DOCTORAL THESIS

Substance misuse and help-seeking amongst Polish migrants in Northern Ireland

Author
Roddy, Shaun

Substance Misuse and Help-seeking amongst Polish Migrants in Northern Ireland

Shaun David Roddy

Bsc (Hons) Social Work

Faculty of Arts, Humanities & Social Sciences

Ulster University

Submitted for the degree of Doctor of Philosophy (PhD)

April 2018

I confirm that the word count of this thesis is less than 100,000 excluding the title page, contents acknowledgements, summary or abstract, abbreviations, footnotes, diagrams, maps, illustrations, tables, appendices, and references or bibliography

Summary Contents

Contents

Appendices

Appendix 1 - Ethical Approval letter OREC

Appendix 2 - Questionnaire Participant Information Sheet

Appendix 3Questionnaire

Appendix 4 Questionnaire Participant Information Sheet in Polish

Appendix 5 Questionnaire in Polish

Appendix 6 Invitation to service user to take part in a piece of research/study English

Appendix 7 Service Users Participant Information Sheet - English

Appendix 8 Semi-structure interview schedule

Appendix 9 Invitation to service user to take part in a piece of research/study Polish

Appendix 10 Service Users Participant Information Sheet Polish

Appendix 11 Invitation to service provider to take part in a piece of research/study

Appendix 12 Service Provider Participant Information Sheet

Appendix 13 Service Providers – Interview Schedule

Appendix 14 Participant consent form

Appendix 15 Correlations of GHQ and Alcohol

Appendix 16 ANOVAS of GHQ

Appendix 17ANOVAS with alcohol use and arrival in NI

Acknowledgements

I would like to thank a number of people and organisations, whom without their support I would not have been able to research this area and present this thesis. Firstly I would like to thank the Department of Education and Learning who funded my studentship to take on this PhD. I would also like to the thank the research graduate school at Ulster University, in particular Dr Jackie Reilly who guided me and supported me in every stage of this research.

I would like to take this opportunity to thank to my supervisors Professor Brian Taylor and Dr Paula McFadden who have guided me and persevered in supporting me on this journey. Their patience knowledge and expertise is truly an inspiration to my completion of this thesis. I would like to make special acknowledgment to Dr Ann Campbell (QUB) and Dr Rodger Manktelow who were my initial supervisors, who supported me in the difficulties of ethical approval, the data collection stage and the beginning of the analysis.

I would like to thank the translators who translated the questionnaires and participant information sheets. In particular I would like to thank Monika Kempa who was the sole translator used in the service users interviews. Her invaluable insight into mental health and the cultural understanding of the research group added depth and gravity to the findings of this thesis

Within this thesis a number of organisations and individuals gave their time to participate including all the health and social care trusts and in particular the mangers of the in-patient addiction units and the mangers of the community addiction teams whom I contacted on a regular basis seeking participants in the research. I would also like to thank the voluntary organisation who gave their time to speak with me, who facilitated and participated in the research.

I would like to extend my sincere thanks to the Polish people in Northern Ireland . I was welcomed at cultural group events and supported in using their online forums to publicise the research. I would like to thank all who completed a questionnaire. I also greatly appreciate the Polish people who came forward, who had or were

experiencing substance misuse problems and spoke about their issues. They spoke honesty and with integrity and gave me permission to speak about their lives.

It is also to be acknowledged of the help and support by Janice McQuilken, librarian at Magee, whose guidance and support throughout the thesis enabled me to complete all sections thoroughly. I would also like to thank Professor Mark Shevlin for advising me on the use of GHQ 12 and the statistical analysis of the quantitative phase.

I would like to thank my family and friends who supported me throughout. I would like to thank my parents Robert and Madeline who always had a belief in me and supported me with guidance and advice. They often 'rolled with the resistance' however somehow kept me on the right track.

Finally I would like to dedicate this thesis to my ever supportive loving wife Sorcha who has been my rock throughout. She is the person whom I relied on most, and has been my soundboard, my counsellor, my motivator. I would like to also acknowledge the patience and perseverance of my children, Caolan, Brogan and Rhiannan, who just took it for granted that I am working on the computer. Their support and understanding has been a catalyst for achievement.

Abstract

Background: The IOM estimated that there 244 million migrants in the world (IOM 2018). Historically, Northern Ireland has been a place where people migrated from. However recently Northern Ireland has experienced positive net migration with a peak from 2004-2010. Migration can affect migrants' mental health. One of the documented and notable consequences of mental ill-health can be increased alcohol and substance use. Research has indicated that factors such as the acculturation and assimilation of immigrants may influence substance misuse as well as the stress of moving.

Aims and Objectives: The aims of this study, were to consider the nature and extent of substance use within the Polish community in Northern Ireland. The objectives were to examine factors affecting access to services; clients' perceptions and experiences of services; and service providers' experiences in delivering drug and alcohol services to immigrant groups. The study was underpinned by a systematic narrative literature review.

Methodology: A mixed methods approach was used. Firstly, a quantitative questionnaire in Polish was used to gather data from a sample of the general Polish population in (n=231). Secondly, semi-structured interviews were conducted with Polish service users (n=18), and with service providers (n=10). The interviews with the service users were conducted via an interpreter.

Data Analysis: Chi-square correlations, t-tests and Anova's were used for quantitative data analysis on SPSS (Version 14). The information from the qualitative phases was analysed using thematic analysis involving the same interpreter as in data gathering.

Results: A cohort of first generation male Poles increased their alcohol use since coming to Northern Ireland. Those with a previous alcohol or substance misuse problem felt that the trauma of migration was a trigger for relapse or potential relapse. Barriers do exist to access and delivery of services in both the statutory and voluntary sector.

Discussion and Conclusion: Health promotion and information on accessing services is needed to guide new migrants through the care pathways of our services. The use of alternative methods of service delivery such as e-health may be more effective than delivering face-to-face talking therapies via an interpreter.

Abbreviations

A8 - Accession Eight

AA - Alcoholics Anonymous

ACMD -The Advisory Council on the misuse of Drugs

ARK - Northern Ireland Access Research Knowledge

BHSCT - Belfast Health and Social Care Trust

BME Black and minority ethnic

CBT - Cognitive Behavioural Therapy

DEL - Department for Employment and Learning

DHSSPSNI - Department of Health, Social Services and Public Safety's

DNA - Did not attend

DSM-V - Diagnostic and Statistical Manual of Mental Disorders

ECMDDA - European Monitoring Centre for Drugs and Drug Addiction

ECR - Electronic Care Record

EU - European Union

GDP - Gross Domestic Product

GHQ-12 - General Health Questionnaire -12

GP - General Practitioner

MI - Motivational Interviewing

NHS - National Health Service

NHSCT - Northern Health and Social Care Trust

NICE - National Institute for Health Care Excellence

NICEM-Northern Ireland Centre for Ethnic Minorities

NIHRC - Northern Ireland Human Rights Commission

NIHSCIS Northern Ireland Health and Social Care Interpreting Service

NINO - National Insurance Numbers

NISCC - Northern Ireland Social Care Council

NISRA Northern Ireland Statistics and Research Agency

NTA National Treatment Agency

ICD-10 - International Classification of Diseases

IOM - International Organisation for Migration

ORECNI-Office for Research Ethics Committee Northern Ireland

SEHSCT - South Eastern Health and Social Care Trust

SHSCT - Southern Health and Social Care Trust

SLT - Social Learning Theory

TTM- Trans Theoretical Model

VPRP -Vulnerable Person Resettlement Programme

WHO - World Health Organisation

WHSCT - Western Health and Social Care Trust

WRS - Worker Registration Scheme

Chapter 1

Introduction; Implications of migration on mental health including policy on immigration and access to health care

1.0 Introduction

Migration is the leaving of one country to settle permanently in another country. A migrant is the person in question. They may live in the host country temporarily or permanently (Castles 2003).

Migrants leave their home country and travel to host countries for a number of different reasons, however, the majority of people are economic migrants who migrate from one country to another to improve the quality of their life (Stalker 2001). Castles (2003), states that large-scale movements of people arise due to accelerating processes of global integration. This is explained by the fact that changes of commodities, capital and resources give rise to movements of people. Migration is not a new phenomenon, however at the time of the data collection for this research there are more people living outside their country of origin than in any other time in history (World Health Organisation (WHO)2009). International migration has grown in volume and significance since 1945 and most particularly since the mid 1980s (WHO 2009). It is difficult to pinpoint accurately the numbers of international migrants there are and it is very difficult to measure because it is a fluid figure. The International Organisation for Migration (IOM) claimed that in 2000 there were 150 million migrants, this figure was more than double the figure in 1965, whilst now in 2018 the IOM estimates that there are 244 million migrants which is 3.3% of the world's population (IOM, 2018p13). In early studies of the mass migrations of the nineteenth century, Ravenstein (1889) cited data from 20 countries, noting especially the growth in cites over the period, driven by the influx of migrants and not merely by birth rates (cited in Lee 1966).

Migration is set to continue in the significant volumes that the world has witnessed over the past 30 years because of growing inequalities in wealth between the Northern and Southern hemispheres of the world; these are likely to impel people to search for better living standards. Factors such as political, ecological or demographic pressures may force people to seek refuge outside their own regions or countries and also with the creation of new free trade areas, it is inevitable that this will continue to cause movements of labour. There is also the impact that war has on countries, currently for example, Syria and Bangladesh are seeing huge numbers of forced migrants leave their homeland.

Migration is now part of the transnational evolution of the world, the reshaping of its culture, societies and its politics. Throughout the world, migratory change and new

migratory paths are developing in response to economic change, political struggles and violent conflicts. Castles and Miller (2009) argue that whatever the causes for migration, there are certain general tendencies which are likely to play a major role.

1. The Globalisation of Migration. This refers to the tendency for more and more countries to be affected by migratory movements. The areas of origin are increasing as well as the areas of destination, therefore most host countries have entrants from a broad spectrum of economic, social and cultural backgrounds.

2. The Acceleration of Migration. Due to the growth in the numbers of migrants in all areas of the world, difficulties of current policies are highlighted and there is a need for a review of government policies.

