpreting services. However the pattern of interpreter use is unclear. The broader literature on interpreting services in the NHS demonstrates that many Trusts still experience insufficient interpreting resources and often rely on untrained bilingual staff or family members (Raval, 2003; Tribe & Lane, 2009). Furthermore, despite the preference of some service users to use family members as interpreters (see 5.3.4.), the British Psychological Society strictly advices against this in therapy settings. Interpreting is a highly skilled job and not something that any family member, or even professional with similar language background, can slip into (Tribe & Thompson, 2008). Using a family member as an interpreter also creates difficulties with regards to confidentiality (Juckett, 2005).

A primary recommendation to enable access to mental health services to Polish migrants is therefore a better understanding of interpreter use by the service users in question and staff members alike. A lot of the time service users might present with "good enough" proficiency of English language, but that might not be enough to make the person feel comfortable in a therapeutic setting.

Furthermore, in order to make Polish migrants aware of the healthcare that is available to them (including the right to an interpreter) more translated resources, into Polish language, should be available. Indeed, many NHS Trust websites have their online information translated but that might not always be the first port of call for people. It is therefore recommended that information on what is available through the NHS and how this support could be accessed should be available in GP surgeries. For this to be possible, it is important that Trusts monitor the ethnicity of the population in their catchment area. Furthermore, it might be helpful to present accessible information on platforms that are frequently visited by Polish community. Examples might include portals such as londynek.net or Facebook Groups, such as the ones used in this study.

4.5. Strengths and Limitations

As outlined in the first chapter of this thesis, previous research on the mental wellbeing of Polish migrants in the UK is mostly qualitative in nature, with small sample sizes and varying research aims. This study intended to contribute to this field of research by employing a methodology that would allow for a larger amount of data and a broader range of the Polish population in the UK. This section will offer a discussion on some of the limitations of this study with respect to the design and methods employed.

4.5.1. FOIRs

Despite there being several benefits to using FOIRs methodology, the biggest limitation of this approach is the inability to control for extraneous variables that affect data collection. FOIRs are meant to be processed and responded to by a dedicated FOI officer. However, it is often the case that they end up being dealt with by a different team member such as an assistant psychologist or a Human Resource Advisor. This is an important confounder as the data reported using FOI is based on the information that the person who processes it is able to obtain and is hence dependent on their own workload, the reasonable request limits and knowledge of the FOIR topic. The impact of these variables can be seen in the variation of responses with regards to which information the Trusts were able to provide and the quality of the information obtained.

The most significant finding of this study, i.e. the lack of monitoring of access to mental health services by Polish migrants, was clear from both the ethnicity data provided and any lack of data collection from Trusts alike.

4.5.2. Survey

An important limitation of this study is the probable overrepresentation of people who have experienced mental health distress, simply because the study was more interesting to them than to other people. In the description of the survey that was posted online mental health was mentioned and so it can be inferred that people who have some experience in this field were more drawn to the survey. The survey descriptions also mentioned access to mental health services so there may also have been a sampling bias towards people who had used services. Although this study cannot, therefore, claim to be representative of the general Polish population of the UK, it captures a large number of young adults who report mental health problems and is therefore of interest when considering the objective of studying their access to mental health services.

All survey participants were recruited through social media, online news media and snowballing techniques, due to the convenience of such methodologies. Hence, the overall sample may be more representative of younger people who tend to be users of social media. Indeed, the average age of participants was 35. Furthermore, females were more likely to participate in the survey which can be explained by the volunteer bias (Fay, Boyd, & Salkind, 2010), where women tend to be more willing to participate in research, and are more likely to seek mental health support (WHO, 2000).

4.5.2.1. Survey Questions

The substantial amount of responses to the survey signify that participants did not struggle to engage with it and the answers provided were meaningful and relevant. The mix of multiple choice answers and free text options gave room for a range of responses. This methodology offered an alternative to previous research in the field that focused on qualitative responses.

The way the survey was structured with some questions allowing for more than one response, made it difficult to keep track of how many people answered the questions. Furthermore, the flow of the survey, could be perceived as repetitive, participants could provide more than one answer to a few questions and depending on their responses, were excluded from some sections of the survey. These factors made it difficult to track the attrition rate of the survey.