3. The Differentiation of Migration. Most countries do not have one type of migration, but more so a mixture of migrant labour, refugees and permanent settlement. This differentiation often presents a major challenge for government policy development.

4. The Feminization of Migration. In the past many migration movements were male dominated. However, since the 1960s, women have formed a large proportion of labour migration and are often the majority, sometimes due to illegal trafficking networks (Castles and Miller 2009).

Because of these general tendencies, migration is evolving with the changes occurring within the societies of the world. Why people migrate varies, but also who migrates and where to and from the change over time. As governments and states try to implement policies and controls to cope with migration, the fluidity of migration can often lead to policy makers and researchers playing catch-up.

There are myriad reasons why people migrate from one country to another or from one region of a country to another some of which will be discussed further in relation to Ireland's migration history. The systems that exist on a macro, meso and micro level often propel the desire to migrate, however no one specific explanation can be used to explain a migrant path.

Migration does reap huge benefits, including better quality of life through employment, political security, better climate and better social security system. However it has been extensively documented that migration can affect the mental

health of those migrating. Bhugra&Mastrogianni (2004) state that in relation to migration and mental health there are both positive and negative results and it is likely to create both losers and winners. The deterioration in mental health in an individual is sometimes a consequence or a symptom of the trauma of migration.

People migrate to improve their wellbeing (Bhugra 2004). However much research has indicated that migration can have a negative impact on mental health (Bhugra 2004). Stillman et al. (2006) argues that to truly understand the effects of migration on mental health a comparison of the mental health of migrants before and after migration needs to take place. The research further argues that existing literature is not able to do this and typically settles for comparing the mental health of migrants to that of natives in the destination countryor region. This fails to take account of any pre-existing differences between the groups. Some studies have tried to examine the mental health of migrants before and after migration, such as Schweitzer et al. (2011). However the task is difficult in that there are many factors that affect mental health and how it can lead to mental illness, and migration may be just one of those complex factors.

One of the documented and notable consequences of mental illnessis increased alcohol and substance use, which may ultimately lead to alcohol and substance abuse or dependence. International research has indicated that migration, on its own, is not a substantial risk factor as an indicator of substance misuse (Johnson &VanGeest, 1997). However other studies have revealed elevated prevalence of substance misuse amongst specific migrant groups, including Norwegian immigrants to Minnesota, Irish immigrants in New York and London, and British Immigrants to Australia (Johnson & Van Geest 1997). Other international research has indicated that factors such as acculturation and assimilation influence substance misuse alongside the stress process (Gilbert 1986, Neff 1987). Subsequently, these are contributory factors in substance misuse amongst migrants. Acculturative stress suggests that the process of acculturation; the process of 'acclimatising to a new culture' is stressful and will encourage substance use and misuse as a coping mechanism. Factors that might reasonably be expected to exacerbate the stress of the acculturation process include frustration due to poor housing, discrimination, poverty and restricted economic opportunities, language barriers, cultural marginality, family separation, and other forms of social isolation and loss of social status (Cheung 1991; Harrison 1997).

1.1 History of Irish migration

In order to explore the research rationale it is necessary to explore the history of migration in Ireland. The history of migration in Ireland seems to have been a mainly one way affair with Irish people being the subject of migration to countries such as the UK, USA and Australia. However it is worth looking at Ireland's migration tapestry and the significant historical and political events that has shaped its population. The 1600's was a significant time in Ireland's migratory history and in particular the northern region of the country. In 1607,the significant event of the 'Flight of the Earls', who were the Gaelic-ruling class in Ireland, left a vacuum in terms of land ownership which Fitzgerald and Lambkin (2008) argue facilitated and strengthened the 'success' of the Plantation of Ulster by offering land to new migrants from Scotland and England. With the influx of new migrants to Ireland existing residents were displaced to a certain extent, some moved county and some themselves migrated to other European destinations like France and Spain. However, during the early 1600's there were different political unsettlements that stemmed the flow of migrants to Ireland and also saw some recent migrants return home to Britain. During this period, it is estimated that 100,000 migrants came to Ireland, with one quarter from Scotland and the rest from England and Wales (Canny 1988 p67, 1994 p108). From 1650-1700 the volume of migrants to Ireland increased with an estimated 190,000 new migrants to Ireland, 80,000 of whom were Scottish, the others from England and Wales (Canny 1994; Smout, Landsman and Devine 1994 , cited in Fitzgerald and Lambkin 2008 p 95). During this time there was also a significant departure of native Irish. These estimated 70,000 migrants (Cullen 1994) did comprise of many military whom had been defeated in battle. Fitzgerald and Lambkin (2008) state that continental Europe was a major draw on Catholic Ireland. It is also worth noting that during this time there were Irish migrants travelling to the Caribbean via merchant ships, often as indentured labourers, and this also facilitated travel to the Southern areas of America. The number of migrants is difficult to estimate though the figures discussed have been upwards of 100,000, however Smyth (1992) believes this to be an over inflated figure. However the early part of the 1700's did see a huge increase in migrants leaving Ireland. There has been much debate about the actual figures however based on different estimates Fitzgerald and Lambkin (2008) estimate that people emigrating from Ireland to North America in the period

1700-1775 to be from 100,000 to 250,000, with a higher number of people emigrating from Ulster than any other Irish province. It is worth noting that although this new migratory path developed, the already established paths to Britain and continental Europe sustained similar volumes of migrants. Migration from Ireland continued during the first half of the 1800's and the failure of crops and pressures on subsistence forcing more to opt for the expensive option of North America as opposed to those travelling across the Irish Sea. Alongside this pieces of legislation such as the 1800 Act of the Union were seen as additional motivators for emigration. By the middle of the 1800's there was a huge population shift in Ireland. The Great Famine in Ireland which claimed an estimated one million lives also was a huge catalyst for migration. It is estimated that in the Great Famine decade 2.1million people left Ireland (Donnelly 2001 p178) But the effects of the Great Famine on migration continued to have an effect on migration into the 1900's with an upwards estimate of 4.5million leaving the shoresbetween 1856 and 1921 (Miller 1985 p346). From partition until the end of the 20th Centrury, it estimated that 500,000 people left Northern Ireland while 1.5million migrated from the republic of Ireland (Delaney, 2002 p1 cited in Trew 2013 p29). During this time there were essentially three waves of migration, the first being the interwar period. The depression in the US during the 1930s and the requirement for labour in Britain motivated the majority of migrants to seek their fortune across the Irish Sea following the 1929 stock market crash. The second wave was during the post war period from the 1950's with the post-war boom and the demand for labour particularly in Britain . The third wave from Northern Ireland took place during the 1970's particularly because of the violence and the third wave from the Republic of Ireland took place in the 1980's due to the economic recession (Trew 2013) By the mid 1990's there was a positive net migration figure particularly due to the 'Celtic Tiger' economic prosperity of the Republic of Ireland and Irish emigrants returning to Ireland. By 2004, the break-up of the former Soviet Union and the EU accessionof8 Eastern Bloc countries , including Poland, Lithuania and Latvia, led to former Eastern bloc citizens availing of free movement within the EU to initially come to the UK and Ireland and Sweden, as other EU member states delayed free movement until 2007. This had a huge influence on inward migration to the UK with specific reference to Northern Ireland and the Republic of Ireland. In the 2001 census in Ireland the population was reported to be 3,847,200 of which there were 224,621 non-Irish nationals living in Ireland.(CSO 2202) Northern Ireland's population was

1,689,300, with 149,772 of whom were migrants (NISRA 2002). In the 2011 census the population and the population make up had changed on the island of Ireland. In the Republic of Ireland the population increased to 4,851,269 with a total of 544,357 non nationals living in Ireland (CSO 2012). In particular the Polish population was now the biggest immigrant group of 122,585 (CSO 2012). In the 2001 census there was no requirement to record Polish as a population group as the number would have been so small. In contrast Northern Ireland experienced a similar influx of migrants particularly from A8 countries. In the 2001 census in Northern Ireland the population of Northern Ireland was 1,685,267 with 27,226 born outside the UK and Republic of Ireland (NISRA 2002). In 2011 the census reported that the population was 1,810,863 with 81,314 residents born outside the UK and republic of Ireland, this is a percentage change of 199% (NISRA 2012). Excluding those born in other parts of the UK and the Republic of Ireland, Polish migrants are the largest migratory group in Northern Irelandas well with approximately 19,658 Poles living here (NISRA 2012).

1.2 Migration to Northern Ireland – A New Experience.

Northern Ireland has experienced migration over the centuries, however the last 50 years it has been mostly one-way traffic, with net migration being negative in that more people left here than came here. As discussed above, in the last 20years Northern Ireland has seen a huge influx of migrants from many parts of the world. In order to get an insight into the migratory flows a number of approaches need to be considered. Trew (2013) explains that because of its position within the UK, Northern Ireland migration data tends to be 'patchy' and that using data from different sources is required to give a clearer picture particularly in relation to inward migration. The main source of data to get an insight into the population of Northern Ireland as discussed above is the census data. This is produced by the Northern Ireland Statistics and Research Agency (NISRA) every 10 years. The census used to give an insight into the recent migration trends are those for 2001 and 2011. In addition, several administrative sources are used to provide insight into population trends, including NHS medical card registration data, births, National Insurance number registration and the School Census.

As detailed above when comparing the migrant population in Northern Ireland between the two census points of 2001 and 2011 there was an increase in the migrant population of 199% (NISRA 2012). The biggest migrant influx has been from Eastern

European countries (NISRA 2005,2011,2018). From 2004 to mid-2007 it was estimated that just over 51,000 people migrated to Northern Ireland; from 2000 to 2004 the figure was 30,000 (NISRA 2008). The expansion of the EU in 2004 was the main source of the increased flow of migrants. Most people coming to Northern Ireland were from one of the A8 countries and to be able to work at that time, migrantsmust have registered through the Worker Registration Scheme (WRS)(Now obsolete). From June 2006 to June 2007, some 9,000 people registered to work in Northern Ireland, a similar level to the previous year. In 2007 in Northern Ireland, 1,900 births here (8% of all births) were to mothers born outside the UK and Ireland, compared to 700 such births in 2001, and of these, 800 births in 2007 were to mothers from A8 countries, compared to 10 such births in 2001 (NISRA 2002). The School Census in 2007 showed that 3,500 primary school children have a language other than English as their 'first' language. This was about 2% of the primary school population, and a large increase on the corresponding figure of 2,400 for the previous year. For secondary school children, the increase was from 1,100 to 1,700 (1% of the secondary school population); and new registrations with GPs from migrants coming from outside the UK was almost 19,400 registrations in 2007, half of which were A8 migrants (NISRA 2008). Over half those registering with GPs gave their reason for coming to the UK as work related, while 20% came for family reasons, 7% for education and 20% gave another or no specific reason. (NISRA 2008).

The overall migration trends described above vary across Northern Ireland. Flows around areas such as Botanic (Belfast), Jordanstown (Newtownabbey) and Strand (Derry) are driven by students, but work is the main reason given by people for coming to Northern Ireland. Information from NHS registrations with GPs shows that in parts of Dungannon, Craigavon, Belfast and Newry and Mourne, annual immigration flows in 2007 exceeded 1 in 30 of the resident population. There is also variation in migration related statistics for children. In 2007 about 2% of primary school children did not have English as their 'first' language; however this figure for schools in Dungannon was 8%. Similarly, while births to mothers born outside Northern Ireland accounted for 8% of all 2007 births, in Dungannon the figure was 18%.This demonstrates that there are particular areas where migrant populations settle, most likely for economic reasons. The largest ethnic group in Northern Ireland in 2011 was the Polish community (NISRA 2012).

Using these figures to calculate migration have their deficiencies. When using National Insurance Number registration or applications for WRS you only capture the working population and discount the families of workers who have travelled or undocumented workers. Using school census only gives a snap shot of migration in schools and does not give the whole picture.However when looking at these figures in conjunction with census figures the picture becomes clearer. Administrative sources indicate that the population of certain migrant groups, notably the Poles increased rapidly, especially since 2004.

1.2.1 Population Groups

In the 2011 census,it was reported that nearly 20,000 Poles now reside in Northern Ireland. Unlike other parts of the UK where Polish migrants have been residing since the 2nd World War, up until 2004 there were few Polish migrants residing in Northern Ireland. After the Accession of the A8 states in 2004 many Polish people migrated here to Northern Ireland. Using the methods discussed,it is apparent that they did continue to migrate here and more importantly decided to stay . As the 2011 census is the main informant source in terms of population it is still worth while getting an estimate of the current migrant population here in Northern Ireland. The overall population of Northern Ireland in 2017 is 1.871 million (NISRA 2018). In 2017 an estimated 22,100 people came to live in Northern Ireland, however 20,900 left. Using some of the administrative sources discussed above and utilised by Trew (2013) in her review of migration inflow to Northern Ireland, medical card registration for 2017, looking at the four largest migrant groups, found that those from the Republic of Ireland was the largest group with 1250 applicants, Romanians the second largest with 1000 applicants and Polish the third largest with 900 applicants. It is worth pointing out that in 2017the medical card application process changed and NISRA(2018) believe that this may have contributed to the reduction in applications in 2017 compared to the previous 2 years. Again using other administrative data sources such an National Insurance number registrations the 2017 figures indicate that Romanian migrants make up the biggest new registration group with 2000 NINO's issued to Romanians in 2017, 1500 issued to Bulgarians and 1450 issued to Polish. Based on these figures there is evidence of a reduction in new migrants coming here compared to the peak of 2007/2008, however the migrants who are here seem to be staying. An indicator of this would be births to mothers in Northern Ireland who were

born outside the UK. Births to mothers from the Republic of Ireland remained at around 3% from 1997 to 2017 (NISRA 2018). Births to mothers from other countries increased from 5.3% in 1997 to 13% in 2017 with the figure significantly rising after 2004 with the enlargement of the EU. In addition to this, examining school census data gives an insight into the population change in Northern Ireland as discussed above that initially occurred in 2004. In 2017 the School Census revealed that in 2017 there were 13,600 children, primary and post primary, who stated that English was an additional language and that English was not their first language. This figure was a 9.9% increase on the 2016 figure and across both Primary and post primary Polish, Lithuanian and Portuguese were the highest languages spoken apart from English. From the figures presented above it is clear that Northern Ireland has become a destination for many and in particular Polish people. The fact that Polish were the biggest migrant group in Northern Ireland at the time of the study is the reason why as a migrant group they were chosen for the research. Further details of which are set out below. From a migrant point of view it is worth now discussing how migrating to Northern Ireland can be complex.

1.2.2 Northern Ireland as a Migrant Destination

Migrating to Northern Ireland is quite different than migrating to other parts of the UK. Northern Ireland is still trying to come to terms with a violent and sectarian past. It is also in the process of negotiating and navigating the process of devolution. So for people coming to live in Northern Ireland there are many unique issues that are present only here and very much different from other parts of the UK. Svasek (2009), states that Polish migrants in Northern Ireland find themselves in a place marked by a history of sectarian violence. This history has shaped the lives of the communities of Northern Ireland. This past shapes peoples emotional dispositions along with the physical use of their space, which may be seen as territorial and defensive. Lysaght (2005 p135) states that in Northern Ireland there exists "complex mapping practices, whereby space is carved into safe and unsafe zones, where both macro and micro territorial considerations exist". The physical segregation that exists in the host community can lead to issues for migrants. Migrants who rent houses are often seen as a threat and as an intrusion of the host communities' space. Svasek (2009), based on findings from ashared history project, found that the troubles did influence how migrants and new comers were treated and perceived by the resident population.

Svasek (2009), also found that the perception of Poles as Catholics influenced "Protestant-Poles emotional interaction" (Svasek2009: p145). This notion was reinforced by previous chief constable Sir Hugh Ord in 2007, when he stated that the biggest emerging threat was racist attacks against migrants. Ord (2007) further commented on the fact that many migrants from the Polish community sought cheap rental accommodation which was most notably available in the most sectarian areas. These migrants then became the target of anti-foreigner attacks. As stated previously, the issue that the majority of Poles are Catholics, in many loyalist/protestant areas they would be perceived as unwanted Catholics. During a conference hosted by the Polish Association of Northern Ireland in 2009, the topic of prejudice and attacks on Polish migrants was discussed and it was argued that Poles were generally better off in Catholic neighbourhoods (No Home From Home 2009). It was further discussed at the same conference that there was perceived to be a generally positive relationship between Poles and the host Catholic community because of their shared faith and the view that the Polish influx has led to a boost in Catholic numbers in the province. This in turn leads to schools, which were seeing a reduction in intake figures, seeing an increase in intake thus reducing fears of closure. Kempny (2011) explored the issues faced by migrants in Northern Ireland through her research exploring representations from Polish migrants living in Belfast. Kempny (2011) discussed how the Protestant-Catholic divide was experienced by migrants and how they interpreted the social constructs of Northern Ireland. Through qualitative research discussing the issues with Polish migrants there were reports of hostility towards migrants and developing an awareness of safe and unsafe areas of Belfast, with a more favourable view towards the catholic population. However, there are conflicting views reported whereby some migrants felt that their experiences of living in predominately protestant areas was pleasant and welcoming. Bell (2017) discusses how Polish migrants adapt to the local situation by reducing their outward catholic identity such as children's school uniforms by changing out of them prior to returning home in the mainly Protestant/loyalist areas.

However there are still some negative attitudes from both sides of the community towards migrants and especially the Polish community. The attitude of 'them coming over here and taking our jobs' is very apparent. In a published report by ARK detailing prejudice and tolerance in Northern Ireland, figures indicated that the number of racist incidents recorded by police rose from 185 such incidents in 2002 to

over 1000 in 2009 (ARK 2009). In a Northern Ireland Life and Times Survey (NILT 2009) only 7% of respondents believed that there was 'hardly any' prejudice against minority ethnic communities in Northern Ireland. When asked which group they felt most prejudice was directed towards, nearly 1/3 (30%) stated the Polish community. In fact this was the largest group. So although coming to Northern Ireland can have a positive impact on peoples' lives, there is the added complexity of migrating into what has been described as a divided society. This becomes increasingly complex when you are perceived as "being from the other side". However, taking these factors into consideration Trew (2013) states that "migration in Ireland and Northern Ireland is not only influenced by local factors but by global economic conditions that generate the push and pull demands of labour and international markets" (2013 p28). This can be described as balancing up the risk and outcomes for individuals. This process has been explored in the narratives of many migrants over the years who have contributed to oral history research . Trew (2013) in her book, Leaving the North, through interviews collected for the Voices of Migration and Return (VMR) oral archive, explored the individual narrative of migrants from Northern Ireland, which provides a holistic perspective of the migratory experience including the destinationand the experience of it. Such research processes help develop an insight into the person behind the migratory process.

This research of this dissertation sets out to explore the impact that the migration process has on both those migrating to Northern Ireland and also on the services that need to respond to the needs of new residents. As has been documented in international research, migrants coming to Northern Ireland may also suffer from mental health problems culminating in alcohol or substance abuse problems. With this there is the potential problem in relation to the responsibility and ability of voluntary and statutory services to meet the needs of individuals from migrant communities. The research was therefore designed to investigate these issues. In their study of Irish migration, Fitzgerald and Lambkin (2008 p34) state that there are 5 basic questions that require investigation: "Why does migration occur? Who Migrates? What are the patterns of 'old worlds' and 'new worlds' and of the flows between them? What are the effects of migration on the 'old world'? What are the effects of migration on the 'new world'?" Within this research there was the additional question of what are the effects of migration on the individual?