In retrospect it would have been helpful to include more questions that explored what participants perceived as ‘lack of time’ to seek mental health support. This research will be important in the future to get a better understanding of how services can account for this difficulty (e.g. possibility of flexible hours, creche etc.). Furthermore, with hindsight, when asking about what help people received, it would have been important to include a category on ‘no treatment received’, to capture people who did seek support but did not receive it, rather than relying solely on those participants writing that in the ‘Other’ box.

4.7. Contributions

The main contribution and aim of this study was to explore the need for the NHS to consider the mental health and service accessibility of Polish migrants who are currently the biggest migrant group in the UK.

It is the first study to investigate what is currently being done within the NHS to monitor and ensure access for Polish migrants specifically as opposed to the broader category of BME service users – under which Polish migrants are not always considered. It has highlighted that due to poor ethnicity data monitoring the NHS is not capturing important data about Polish migrants’ access to mental health services. It is hoped that these findings will put Polish migrants on the agenda, that this will be a conversation starter and an invitation to reflect on the current state of the NHS.

The results of the survey provide novel understandings of factors affecting the psychological wellbeing of Polish migrants in the UK and factors affecting their access to, barriers to, and experience of psychological services. The study was also the first one asking about what participants identify as the cause for their distress. The findings have multiple implications for service improvement (see above).

4.8. Reflexivity

‘Reflexivity refers to the ability to notice and reflect on how one’s research assumptions, values and biases might affect how research is conducted and how the findings are interpreted (Willig, 2008).”

As previously mentioned, I share a number of characteristics with the participants. I identify strongly with the label of being a migrant. To me, being a migrant signifies a sense of never quite belonging, always feeling torn between two countries. When conducing this research, I brought with me a strong belief that the burden of ‘access’ should not solely rest on the Polish migrant, who might not feel equipped to ask for help, or worse still, due to the political rhetoric of “stealing jobs” and “being a burden on the NHS”, feel unworthy of it. In that respect I found myself aligning with an activist position, where it is my hope that this research will shed further light on the rights of this population. Furthermore, I identify as a cis gender woman. The majority of the survey sample reported to be female and as such it is likely that my own experiences match those of the study population. It also needs to be noted that I bring with me the ideological influences associated with being a trainee at the University of East London. Consequently, the reporting of causal beliefs identified in this study are likely to have been influenced by a social constructionist ideology around the importance of social context in making sense of distress.

In terms of execution and analysis of data it is difficult to say how both my personal, and professional, identities have impacted on the analysis of findings and the subsequent write-up of this thesis. I believe that the use of FOIR and survey methodologies helped to reduce any potential bias in data collection. Furthermore, most of the data was analysed using descriptive and inferential statistics.

However, I acknowledge that due to my Polish name, and ability to communicate in Polish, it might have been easier for me to be accepted by the Polish online community which allowed me to share the link to the survey with the participants. Similarly, the fact that I speak Polish could have, possibly, made me appear more approachable to potential participants. My alignment with the community in ‘our’ strive for better access to mental health services could have made taking part more appealing to participants.

When thinking about what I could have done differently I regret not conducting initial, informal, interviews with people form the community. By approaching the Polish Social and Cultural Association in Hammersmith I could have consulted the community in thinking about designing the survey and which questions would have been helpful to ask. In doing so I could have counterbalanced some of my own ideas and assumptions about what it means to be Polish in the UK.

4.9. Dissemination

The work done so far has been presented by the author during two of her clinical placements. The feedback was overwhelmingly positive. Both teams reported having worked with a number of Polish individuals and families in the past, and described feeling like not enough attention had been paid to this particular community by services. Both teams reported not being aware of any outreach initiatives or service development project that involved the Polish community and agreed that there was a definite need for this research.

It is very much the aim and hope of the author to publish the final findings of this thesis and in so doing contribute to the current research base on the mental health of Polish migrants in the UK. The final findings will be fed back to NHS national managers and the Polish community through the Facebook groups and online magazines used to recruit study participants.

4.10. Future Research

The current study offered a new methodological approach to investigating the mental health needs of Polish migrants in the UK. The use of FOIRs and a survey enabled the researcher to capture a large number of participants. It is however advised that future research focus on larger scale, epidemiological, studies. The current literature on the mental health of Polish migrants is largely based in small-scale projects, on doctoral or master theses or local service initiatives. A nationwide, epidemiological study would offer an insight into the differences within the ‘White other’ ethnic category and present a clearer picture of the needs of the very distinct populations compromising this groups.

This study highlighted a further need to investigate the pattern of accessing mental health services amongst this community. It was found that Polish migrants who have lived in the UK for longer were more likely to seek help for their difficulties. The motivations for that are unclear, as outlined previously, this could be due to having a better understanding of services and language or alternatively, as suggested by older reports, longer stay in the country could be associated with more severe emotional difficulties. Future research should therefore focus in more depth on the mechanisms and motivations behind help seeking in this migrant group.

Furthermore, the existing research has largely been gathered through traditional methods, where the Polish community was placed as the research subject, to be investigated by academics or professionals. This kind of research set-up tends to position the NHS as the powerful provider of services while the community continues to be positioned as a passive recipient. It is therefore proposed that Community Based Participatory Action Research (CBPR) is considered in future research. CBPR would allow for the involvement of Polish migrants, consequently empowering the community to change the status quo, challenge some of the reported barriers and develop relevant solutions, sustainable outcomes and progressive social change (Hall, 1981).

4.11. Research Implications

The study findings also pose the question of whether NHS services are the best place for this group. Improving access to services for Polish migrants is a complex issue. The NHS is arguably not good at dealing with distal causes of distress (e.g. migration or work stress). In his work, David Smail (2001) argues that we are shaped by many powers, most of the influences on our lives are not the people directly around us, but economic, social and cultural influences. Indeed it has been asserted that symptoms of mental health difficulties are of lesser importance to migrants who are concerned with other problems, such as grief or anger over past injustices or a myriad of difficulties associated with the migration process (Van der Veer, 1998). As a consequence, treatments that focus primarily on symptoms of mental health may be seen as too narrow in scope to address the high level of distress and many practical difficulties experienced by migrants.

Smail points to collective action as a way of taking control of our lives (Smail, 2001). Indeed, as outlined in the previous section, undertaking Community Based Participatory Action Research with the Polish community in the UK would offer an alternative solution to some of the hypotheses arising from the present study. Engaging the Polish community in a dialogue would help answer questions around the sources of feelings of isolation or identify causes of work stress. It would allow for the community to take an active part in coming up with the adequate support for some of these experiences, some examples could be informing people of their right to NHS care, finding ways to support work stress, developing culturally appropriate alternative non-statutory forms of care or support groups withing the community.

4.12. Conclusion

This study demonstrated that there is a need for, and a willingness from, the Polish community to engage more with mental health services in the UK. This Thesis has argued that Polish migrants have become a racialized group in the UK (e.g. Rzepnikowska, 2018), they have in recent years been increasingly exposed to discriminatory rhetoric in British politics and media, and so the interplay of this negative attention, of class and socioeconomic status, all play a role in making this group particularly vulnerable to emotional distress. However, their needs continue to go unnoticed, usually masked by their “whiteness” and lost in NHS statistics under the category “White Other”. The FOIRs confirmed this to be the case.

Furthermore, distrust in the GP, language difficulties, lack of information and misconceptions around accessibility of services have been identified as barriers that exists between Polish service users and the NHS. Survey respondents reported psycho-social factors as the main suspected cause for their distress, these included work stress, isolation and loneliness, family stress, relationships problems and migration. Some factors, such as isolation, and racism, might also be at least partly related to being a migrant.

Positive findings included a willingness from the community to engage with mental health support. The majority of participants who received talking therapy through the NHS reported having found it helpful. However, due to the vulnerability of this population and high incidence of reported mental health difficulties it is important that better access to services continues to be considered.

It is the role of the NHS to build culturally competent services and ensure equal access to all subgroups of the population. The Thesis outlined a number of recommended strategies for building a more positive relationship between Polish migrants and mental health services. These included adopting community approaches that would be more relevant to the Polish community which is more aligned with a collectivist culture (e.g. community and narrative approaches, see Wood, 2012) and pay attention to the identified causal beliefs of distress which centre around psycho-social factors such as stressful work conditions and isolation.

Finally, the narrative review section of this Thesis highlights the limited amount of papers published on this topic and the need for more research in this area. Particularly epidemiological studies looking at Polish, and other European migrants', access to care and their relationship with local population as the landscape of post-Brexit UK continues to change.