1.3 Policy Introduction

This section will discuss further the specifics of migration in relation to Polish people coming to Northern Ireland. In order to do so, it is necessary for this to be discussed in the context of European Union (EU) migration policy followed by Polish migration policy. EU migration policy will be examined in historical terms looking at the Treaty of Rome in 1957 right up to modern day social policy. Polish migration policy will be examined with specific reference to political change in Poland in the 1980's. In order to explore all the issues it is necessary to examine firstly the development of British migration policies over the last four decades. This will aid the understanding of the migration path of Polish nationals to the UK including the freedom of movement of EU nationals. The migration will also be discussed in the context of coming to Northern Ireland and what specific issues arise. In a separate section, the current legislation pertaining to Polish migrants coming to the UK will be examined. This will look at rights, access to services such as health and social care, and social security.

1.4 Historical overview of UK Migration

Due to the changing dynamics, levels and paths of migration the phenomenon has recently been described as 'new' (Koser and Lutz 1998). Traditional emigration countries are now destinations for immigration, such as Ireland and Italy. Furthermore countries which in the past limited emigration are now the source of mass migration movements such as Poland. Due to the accession of a number of Eastern European states in 2004, migration from these countries surged, especially to the UK. However it is not a one way process whereby push factors encourage people to leave their home place but a case that host countries often develop migration policy in order to entice migrants to fulfil labour requirements like the UK (Duvell 2002).

1.4.1 British Migration since 1800's

The UK has, throughout history, been a destination for many migrants. After the abolition of slavery in 1833, many migrants from overseas British colonies settled in the UK. Whilst Irish migrants have steadily crossed the Irish Sea and settled in Britain, in recent history one of the most significant events which led to mass migration to the UK was the end of the Second World War. At this point in time there was an economic boom, a demand for cheap labour and also a 'liberal' migration policy within the British Commonwealth (Castles 2003). Because of this there was

mass migration from outside of Europe including India and the Caribbean. Over the next forty to fifty years there were spikes and troughs in migration which were largely due to economic reasons and the liberal UK immigration policy. Migration policy and legislation has changed over the last century from being liberal to being selective and aiming to control. The first piece of legislation controlling migration was introduced in 1905. The Aliens Restrictions Act 1905 aimed to restrict East European Jewish migration. Subsequent Acts, also detailed specific criteria for migration to the UK. The first was the 1948 British Nationality Act, which granted freedom of movement to all Commonwealth citizens. This resulted in steady increases in migration. In 1953 Commonwealth migration was 3,000 per year, this rose to 46,000 in 1956 and 136,000 in 1961. There was concern at the time about the number of economic migrants coming in to the UK and in response the Commonwealth Immigrants Act was passed in 1962 (Panayi 2010). The feeling and attitudes were summed up at the time in the comments made by the Conservative Home Secretary at the time Rab Butler;

> "The justification for the control....is that a sizeable part of the entire population of the earth is at present legally entitled to come and stay in this already densely populated country. It amounts to one quarter of the population of the globe and at present there are no factors visible which might lead us to expect a reversal or even a modification of the immigration trend".

Rab Butler MP 16th November 1961

The restrictions within the new legislation required that migrants have a job before they arrive, have special skills or who could contribute to the labour needs of the national economy. The 1968 Commonwealth Immigration Act then restricted African or Asian migration and finally the Immigration Act of 1971 ended primary Commonwealth immigration altogether, which meant that any immigration after that time was only permissible in the case of family reunification. The 1981 Nationality Act ended, for most commonwealth citizens, the right to settle in the UK. In 2002 the Labour Government of the UK introduced the Nationality, Immigration and Asylum Act (NIA). As a result the current legal framework in relation to immigration and asylum is complex and fragmented (Duvell, 2008). Due to the complex web of legislation, there exists 85 different immigration categories, each with specific rights, conditions and limitations (Gropas, 2007). Out of the 85 categories Polish migrants fall into the A8 category. In addition in the 2014 Immigration Act was introduced

which added complexity to status and rights of migrants. In a policy briefing by LGiU (2014) the act was stated to have a number of aims, including ensuring checks are carried out by landlords and employers on the legal migration status of migrants. Also there was the introduction of NHS charges for temporary migrants which has in itself implications in demonstrating someone's migratory intentions and also greater emphasis on the 'not normally resident status'. In addition the legislation also placed additional access barriers to other services such as housing. The 2016 Immigration Act added restrictions to working and living in the UK . The Act not only made changes to immigration law but also to areas such as housing, social welfare and employment to create a 'hostile environment' (Immigration Law Practitioners Association 2016). Issues that will be discussed further

1.5 Polish Migration History

In order to examine more in-depth as to why so many Polish people immigrated to the UK, estimated to be 2.9 million from 2004 to 2009 (Central Statistical Office, Poland), it is worth looking at the migrant paths from Poland in the fifty years prior to the 2004 accession.

After the Second World War there were approximately 160,000 polish migrants in the UK (Burrell 2006). Many of these were ex-servicemen who had fought alongside the allies during the Second World War. However immediately after the War the nature of outward movement changed with the establishment of the communist regime. Outward mobility was significantly limited and highly politicized, even though there was relative freedom of movement within the Eastern Bloc (Burrell 2009). Poles could travel outside of their country, but people could not keep their passports at home and going west hinged on permission from the government, which was usually only granted through invitations, student places and specific job offers (Burrell 2008). However after some relaxation in mobility stipulations after 1956, there was considerable emigration from Poland under communism (Iglicka 2001). Sword (1996) suggests that from 1956 between a few hundred and few thousand Poles came to Britain each year up until the 1980's when there was a surge in migration from Poland. This surge was brought about by political upheaval and social unrest.

1.5.1 Poland in the 1980's; a catalyst for migration.

During the 1980's there was huge unrest in Poland. People started to mobilize against the government and challenge draconian legislation On Monday, June 30 1980, the government of Poland announced a "reorganization of meat distribution" (Burrell 2009). The result was an immediate price increase of almost 60% and greater difficulty in obtaining meat. On July 1st, strikes broke out in factories throughout Poland starting with a tractor factory in Ursus, steel works in Huta near Warsaw, and a helicopter factory at Mielec. Between 3-10 July agitation spread within Warsaw to the aircraft factory at Swi and at Swidnick, workers formed strike committees, their demands dealt with wage increases and the cancellation of the price rises. The government granted wage increases: 10% on average, sometimes as high as 20%; often granted preferentially to strikers in order to calm the movement.

In mid-July the strike hit Lublin. On July 17, the city with a population of 300,000 and just 100 kilometres from the USSR was completely paralyzed. Railway workers had discovered that a train labelled "fish" was filled with meat and headed for the Soviet Union; they shut down rail traffic by leaving trains and engines on the tracks. Everything was on strike, buses, bread and milk delivery, nursing, construction, water service; the meat would have to be distributed to the population. The government sent Jagielski, the then deputy Prime Minister to try and calm the situation and the Party issued an official summons to return to work. Everything ended two days later, but the fact remained that an entire city organized itself to go on strike; the demands did not remain merely economic. Fifteen days later, the Lublin railway workers began electing union representatives directly and other Lublin workers followed their lead. Work started again in some regions but strikes broke out in others. Everywhere the authorities gave in and granted wage increases. According to the Financial Times the government established a fund of 4 billion zlotys in July to pay these increases. Official agencies were instructed to make 'good meat' immediately available in factories where work stoppages threatened. Towards the end of July the movement seemed to recede; the government thought it had stopped the movement by negotiating factory by factory. It was mistaken. The explosion was merely incubating as the one-week strike of Warsaw's dustmen at the beginning of August showed. On 14 August, the firing of a militant of the free trade union movement, a worker known for being outspoken and for his sincerity, provoked the outbreak of a strike at the Lenin shipyards in Gdansk. The general assembly drew up a list of eleven demands;

proposals were listened to, discussed and voted upon. The assembly decided to elect a strike committee mandated on the basis of the demands which included: the reinstatement of fired workers, increases in family allowances, wage increases of 2000 zlotys, the average wage at the time was 3000-4500 zlotys a month, the dissolution of the official unions, suppression of the privileges of the police and bureaucracy, the building of a monument to the memory of the workers killed by the militia in 1970, the immediate publication of truthful information about the strike. The management gave in to the reinstatement of Anna Walentynowicz and Lech Walesa and on the construction of the monument. On 15 August a general strike of more than 50,000 workers paralysed the Gdansk region. Throughout August strikes continued. On 28 August the strikes spread further. They affected the copper and coal mines of Silesia where workers had the highest standard of living in Poland. Thirty factories were on strike at Wroclaw, including the steel mills of Nova-Huta and at Rzeszois. Inter-factory committees formed in various regions. Ursus sent delegates to Gdansk. An agreement was signed on 31 August at Szczecin and at Gdansk. The government recognised the 'self-managed' unions. Although the mass strike had its most dramatic expressions in August 1980, the working class kept up the initiative against the first incoherent responses of the Polish bourgeoisie for some months, into early 1981. Despite the agreements drawn up in Gdansk, workers' struggles continued, with occupations, strikes and demonstrations. Workers' demands broadened, with economic demands widening in scope and depth, and political demands becoming increasingly more radical. In November 1980, for example, there were, in actions centred on the Warsaw area, where there were demands for control over police, army, security police and public prosecutors. At the economic level, there were occupations of government offices in protest at meat shortages. Elsewhere there were strikes and protests about the meat ration allowed over the Christmas period.

In January 1981, whilst the Solidarity movement, known as Solidarnosc, was discussing Saturday working with the government three million people failed to turn up for work and heavy industry came to a standstill. Lech Walesa appealed for there to be no confrontation with the government. In January and February 1981 there were strikes demanding the removal of corrupt officials. In March there was the threat of a national general strike in response to police violence in Bydgoszcz. In the end this was called off by Solidarnosc after a deal with the government. The union accepted that "there was some justification for police interference in Bydgoszcz because of a

climate of tension in the city." In the period following Bydgoszcz seven joint commissions were set up to officially institutionalise government-Solidarnosc collaboration. However, the struggles had not finished. In mid-July 1981 fuel and price rises of up to 400% were announced, as well as cuts in the meat rations for August and September. Strikes and hunger marches reappeared. Solidarnosc called for an end to the protests. Many other issues were also taken up - corruption, repression, as well as rationing. By late September two thirds of Poland's provinces were affected. The strike wave continued developing into mid October 81.Although the government's summer announcements were clearly threatening, it was not until 13th December 1981 that the clamp down of military rule was undertaken. The police state had 300,000 troops and 100,000 police but it was 17 months after the start of the movement before the Polish ruling class felt confident that it could physically attack workers' strikes, occupations and demonstrations. Polish people had been the most outspoken against communist rule and demonstrated their discontent against the totalitarian regime with actions of strike. Because of such discontent and struggle within Poland many people emigrated, with Britain being a primary destination. Burrell (2006) states that

"Migration for these people represented a new experience of border crossing – the opportunity to traverse the political barriers of the continent and escape to the mystical 'west', and in doing so, outmanoeuvre the Polish authorities. If refugee border crossings were about survival, the narratives of those leaving communist Poland were about getting the better of bureaucrats and overcoming corruption. Recounting these migrations provided an opportunity to assert personal resistance against the system and highlight the chaotic, intrusive and pedantic nature of state affairs"

(Burrell 2006 P31).