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APPENDIX A: FOIR REQUEST EMAIL

Dear Sir or Madam,

I hope this email finds you well.

My name is Suzanna Chojnacki, I am carrying out my doctoral research at the University of East London (UEL).

This project aims to review how adult mental health services meet the needs of Polish people. I would like to request, under the Freedom of Information Act, the following information regarding all adult mental health services provided by your trust:

1) The number of people seen by adult Mental Health Services in the latest year for which you have complete data, by ethnicity (specify which year please). If possible, please break this down further by gender and age.

2) The number of people seen by adult Mental Health Services in the latest year for which you have complete data, by nationality. If possible, please break this down by gender and age.

3) The number of people seen by adult Mental Health Services in the latest year for which you have complete data, by country of birth. If possible, please break this down by gender and age.

4) [If not provided an answers to Qs 1-3] the number of times Polish people used your Adult Mental Health Services in the latest year for which you have data? If possible, please break this down by gender and age.

5) The number of times a Polish interpreter was used within adult mental health services in the past year

6) The number of people for whom the Mental Health Act was used in the past year, broken down by Ethnicity, Nationality and/or Country of Birth

7) The number of times the four most frequently used psychiatric diagnoses were used in the past year, broken down by Ethnicity, Nationality and/or Country of Birth

8) The number of people that received psychological therapies in the past year, broken down by Ethnicity, Nationality and/or Country of Birth

9) Does your trust have a policy, programme or initiative that focuses on ethnicity/diversity/cultural competence/race inequality relating to:
a. The provision of adult mental health services?
b. Operational aspects of mental health services e.g. staffing / recruitment / support?
If yes, please include the policy/policies in your response.*

10) What number of adult Polish people are in your catchment area?

11) What is the adult population of your catchment area?

Thanks very much for your help with this matter. I look forward to hearing from you.

Yours faithfully,

Suzanna Chojnacki
Trainee Clinical Psychologist
School of Psychology
University of East London

APPENDIX B: FOIR FOLLOW-UP EMAIL

Dear Sir or Madam,

I hope this email finds you well.

I am getting in touch with you regarding a Freedom of Information Request that was made to you on the XXX, please see below. Under the Freedom of Information Act 2000, you are required to respond to my request within a maximum of 20 working days, which will be the date of XXX.

Since I still have not heard from you I would very much appreciate your response or feedback.

Thanks very much for your help with this matter. I look forward to hearing from you.

Kind regards,

Suzanna Chojnacki
Trainee Clinical Psychologist
School of Psychology
University of East London

APPENDIX C: FULL SURVEY (ENGLISH VERSION)

Survey

- Are you a Polish migrant in the UK (if answered NO, taken to the end of the survey)
- Age
- Gender
- Profession
- Years living in the UK

1) During your stay in the UK, have you experienced mental/psychological/emotional/ distress to the point that you thought you would need help from someone outside of your family?

Yes
No
Don't know

(If answered no, taken straight to Question 9)

2) What problems were you struggling with? (Pick the most appropriate, can be more than one)

- ▪ *Anxiety*
- ▪ *Depression*
- ▪ *Phobias*
- ▪ *Obsessions and Compulsions*
- ▪ *Panic*
- ▪ *Post-traumatic stress*

- ▪ *Psychotic experiences*

- ▪ *Suicidal thoughts*
- ▪ *Suicide attempts*
- ▪ *Self-harm*

- ▪ *Other:*

3) For the problem that is causing you the most worry/distress, what do you think is causing it? (Pick the most appropriate, can be more than one)

- ▪ *Family stress*
- ▪ *Relationship problems*
- ▪ *Loss of loved ones*
- ▪ *Isolation/ loneliness*
- ▪ *Abuse or neglect in childhood*

- *Chemical imbalance*
- *Other unhappy or distressing childhood experiences*
- *Work stress*
- *Unemployment*
- *Drug or alcohol abuse*
- *Heredity (genes)*
- *Disorder of the brain*
- *Unstable personality*
- *Hectic pace of modern life*
- *Unconscious conflict*
- *God's will or fate*
- *Experience of racism/ discrimination/ prejudice*
- *Impact of Brexit*
- *Migration - and adjustment to life in the UK*

- Other:

4 a) Did you seek support for any of the problems you were struggling with?