This demonstrates how, although migration may have been for economic reasons, i.e. leaving from a socialist or communist country to a capitalist society, there may be underlying reasons i.e. to escape the oppressive state that was experienced by many Poles, especially during the 1980's (Sword 1996). After the fall of communism in 1989 migration from Poland took on a new dimension. Emigration continued as it had always done but this time it was easier to leave (Iglicka 2001). However entering a new country was still as difficult. Those coming to Britain legally relied on short-term visas, official work offers or marriage. The economic pain of transition nevertheless

pushed hundreds of thousands of Poles to emigrate, although Britain was not a major destination in the way that Germany, Italy, Greece and the US were (Burrell, 2006).

1.6 Polish Migration Policy

On the eve of Poland joining the EU a consultation document was published by the Institute of Public Affairs in Warsaw discussing the needs and priorities for a Polish migration policy. The author Krystyna Iglicka stated that Polish migration policy faces various challenges such as the need to prevent the outflow of specialist workers recruited by Western European countries. Iglicka (2005) further stated that Poland does not have a comprehensive migration Policy. This will be examined in terms of Poland's previous experiences of migration and how after the Accession in 2004 Poland's policy on migration and immigration changed.

1.6.1 Background to Polish Migration Policy

After the Second World War until the collapse of communism in 1989, Poland's migration policy reflected isolationist principles which was similar across many of the Soviet Bloc countries (Iglicka 2005). It was difficult to leave the country because of the restrictive passport and exit-visa policies and those who were granted permission to leave were always set a time limit on the stay abroad. However, it is estimated that 6 million Poles chose this opportunity to seek a better life abroad, sacrificing their chance to return home again. Germany, for many, was the country of destination and just over 10 percent of all post-war emigrants travelled to the United States.

In the Post-war period the Polish government's main driver in terms of migration policy was to become an ethnically homogenous country (Iglicka 2010). This involved two things. Firstly it involved improved settlement conditions for Polish citizens who had repatriated from the former Soviet Union and secondly, it involved an effort to eliminate what the government described as "hostile and temporary elements," these were people of ethnic German descent (Iglicka 2010).

Immigration to Poland was never an issue for the authorities so there was no need for any structured policy or administrative departments in order to deal with it. However, after the fall of communism in 1989 a new political dawn emerged and with it the

anticipation of immigration and the need for policy and administration. Along with other Central European countries, Poland witnessed several new trends in a short period of time. These included;

- the massive short-term mobility of citizens from the former Soviet Union;
- labour migration to both Eastern and Western Europe;
- permanent migration into Poland, mainly from other Eastern European countries;
- the formation of new immigrant communities of Chinese, Vietnamese, and Armenian origin;
- inflows of asylum seekers;
- lower levels of emigration;
- the return of Polish citizens living abroad

In 1989, the only law dealing with migration was the Aliens Act of 1963, which was enacted when few foreigners entered Poland. The act defined the conditions of entry into the country, internal movement, and departure.

It took time for the Polish government to deliver a new Aliens Act of 1997. It was greatly influenced by a law and order focus and potential EU accession. In April 2001, the Polish Parliament passed comprehensive amendments to the Aliens Act to help clear the path toward EU membership. A separate part of Polish immigration policy dealt with repatriation. The Repatriation Act of 2001, was the first comprehensive document regulating resettlement of people of Polish ethnicity or descent.

Since Poland joined the EU in 2004 it has had to change the focus of its migration policy. Iglicka (2010) states the focuses have been on;

- return migration of Poles who emigrated to Western Europe. This was facilitated under promotion of business ideas and tax relief.
- the need for skilled and unskilled foreign workers in sectors such as agriculture and construction
- control of the eastern border and free movement for Polish citizens under Schengen.

In order to compensate for the labour shortages that accession has created within Poland the government has pursued a policy to try and make it easier for non-EU citizens to work in Poland. As of January 2009, the government had streamlined the process employers need to follow to request a work permit, mainly by reducing the number of required documents.

This resulted in an increase from 18,000 work permits in 2008 to 29,340 in 2009 (Ministry of Labour and Social Policy). Ukrainians made up 33% of the recipients, the biggest grouping. Other nationality groupings included Chinese (15%), Vietnamese (9%), Belarusians (6%) and Turks (6%). Most of the work permits were granted in manufacturing, financial institutions, construction, hotels, and restaurants. Going forward Poland has no choice but to embrace common EU migration policy. In terms of its own internal policy, Poland needed to act quickly to address a second wave of economic migrants exiting the country as Germany and Austria open their labour markets to Polish workers in May 2011.Poland needs to focus on attracting economic migrants from non- EU countries. Iglicka (2010) stated that Poland lags behind its Western neighbours in regulating and developing services for immigrants. Therefore it would seem apparent that Polish policy in terms of managing migration has been limited due to fact that it was never needed. However it faced challenges in implementing a comprehensive policy and the systems that support it in order to sustain the workforce required for economic growth.

1.7 EU Migration Policy

In order to understand why there has been an increase in migration to Northern Ireland, particularly from Poland, it is necessary to examine policy not only within countries but at a European level as it has huge influences on the countries within Europe. Europe absorbs an estimated 2 million migrants each year – more as a proportion of its population than any other part of the world, including North America (Brady 2008). This influx is altering the make-up of member-states' populations, more than birth rates or death rates. Increased migration into Europe is part of a global trend. Cheaper travel and more information entice skilled and unskilled workers from poorer countries to rich ones. This is also compounded by the movement internally of European citizens, who through the 'freedom of movement' programme, travel between members states.

Immigrants have become the subject of political debate in many European countries. The flow of workers into the UK and Ireland following the EU's 2004 enlargement was the largest inward migration ever recorded into either country over a two-year period (Brady 2008). Issues facing EU migration Policy are that there is free movement of citizens within the EU and also that the EU, through its numerous member states, has many land and sea borders. Both of these have implications in terms of security which impedes and shapes much of the policy around migration (Hix 2007). Many Europeans would agree that a concerted EU effort to manage migration is not only desirable but also necessary in order to sustain the right to free movement of people, which is one of the fundamental principles of the single market (Brady 2008).

1.7.1 History of EU Migration Policy

The 1957 Treaty of Rome was the basis for the establishment of a European immigration policy, but from this time period until the 1990s, a common immigration policy was not created (Burrell 2009). The 1957 Treaty of Rome was concerned very much with individual rights of EU citizens. The issue of immigration was only addressed on a European level and in relation to the Treaty of Rome (1957), if and when EU residents felt their rights as EU citizens were impeded. The European Union allowed nation states to handle migration flows individually and therefore final decisions concerning immigration lay with nation states. Nation states had their own immigration agendas and they were based upon economic considerations, which allowed each country to exert control over immigration issues. However the 1957 Treaty of Rome was when the freedom of movement was introduced. For many years, and currently this directive is a source of much of the migratory flows within Europe.

> *"Every citizen of the Union shall have the right to move and reside freely within the territory of the Member States, subject to the limitations and conditions laid down in this Treaty and by the measures adopted to give it effect."*

Article 21 Treaty on the Functioning of the European Union 1957

The policy of free movement was intended to make it easier for people of working age to take up employment or self-employment, including setting up a business in

another Member State. Since the introduction of the policy, it has been revised and updated to ensure that free movement can continue, for example, qualifications in certain professions were the subject of mutual recognition regulations so that professionals such as doctors could work in other Member States. In 1990, it was clarified that retirees and students could go to live in another member state and issues around access to healthcare were also clarified. In 2004, coinciding with eight new member states joining the EU, a directive (2004/38/EC) was adopted which consolidated previous EU legislation on the subject and provided greater clarity as to the meaning of the limitations on free movement that can be applied on the grounds of public policy, public security and public health. However, much of European Union immigration policy now is very much focused on external borders due to the huge pressures from illegal migration from outside the EU, particularly Africa. This has been exacerbated in the past six years with the huge humanitarian crisis affecting member states due to the war in Syria.

The Maastrict Treaty of 1992 was a progressive attempt to control European migration flows. It aimed to create a common admission policy and most importantly, it reassessed the status of non-European citizens. However, it was never formalised into a structured European migration policy that was endorsed by all member states. It was not until the Amsterdam Treaty in 1999, that the European Union formalised a policy in terms of migration. Since the Amsterdam Treaty came into force, the EU has developed its competence in the policy fields of asylum and migration through the implementation of the Tampere Programme (1999-2004) and the Hague Programme (2004-2009) (Brady 2008). The two programmes were designed to build and implement common EU asylum and migration policies. It is argued that the aim of establishing a common migration policy within the European Union in the long term was established in the Tampere Program (Hix 2007). Within the Tampere Program four milestones were identified for creating a common European asylum and migration policy:

- partnership with countries of origin;

- a common European asylum system

- fair treatment of third country nationals

- management of migration flows (Hix 2007)

The Hague Programme (2004-2009) set to build upon the Tampere recommendations by looking at the external dimension of migration and asylum by developing partnerships with developing countries and regions of origin and transit. The Hague Programme recognised the importance of legal immigration in supporting and fostering EU economic growth and competitiveness, in line with the Lisbon Strategy.