Yes
No
Other:

(Participants who answered No, taken to question 4 b), then Question 9)

4 b) If No, what stopped you?

4 c) If Yes, where did you seek it?

- *NHS*
- *Charity*
- *Private Practice*
- *School/Work*
- *Back in Poland*
- *Spiritual or Religious Leader*

- *Other*

5) What form of help did you receive? (You can tick more than one)

- *GP*
- *Medication*
- *Talking Therapy:*
    - *How many session:*
- *Alternative Medicine/Therapy, please specify:*

- *Other*

6) Did you encounter any barriers? If so, what where they?

- *Lack of information*
- *Language barriers*
- *Lack of time*
- *Finances*
- *Child care*
- *Waiting times*
- *Stigma*
- *Not wanting to discuss personal issues*

- *Other:*

7) What help would you have liked to receive?

8 a) What language did you receive care in?

8 b) What language would you prefer?

9) Are you aware that you are entitled to free mental health care via the NHS?

10) Have you received talking therapy through the NHS?

Yes
No

(Participants who answered No taken to the end of the survey)

11) Please give the name of, or describe in one sentence, the type of therapy you received:

12 a) How many sessions were you offered?

12 b) How many sessions did you attend?

13 a) What language did you receive care in?

13 **b) What language would you prefer?**

14) Did you find speaking about your problems helpful?

‘Strongly Disagree’ ‘Disagree’ ‘Neither Agree or Disagree’ ‘Agree’ ‘Strongly Agree’

15 a) Did you feel like your cultural background and values were talked about and considered in the care that you received?

‘Strongly Disagree’ ‘Disagree’ ‘Neither Agree or Disagree’ ‘Agree’ ‘Strongly Agree’

15 b) Would you have liked it to be?

‘Yes’ ‘No” ‘Don’t Know’

16 a) Did you feel like your religious values were talked about and considered in the care that you received?

‘Strongly Disagree’ ‘Disagree’ ‘Neither Agree or Disagree’ ‘Agree’ ‘Strongly Agree’

16 b) Would you have liked it to be?

‘Yes’ ‘No” ‘Don’t Know’

<u>17) Is there anything else that you would like to add?</u>

APPENDIX D: ETHICAL APPROVAL

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Mary-Jane Budd

SUPERVISOR: **John Read**

STUDENT: Suzanna Chojnacki

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: What might need to change to make mental health services accessible/used by Polish people?

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED <u>BEFORE</u> THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is <u>not</u> required but the student must confirm with their supervisor that all minor amendments have been made <u>before</u> the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

1. APPROVED

Minor amendments required *(for reviewer)*:

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):*
Student number:

Date:

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐ MEDIUM (Please approve but with appropriate recommendations)

☐ LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: *Mary-Jane Budd*

Date: 06/06/2019

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

UNIVERSITY OF EAST LONDON
School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Tim Lomas (Chair of the School Research Ethics Committee. t.lomas@uel.ac.uk).

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. When submitting this request form, ensure that all necessary documents are attached (see below).
4. Using your UEL email address, email the completed request form along with associated documents to: Dr Tim Lomas at t.lomas@uel.ac.uk
5. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
6. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

1. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
2. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.
3. A copy of the approval of your initial ethics application.

Name of applicant:	Suzanna Chojnacki
Programme of study:	Doctorate in Clinical Psychology
Title of research:	Psychological Wellbeing of Polish Migrants: What is the Role of the NHS?
Name of supervisor:	Professor John Read

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
Title of the study to be changed due to error on ethics application where aim of the study was mistaken for its title. The proposed amendment is to ensure that the title is: **Psychological Wellbeing of Polish Migrants: What is the Role of the NHS?**	To ensure consistency of the title throughout all documents

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	x	

Student's signature (please type your name): Suzanna Chojnacki

Date: 19th March 2020

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	
Comments		

Reviewer: Tim Lomas

Date: 19.3.20

APPENDIX E: PARTICIPANT INFORMATION SHEET

Information Sheet

Principal Investigator
Suzanna Chojnacki (Trainee Clinical Psychologist)

Department of Clinical Psychology
University of East London
Water Lane, London, E15 4LZ
Email: u1725750@uel.ac.uk

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?
I am a Trainee Clinical Psychologist currently studying at the University of East London, in the School of Psychology. As part of Doctorate thesis I am conducting the research you are being invited to participate in.

What is the research?
I am conducting research into the use of NHS Adult Mental Health Services by Polish migrants living in the UK. I am interested to find out how the NHS is currently monitoring access for this population, how many Poles are in fact using mental health services and in what way, and what might need to change to make these services more accessible to this population. My study involves an online survey of Polish migrants living in the UK to find out what their experience of seeking mental health support while living in the UK has been like.

The finished research will be written up into an academic thesis. The aim is for it to eventually be summarised into an article and submitted for publication in a psychology journal.

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?
You have been invited to participate in my research as someone who fits the kind of people I am looking for to help me explore my research topic. I am looking to involve Polish migrants to find out if they have experienced any mental health difficulties while living in the UK, if they have sought any support for those difficulties, and how they experienced any support that they have received. I will use the results to think about what might need to change to make mental health services more accessible to Polish migrants living in the UK

I emphasise that I am not looking for ‘experts’ on the topic I am studying. You will not be judged or personally analysed in any way and you will be treated with respect.

You are free to decide whether or not to participate and should not feel coerced.

What will your participation involve?

If you agree to participate you will be asked to complete an online survey. The survey should take a maximum of 10 minutes to complete.

Prior to starting the survey, you will be asked to read this information sheet and provide informed consent to participate.

The survey consists of approximately 15 questions asking about your personal mental health and your experience of seeking support for any mental health difficulties while living in the UK.

You do not have to answer all questions asked, and can stop your participation at any time.

I will not be able to pay you for participating in my research but your participation would be very valuable in helping to develop knowledge and understanding of my research topic.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times.

The survey is completely anonymised. You will not be asked to provide your name or contact details.
The online version of this questionnaire has been constructed as an anonymous survey, meaning no emails, IP addresses and/or geolocation data will be identified in the responses. HTTPS survey links (also known as secure survey links) have been used, giving Secure Sockets Layer (SSL) Encryption while a questionnaire is being completed. During the study data collected online will be stored on an EU-based server and will be subject to EU Data Protection acts. All online data will be completely destroyed following completion of data collection.

When you have returned/completed the survey, you will be given a short participant code that is individual to you, so that if you wish to withdraw from the study you can provide this code in an email to me in order for your data to be extracted and deleted.

What if you want to withdraw?

You do not have to answer all questions asked, and can stop your participation at any time without explanation, disadvantage or consequence. However, exiting from the survey part way though completing it still allows data up until that point to be stored. Should you like to withdraw your data from the study entirely, you may do so for up to a month after you complete the survey. Please just contact me via email and provide your participant code.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Suzanna Chojnacki (Trainee Clinical Psychologist)
Email: u1725750@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Professor John Read. School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: j.read2@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.lomas@uel.ac.uk)

APPENDIX F: PARTICIPANT CONSENT FORM

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

Psychological Wellbeing of Polish Migrants: What is the Role of the NHS?

Please tick each box when you agree with the statement:

○ I have read the information relating to this projects and I have had the opportunity to discuss the details and ask questions about this information if I so wished.

○ I understand that my involvement in this study and particular data from this research will remain confidential. Only the researcher involved in the study will have access to any identifying data. It has been explained to me what will happen once the research study has been completed.

○ I understand that the research forms part of the requirement for a doctoral degree in psychology and the findings may result in publication.

○ Having agreed to take part, I understand I have the right to withdraw from the research at any time up to one month after I complete the survey, without disadvantage to myself and without the need to give a reason.

APPENDIX G: PARTICIPANT DEBRIEF SHEET

Debrief Sheet

Thank you for your participation in this research study! I hope you enjoyed the experience. Your responses will be collated and analysed together with the responses of other participants. The finished research will be written up into an academic thesis. The aim is for it to eventually be summarised into an article and submitted for publication in a psychology journal. Your participation is highly appreciated.

If you would like further information about my research, have any questions, concerns or would like to provide feedback on how it was to take part in this study please do not hesitate to contact me.

If you need support with any distress you may experience from completing the survey, please consider letting a trusted friend or relative know how you are feeling, contacting your GP or ringing the Samaritans on 116 123

Suzanna Chojnacki (Trainee Clinical Psychologist)
Email: u1725750@uel.ac.uk

APPENDIX H: FACEBOOK SURVEY INFROMATION

Good Day!