Policies identified in order to sustain the current expectations of member states include policies in the following fields:

- Migration management, including rules for admission for employed and self-employed persons, students and other persons, family reunion, border control and visa policies, economic and demographic needs assessments, etc.
- Immigrant integration, including secure residence rights, equal treatment and mobility, acquisition of nationality, anti-discrimination and diversity.
- Relations between source and sending countries, including brain drain/gain, return and circular migration, readmission. Karyotis (2007)

The European Commission would argue that migration policies are designed parallel to, but separately from, asylum policies, that are based on humanitarian principles embodied in international conventions. Much of the current policy on current migration focuses on the need for a coherent comprehensive and common approach to migration between member states. However, it has been argued by some commentators that the European Union's migration policy is shaped by issues around security and not economics. Karyotis (2007) argues that The Treaty of Amsterdam in 1999 signalled a liberal approach by the EU to migration, by recognising the positive contributions made by labour migrants. Europe is an aging continent and with the demand on public pensions there is the increasing need for economic migrants to carry out the jobs in the ever growing service sector (Hix 2007). The concept of the ageing population is strengthen by the current figures which demonstrates that the number of citizens over 65 is increasing in every EU member state (EuroStat 2017). It is projected that by 2060 the proportion of 15-64 in Europe will decline from 67% to 56%, while the over 60 category will increase from 18% currently to 30% (Eurostat 2017).

With the liberal policies at the beginning of the millennium and need for labour due to continued economic growth, Europe's migration policy has changed to focus more on managing a fortress type continent. September 11[th,] 2001 halted the 'liberalisation' of EU migration policy (Karyotis 2007). Karyotis (2007) continues by arguing that the events of Septemeber 11[th,] 2001 in fact added to the already 'securitization' of migration. He argues that anti-immigration member states used September 11th as a means to influence policy in-line with their own political thinking. This is further supported by Hix (2007), in his statistical study of voting by Members of the European Parliament (MEP's) on migration policy. Hix (2007) concluded from his study that politics rather than economic interests ultimately shape migration policy outcomes in the EU parliament. He further concluded that the MEP's position on the left-right political dimension is a strong predictor of their voting behaviour on migration issues as opposed to the economic preferences of the MEP's member states. MEP's on the right wing would support more anti-immigration policies while left-wing MEPS would be more in favour of liberal immigration policies. It is therefore realistic to assume that migration policy within the EU is shaped very much by political ideologies and the current threats to individual member states. Which is ultimately one of the fundamental reasons that the UK has now decide to leave the EU in the process known as Brexit. The UK's relationship with the EU has been tainted. Just two years after joining in 1975 there was questions over whether the UK should remain, then in the 80's the then Prime Minister Margaret Thatcher had a tough stance with the EU over UK contributions, which subsequently led to UK contributions being reduced from 20% to 12%. With different EU -UK incidents in the next 20 years the events of the last decade seemed to add momentum to the leave decision. With the increased migration from 2004, then the economic downturn in 2008, increased asylum seekers and the refugee crisis the UK public was promised by the Conservative Government that its relationship with EU would be re-negotiated. But was the increased migration and the perceived threat of UK sovereignty the deciding factor. One study conducted in the UK found that there was a strong correlation between negative attitudes towards immigration particularly EU immigrates and a leave vote, and those sampled who had a positive attitude towards EU migration were more inclined to vote remain. In the analysis of the study factors such as age, educational attainment and political persuasion were used as predictors of the respondents vote, however when prejudice and migrant group contact was added

as a variable in the analysis the variances were explained a lot better. In conclusion "prejudice towards EU immigrants was found to be a powerful predictor of support for Brexit" (Meleady, R., Seger, C. Vermue, M. 2017)

1.7.2 The Role of Social Policy in Migration: European Union

In order to further understand the complexities of migration it is pertinent to conduct an analysis of EU Social Policy in terms of welfare and control of migration. It has been argued that the accession of the A8 countries to the EU in May 2004 was the pivotal point which marked a surge of Eastern European economic migrants coming to the UK. It is also clearly evident from the various statistics produced by the host countries and the home countries that this date marked the beginning of a movement of thousands of people. However, it is argued that many conditions were in place prior to May 2004 which led to this huge migratory surge. Over the last 20 years from 1998, the EU has attempted to create a common policy on the control of immigration and asylum through the Tampere (1999-2004) and Hague Programmes (2004-2009). Within this context, the EU has on the one hand attempted to restrict the number of asylum seekers and on the other hand promoted the movement of people through the common market. Duvell (2002) comments that a better understanding of the policy would be gained by placing it in context of the EU's concerns in terms of the labour markets being more flexible in Europe, however without diminishing security. The demands for labour can and have been fulfilled to a certain extent by the free movement of people; however asylum seekers and refugees do not fit into this model. The effect being that there has been an attempt to harmonise asylum procedures and entitlements in order to avoid making one country more attractive than another. Duvell (2002) further argues that this includes issues over access to labour markets. Olsen (2000) states, that the adaptation of welfare states in terms of control and access to them has been a further development by EU Governments to control migration. With increased globalisation comes greater mobility. But Hemerijck (2001) argues that in the OECD countries (Organisation for Economic Co-Operation and Development) there are problems with targeting the need for specific labour at different times. This in turn signals the requirement for conditional access to labour markets which is controlled by government policy and legislation. Since 1998 EU

policy and more so UK policy and legislation has focused in on this. However the mobility of asylum seekers and illegal immigration has implications due to it being unregulated. Duvell (2002) comments on this by stating that asylum seeking is linked to claims for welfare support, and therefore drains public funds. Illegal or uncontrolled immigration feeds 'shadow labour markets, with possible negative consequences for tax revenue. With increased globalisation, labour markets aim towards the idea of flexibility as opposed to stability. This in turn needs to be supported by the welfare systems that that they operate within. Up until the late 1990's EU policies were driven by the principle of free movement. This principle was feasible because the labour markets in the EU were well regulated, provided benefits and services for those outside employment and enabled guest workers to settle (Duvell 2002). This was reinforced by the Common Agricultural Policy and the Cohesion funds which funded EU projects in less developed peripheral regions of the EU, areas which were previously the sources of migrant labour. However, the harmonisation of the EU system was upset by the global economic change (Olsen 2000). Esping- Andersen (2002) argues that welfare systems in the EU, excluding the UK, were coming under challenge due to global economic changes. The European Social Model of welfare, operated within a system of high replacement rates, funded through earnings related social insurance benefits. This model was dependent upon a 'breadwinner –housewife' with the male workers wage the key source of income and welfare provision. The UK on the other hand was moving towards a new concept of social citizenship whereby individuals are responsible for their own welfare needs. This model ensured low tax rates and low benefit rates with an emphasis on income support. This in turn encouraged the growth of low paid work and also part-time work, a lot of which was taken up by married women (Iversen and Wren 1998). With the UK welfare system designed to encourage employment of all levels it is sufficient to argue that the UK in times of economic boom would act as a 'Mecca' for eligible economic migrants. The fact that work is encouraged and facilitated, and also the fact that there are comparatively low levels of taxation compared to other EU countries, it would seem that the UK has a certain type of magnetism to economic migrants. Scandinavian countries on the other hand have high levels of taxation, and thus this may act as a deterrent to economic migrants (Esping- Andersen 2002, Hemerijck 2013). In conclusion it would appear that the EU is striving to implement a policy of managing migration by working collectively internally and in partnership with the

countries of origin of non-European immigrants. This would seem difficult to implement in an era of heightened security due to threats from international terrorism. This can be greatly influenced at a European level by member states political ideologies and aspirations. Other influences such as welfare systems and taxation levels in member states do influence the flows of migration.

1.8 UK Migration Policy at the time of Polish Accession

The UK's policy on migration was to allow for the free movement of EU nationals upon accession. Ireland and Sweden also choose to facilitate free movement of nationals from the A8 countries. Other European countries opted to delay implementation of free movement. It has been widely argued by writers in the field of migration that he UK did not expect or plan for the unprecedented numbers of migrants coming to the UK from the A8 countries and in particular Poland (Duvell 2008, Burrell, 2009). The Home Office post accessions flows to the UK were estimated to be from 5000 to 13000 per year up until 2010. One of the main assumptions used to calculate this figure was that Germany would also open up the labour market to new accession nationals, however Germany did not do this. It has also been argued that welfare systems inadvertently attract certain types of migrants. Because of the nature of the UK welfare system it attracted young professionals who are flexible in their work. The UK welfare system facilitates low paid work through subsidy benefits and the level of taxation compared to other EU models of welfare is low. At the time of the EU expansion the UK's economy was growing at a rate parallel to the post war boom. The UK economy, thus was in need of workers. As stated previously, the face of globalisation has changed from stability to flexibility, therefore the labour demands fluctuate with the economy.In terms of why so many Polish migrants came to the UK, it is first argued that Poland was most notably resistant to totalitarian regime so more willing to embrace capitalist society. Poland had an unsettled history and very recently in the 1980's the Polish masses demonstrated how much they wanted and demanded change (Burrell 2009). At the time of EU enlargement the UK had a high GDP whereas the Polish GDP was considerably lower. Alongside this were the high levels of unemployment in Poland and there was a need for workers in the UK. In UK, recruitment agencies actively recruited in Poland, just after the enlargement at recruitment fares across Poland. So alongside the general conditions in place that facilitated mass migration to the UK,

there were specific conditions in place that appealed to the Polish people particularly (Burrell 2009).

1.9 The Road to Northern Ireland for Polish Migrants

Northern Ireland has typically been a country that has seen many of its young people migrate to find work. The economic conditions in Northern Ireland were difficult mainly due to the fact that as a region it is on the periphery of the UK and Europe, has had years of violence and civil unrest coupled with a lack of international investment. So why has the Northern Ireland become a destination for migrants?