My name is Suzanna Chojnacki and I am doing a Doctorate in Clinical Psychology at the University of East London. I am currently conducting research on the mental health of Polish migrants in the UK. I would be very grateful if you completed the following survey - it should not take more than 5 minutes. I think that this is an important topic for us Poles, especially taking into account the current political climate, and your participation will be very much appreciated! More information is available in the link (there is an option in Polish).

Many thanks,

Suzanna Chojnacki

APPENDIX I: POLISH EXPRESS ARTICLE

Poland's accession to the European Union coincided with serious shortages of the workforce in the UK. The new job opportunities and the right to free movement attracted many Poles. To date, we are the largest group of immigrants in Great Britain.

Existing research, although limited in its scope, clearly show the need for better psychological support for Polish migrants. Interviews with Polish migrants living in the UK demonstrate negative impact of migration on mental health. Reported causal factors include frustration and stress related to language difficulties, discrimination, isolation, financial problems and lack of knowledge of British culture.

A recent survey conducted by the Polish Psychologists' Association with 450 Poles living in the UK examined the pattern of Polish migrants access to psychological support. It has been reported that 55% of respondents believed that they would have liked to receive psychological help during their stay in the UK. However, only 24% felt able to access the help they needed.

According to a Polish Doctorate student conducting research on mental health of Polish migrants in the UK at the University of East London:

- In the study, I want to get information about whether Polish migrants living in the UK access NHS mental health service. I am interested in the opinions of Polish migrants, regardless of whether they used mental health services in the UK.

Participation in the study would require short survey (5-10 minutes) contained in the link below. The link contains more information about this research and the University of East London where the research is being conducted.

APPENDIX J: INTERNATIONAL STANDARD CLASSIFICATION OF OCCUPATIONS (ISCO-8)

MAJOR AND SUB-MAJOR GROUPS

1 Managers

- 11 Chief Executives, Senior Officials and Legislators
- 12 Administrative and Commercial Managers
- 13 Production and Specialized Services Managers
- 14 Hospitality, Retail and Other Services Managers

2 Professionals

- 21 Science and Engineering Professionals
- 22 Health Professionals
- 23 Teaching Professionals
- 24 Business and Administration Professionals
- 25 Information and Communications Technology Professionals
- 26 Legal, Social and Cultural Professionals

3 Technicians and Associate Professionals

- 31 Science and Engineering Associate Professionals
- 32 Health Associate Professionals
- 33 Business and Administration Associate Professionals
- 34 Legal, Social, Cultural and Related Associate Professionals
- 35 Information and Communications Technicians

4 Clerical Support Workers

- 41 General and Keyboard Clerks
- 42 Customer Services Clerks
- 43 Numerical and Material Recording Clerks
- 44 Other Clerical Support Workers

5 Services and Sales Workers

- 51 Personal Services Workers
- 52 Sales Workers
- 53 Personal Care Workers

54	Protective Services Workers
6	**Skilled Agricultural, Forestry and Fishery Workers**
61	Market-oriented Skilled Agricultural Workers
62	Market-oriented Skilled Forestry, Fishery and Hunting Workers
63	Subsistence Farmers, Fishers, Hunters and Gatherers
7	**Craft and Related Trades Workers**
71	Building and Related Trades Workers (excluding Electricians)
72	Metal, Machinery and Related Trades Workers
73	Handicraft and Printing Workers
74	Electrical and Electronic Trades Workers
75	Food Processing, Woodworking, Garment and Other Craft and Related Trades Workers
8	**Plant and Machine Operators and Assemblers**
81	Stationary Plant and Machine Operators
82	Assemblers
83	Drivers and Mobile Plant Operators
9	**Elementary Occupations**
91	Cleaners and Helpers
92	Agricultural, Forestry and Fishery Labourers
93	Labourers in Mining, Construction, Manufacturing and Transport
94	Food Preparation Assistants
95	Street and Related Sales and Services Workers
96	Refuse Workers and Other Elementary Workers
0	**Armed Forces Occupations**
01	Commissioned Armed Forces Officers
02	Non-commissioned Armed Forces Officers
03	Armed Forces Occupations, Other Ranks