1.19.1 Freedom of Movement

As stated earlier, on the 1st of May 2004 ten countries joined the European Union (A10)- eight central and Eastern European Countries (A8);Poland, Hungary, Lithuania, Estonia Latvia, Slovakia, Slovenia, Czech Republic, and Malta and Cyprus. The EU guarantees free movement of workers for all its citizens and eventually citizens of the accession countries will be free to move anywhere in the EU to look for work. Citizens of Malta and Cyprus have relatively free access to the EU labour market and in particular to the UK, both of which were part of the British Commonwealth. However, member states had concerns about opening up the labour market to a potentially large amount of economic migrants; that is migrants who migrate to find employment and gain economically. The Accession Treaties therefore gave the existing 15 member states the option of delaying the full implementation of the free movement of workers for up to seven years. Twelve of the 15 countries choose to exercise the delay of full freedom of movement, however three countries wavered this right, Ireland, the United Kingdom and Sweden. So from the 1st of May 2004 citizens of the A8 countries were able to access the labour market of the UK. The only conditions were that they were obliged to register on the UK Home Office Worker Registration Scheme (WRS) if they are employed in the UK for more than one month. The main reason for this was to implement part of the UK's 'managed migration' approach. In October 2001 the then Home Secretary David Blunkett announced that there was to be a 'fundamental reform' of the migration and asylum policy. The proposed reforms were detailed in the White Paper 'Secure Borders, Safe Haven'. Sales (2007) argues that the bulk of the proposal in the paper involved tightening the controls on asylum seekers and 'illegal immigrants'. Another aspect of

the paper was the welcoming of economic migrants. With the country's economy growing the need for labour was also growing. At the time Northern Ireland was also enjoying economic prosperity and therefore needed economic migrants. Northern Ireland has traditionally been a place of emigration, however in the last decade more people have been coming to live in Northern Ireland than leaving (NISRA 2009). The biggest ethnic group now in Northern Ireland is the Polish community (NISRA 2018). Figures used to calculate migration have their deficiencies however it is estimated that over 40,000 Poles resided in Northern Ireland up until 2009. It is difficult to determine if these Poles still reside, however at the latest census in 2011 18,000 people stated that Polish was their first language (NISRA 2011). Unlike other parts of the UK, which already had Polish migrants living there, up until 2004 there were virtually no Polish migrants residing in Northern Ireland. After the Accession of the A8 states in 2004 many Polish people migrated here to Northern Ireland. As with other parts of the UK during the late 1990's and up until 2007 Northern Ireland was experiencing economic prosperity with many industries including the building and manufacturing industries recruiting economic migrants. Anecdotal evidence indicates that one local US based company did in fact travel to Poland to recruit for its manufacturing plant in Co. Londonderry. Burrell (2006) also indicated that the ability to move between Northern Ireland and Republic of Ireland without hindrance was an added benefit for economic migrants.

1.10 Worker Registration Scheme (May 2004 - April 2011)

Since many of those coming to the UK and Northern Ireland were coming here to find work it is worth discussing the systems that were in place to register migrant workers. This section will discuss further the process of the Worker Registration Scheme and how the systems set to regulate workers. Also to be discussed is how the failure to register within this system renders the worker invalid for entitlement to benefits.The WRS was in place at the time of the data collection for this study therefore it has a bearing on the lives of migrants.

When a Migrant worker came to Northern Ireland and is a citizen of one of the A8 countries they needed to register with the Worker Registration Team at the Home Office. There are some scenarios when a migrant worker did not need to register. These included when the workerwas self-employed or was providing services in the

UK on behalf of an employer who was not established in the UK.The worker needed to register under this scheme within one month of starting a new job. If they did not apply within one month of starting a job, their employment will be considered illegal after that date, and would continue to be illegal until they obtained a registration certificate. Applications needed to be accompanied by the applicant's passport and a payment of £90. If the worker stopped working for the employer, the registration card and certificate would have become invalid. If new employment was gained then a new certificate was to be obtained but no cost was incurred. To try and make this bureaucracy easy to understand here is a flow chart to try and simplify it.

Figure 1: Worker Registration Scheme Process Flow

An EU Citizen arrives in the UK seeking work

↓

Person secures employment

↓

Migrant worker applies for a National insurance	←	Migrant worker applies for a worker registration scheme certificate within 30 days of commencement of job, £90 fee	→	Migrant worker's employer supplies a letter detailing the start of employment .

↓

Migrant worker applies for a WRS certificate with new employers details	→	Migrant worker receives WRS certificate with employers details	→	Copy given to employer

Change of job

Continuous employment for 12 months with no more than 30 days break

↓

Full rights of free movement, EEA Registration certificate

↓

Access to benefit system

Roddy 2012

It is argued that this system added to the vulnerability of migrant workers who travelled to the UK. Migrant worker support groups have indicated that more than 50% of workers were not registered under the Home Office WRS at the time when it was live (Burrell 2006). Reasons given were they were not aware, employers didn't tell them or the work was casual. Therefore workers were not eligible for welfare support in times of need. This increased the risks for migrant workers in that it has been stated that migrant workers are most vulnerable in economic downturn. Taran (2009) states that, migrants are the hardest hit in recession by being the first to be made unemployed and often are not eligible for welfare support. The Law Centre NI (2009) published a report and stated that the migrant workers are unable to claim support from the social security system because of a number of reasons;

- losing employment before the requirement to be registered under the Home Office scheme for twelve months without interruption for more than thirty days is fulfilled. Temporary and seasonal workers are particularly vulnerable to falling into this group;

- failure to satisfy the A8 and A2 registration requirements. This can include reasons such as, failure to register a change of employment within thirty days of starting a new job through or not registering in the first place;

  It is worth noting that the WRS scheme finished in 2011 however it did have an impact on the group in question. It also demonstrates how policy and bureaucracy can impact the lives of migrants and render them increasingly vulnerable

1.11 Focus of the Study

Migration does reap huge benefits, however it has been extensively documented that migration can affect the mental health for some of those individuals migrating (Bhugra&Mastrogianni 2004). The deterioration in mental health in an individual can be a consequence of migration. There are a number of theoretical frameworks that might be used to understand this.

1.   A mental health problem existed prior to immigration and the experience of migration has exacerbated it.

2.   The experience of migration has created a mental health problem.

People migrate to improve their wellbeing. However, much research has indicated that migration can have a negative impact on mental health (Bhugra 2004). In a public address in 2007, Dr. Ali Hussian (Consultant Psychiatrist, Western Health & Social Care Trust, World Mental Health Day Oct 2007) stated that due to cultural differences people with mental health problems present symptoms in different ways. Other factors such as support networks and employment may affect mental health. Howeversuch comparative studies have failed to take these factorsinto consideration when assessing mental health as will be discussed in the later chapters particularly the literature reviews.

This research will take into consideration theories that are to be discussed in the later chapters. The theories try to give an understanding to the complexities of mental health and migration and also the reasons as to why some individuals do have negative consequences when migrating. However, it will not set out to prove or disprove any of these theories. Within this research the focus will be specifically on substance abuse as an indication and in fact a mental health problem within the Polish community in Northern Ireland.

In a review of research by Johnson &VanGeest (1998) they found international research has indicated that migration is not a substantial risk factor on its own as an indicator of substance misuse. However other studies have revealed elevated prevalence of substance misuse amongst specific migrant groups, including Norwegian immigrants to Minnesota, Irish immigrants in New York and London, and British Immigrants to Australia (Johnson & Van Geest 1998).Stress, trauma, isolation and confrontation may well be experienced by migrants coming to Northern Ireland and particularly within the Polish community. It is therefore very realistic that people

within the Polish Community may suffer from alcohol or substance abuse as a consequence of migration.

In order to support and treat people with mental health problems and in particular substance and alcohol dependence, access to, and effective use of services is paramount. The review of Mental Health and Learning Disability with specific reference to drugs and alcohol, Bamford (2005) identified a vision and the principles for the addiction services in Northern Ireland. A review of current provision also looked at the voluntary and community provision as well as hospital provision. In the recommendations for the organisation of services for those with alcohol and substance misuse, recommendations borrowed heavily from the National Service Framework (NTA 2007) for alcohol and drugs. The Review recommended the adoption of the 4 Tier model of service delivery recommended by the Substance Misuse Advisory Service and the Models of Care document developed by the National Treatment Agency (2006). A comprehensive service requires all of these Tiers tailored to individual need.

Treatment within statutory organisations of substance misuse within the community focuses very much on the techniques of counselling, Cognitive Behavioural Therapy and Motivational Interviewing (Miller & Rollnick 2002), using Prochaska and DiClemete's (1983) model of change to help understand the cycle of change. Within hospital inpatient services, treatment is different. It focuses on detoxification but also, group work, counselling, Motivational Interviewing, education and social support as detailed within the Bamford Review (2005) and promoted within the National Institute for Health Care Excellence Guidelines (NICE). Counselling, motivational interviewing and group work all use language and effective communication skills. Many of these underlying themes maybe lost in translation. A Social Worker, who has worked with a Polish lady with an addiction, described how it was extremely difficult to express empathy, respond to negative comments and motivate through an interpreter. However this is only one example of someone who has reached treatment services. A voluntary worker in Belfast has stated that the drop-in service that provides support for the homeless would see on average 30 homeless people every day from the Polish community. She would claim that they all have alcohol problems and also expressed concerns for their inability to access services. Speaking with another drugs outreach worker in Belfast the problem seems to manifesting itself, and again mainly among Polish immigrants.

The New Strategic Direction for Alcohol and Drugs (2011) does identify homeless and migrant workers as a vulnerable group however the question of how big the problem is or how it is to be tackled, is not answered. This proposed research would identify the need, if any. It will also complement and work in tandem with the current system but also identifying any gaps in the service provision.

There has been s a relatively new expanding migrant population here in Northern Ireland who may or may not have specific health and social needs that are not yet fully understood. This research will help to assess the extent of alcohol and substance misuse and the uptake of services.

In conducting this research a further understanding of alcohol and substance abuse problems among migrants may be developed. Also, it may help to understand the specific needs of migrant groups in our ever-expanding multi-cultural society.

Therefore, it may be pertinent to ask, "is the health care system in Northern Ireland designed to be effective enough to respond to the specific health needs of migrants and their families?"

1.11.1 Research Question/Overarching Aims:

To consider the nature and extent of substance use/misuse within the Polish community in Northern Ireland who access community support services.

To consider factors affecting access to services, clients' perceptions and experiences of services.

The specific aims of the study will be to:

1. To conduct a substantial literature review and consider recent research within national and international contexts.

2. To conduct a study of the extent of substance use/misuse amongst a sample of the Polish community in Northern Ireland.

3. To investigate service users' experiences and perceptions of drug and alcohol services in the Province.

4. To consider the views of service providers from voluntary and statutory services.

5. Conclusion and recommendations for policy and research

1.12 Drugs and Alcohol – A Northern Ireland Context

It is worth noting that throughout this thesis there is a strong reference to drug and alcohol use and it is therefore pertinent to give an insight into drug and alcohol use across the jurisdictions in question. Also, in order to consider the results of this study it is worth exploring the prevalence of drug and alcohol use in Poland and then in the UK and Northern Ireland so that a comparison can be made.

Firstly in terms of alcohol use, the World Health Organisation in conjunction with the European Monitoring Centre for Drugs and Drug Addiction (ECMDDA) publicises alcohol consumption by country, and this data will be used. The reported information is based on data collected from 2008-2010 as this was the period of time of the data collection within this research . Lifetime abstainers from alcohol in the UK, including Northern Ireland, is 12% for males and 18% for females, or 15.1% for both sexes. The lifetime abstainers in the Republic of Ireland are 3.7% for males, 18% for females or 6.7% for both sexes. Poland has a lifetime abstention rate of 15.8% for males, 37.8% females or 27.3% for both sexes. In terms of actual alcohol consumption the rates per capita in litres of pure alcohol among drinkers is detailed: UK (including NI) 13.8 litres; Ireland 14.7litres; and Poland 24.2 litres.

The most recent prevalence study of drug use in Poland was in 2012 and it reported that in terms of lifetime prevalence cannabis had the highest lifetime prevalence among 15-64 year olds at 12.2% followed by amphetamines at 2.9%, ecstasy at 1.1% and cocaine at 0.9%. Compared to the UK the figures are relatively low. In the UK lifetime prevalence of cannabis use was 29.9%, amphetamines 11.1%, cocaine 9.5% and ecstasy 9.3% (Crime Survey for England and Wales (2011/2012). In Scotland Lifetime Prevalence use of Cannabis was 26%, followed by ecstasy 9.8% with amphetamines the same at 9.8% and cocaine at 9.1% (Scottish Crime and Justice Survey 2013). In Northern Ireland the Drug Prevalence survey from 2010/2011 reported that lifetime prevalence of cannabis use was 24%. After cannabis, the most commonly used substances were ecstasy at 9%, cocaine and amphetamines 6%, LSD 5%, and solvents 4%.

1.13 Access to Health and Social Care Services

One of the main issues reported by researchers is the confusion between access to social security and health services (Mills 2007). The eligibility criteria for which are different and with the introduction of tighter regulations under the 2014 and more

recent 2016 Immigration Acts the eligibility criteria has tightened and maybe misinterpreted. Often migrants confuse the two in terms of eligibility of access and provision. Under Government regulations and directions it is stated that people who are 'ordinarily resident' here are exempt from charges for services provided by the Health and Social Care Services here in Northern Ireland which is equivalent to the National Health Services which operates in England Scotland and Wales. What are migrants entitled to?

The Law Centre NI (2009) analysed the Department of Health, Social Services and Public Safety (Northern Ireland) policy and legislation on access to eligibility to services and published a guide for migrant workers. The guide stated that: 'Emergency and immediately necessary treatment is provided free of cost to everybody regardless of nationality and immigration status'. The guide further highlights that all services in a hospital accident and emergency department are free. Additional routine treatments are provided free of cost to persons who live in Northern Ireland. These include the GP (General Practitioner or family doctor) service and all hospital and community services and prescriptions. This includes GP services. Therefore, the entitlement to free treatment is not dependent upon nationality or whether a patient has paid national insurance. So the issue therefore is the classification of someone who is 'ordinarily resident'. Department of Health, Social Services and Public Safety's DHSSPSNI Provision of Health Services to Persons not Ordinarily Resident Regulations (2005) explains that an ordinarily resident is someone who is "lawfully living in Northern Ireland voluntarily and for a settled purpose as part of the regular order of his/her life for the time being" . So therefore it is the application of this test that determines whether someone is entitled to free medical care. Deciding whether someone is ordinarily resident is decided on an individual basis. DHSSPSNI guidelines state that 'the person should have an identifiable purpose for his/her residence here and that purpose must have a sufficient degree of continuity to be properly described as settled" (DHSSPSNI, 2005). In terms of migrant workers who are here either working or self employed, they are ordinarily resident, unless they plan to reside in the province for less than six months. However six months is only a guideline. The Law Centre NI (2016) in its most recent guidance and the stipulations are the same however it is worth noting that the application for a medical card now includes questions in relation to reason why the applicant is in Northern Ireland and if they are temporary this affects their eligibility.

This may be the criteria whereby migrant workers are deemed as eligible, and in real terms the majority of Polish nationals who reside in Northern Ireland have access to free health care. However not all Polish nationals have registered with a GP. In the time between 2005 and March 2009 nearly 34,000 Polish nationals registered for a National Insurance number in Northern Ireland. In that time less than 20,000 registered with a GP. The registration figure for the GP lists also includes children who would not be required to register for a national insurance number. From these statistics it is clear that many Polish workers who came to Northern Ireland were not registered with a GP and thus would find it difficult to access other health care services. In terms of barriers to GP and other health care services some research has indicated that there are functionality barriers to health care access for migrant workers Mills (2009). The language barrier is the most consistently cited problem facing migrant workers. This has been reinforced by published research conducted here in Northern Ireland by Northern Ireland Centre for Ethnic Minorities (NICEM 2009). In 2006 the Scottish Executive also published similar findings in research amongst migrant workers detailing that friends, family and co-workers were consistently identified by migrant workers as the main sources of information on services. Concerns were expressed about confidentiality issues given the common practice of relying on friends/family to assist with translation/interpretation. In NICEM's 2009 research respondents were quoted as saying that the level of health care was unsatisfactory and one respondent stating that they didn't trust their GP. These type of responses were also evident in the Scottish Executives research where it states that "there was a perception amongst A8 nationals that the quality of health care was much better in their own countries, though often the health care systems they were familiar with had distinctly different features around access to services". This was reinforced by the findings of NICEM (2009) that some Poles wait until they go home for visits to seek medical attention in their home country as opposed to accessing health care here in Northern Ireland. These findings were reiterated in a policy briefing by Kouvonen, Bell and Donnelly to the Northern Ireland Executive in 2014. In a recent piece of research Madden et.al. (2017) found that Eastern European migrants found that the UK system of health care was inferior to the customer focused style of health care in their home country. The research also found that there were high levels of distrust, dissatisfactions and frustration with the GP gatekeeper system. There was also

evidence that Eastern European migrants also had a lack of understanding of how the health care system works (Spencer 2007, Tobi 2010, Patel 2012).

1.15 Conclusion

In conclusion it is apparent that the migration path for many Polish Nationals to the UK has many underlying currents including the history of Poland and the UK, Poland's resistance to communism, and migration; the policies of the EU, Poland and particularly the UK. It is also argued that welfare systems play a role in influencing migratory paths and controlling migration.

In the context of Northern Ireland, migrating here is a uniquely different experience for those Polish migrants who would have settled in other parts of the UK due to political and religious divide. This may add additional stressors to the migratory process. These additional stressors may have included understanding the often complex systems for worker registration; the successful completion of this scheme determined the workers eligibility for access to the welfare system. Statistics have proven that take up of the WRS is considerably low compared to the number of A8 migrants and in particular Polish who have come to this country.

This fiscal welfare system may often be confused with the healthcare system which has a different set of eligibility criteria and has thus changed again in 2016. The health care system when accessed may also be confusing. Some of these issues will be explored in this thesis.

1.15 Structure of Thesis

Chapter one provides a general overview of migration and some theoretical explanations of migration. It also provides a contextual introduction of migration here in Northern Ireland and introduces the research question and associated rationale for the research. A more detailed analysis of international research will be covered in Chapter four.Chapter one will also explore the policy in relation to the migratory process. It will provide an overview of the migration path from Poland to Northern Ireland and examine UK migration legislation and policies. Within this chapter there will also be an examination of migrants access to personal health and social services and how policy and legislation are being implemented in relation this. The policy section of the chapter is different from the literature review in that it specifically examines how policy and legislation within the UK, Poland and the European Union shape and influence migratory paths. It also examines how specific pieces of legislation influence accessibility and eligibility to welfare services.

Chapter Two examines relevant theories pertaining to the thesis. It was apparent during the review of literature that certain theories were prevalent when examining the impact of migration on mental health. The first of these was the theory of migration, as different commentators do give different explanations for migration and different migratory paths that people take. Also,theory of acculturation and in particular Berry's (1997) model is important, as this is used later in the thesis in a sense to gain an understanding of the results. Also within the theory chapter there is an in-depth look at some of the theories of substance misuse and addiction and change. These give further explanation as to why people use and abuse substances and can recover.

Finally there is an examination of the theories of help-seeking which helps to understand why help-seeking can be challenged particularly in relation to mental health and accessing services in another country

Chapter three will provide a review of literature which focuses on migration and mental health, both within the UK and internationally. The chapter contains details of the method employed to conduct the literature search. The chapter examines some the research areas identifying similarities with the Northern Ireland situation. The literature review also focuses on the aims and objectives of this study so there is a pronounced emphasis on substance and alcohol use/misuse amongst migrant

populations. Further research is reviewed in terms of particular variables and also service utilisation.

Within chapter four the main methodological approach is discussed in detail. Within this chapter the method used within the three research phases will be discussed. The chapter will also discuss the reasons for the mixed methods approach used in the research drawing on the different paradigms used in social sciences research. Included in the discussion will be contextual details of sampling selection method, research instruments used, data analysis, limitations of the methodology, and ethical considerations from each of the studies.

The findings of each of the three studies will be presented in three different chapters. Chapter five will present the statistical analysis from the questionnaire responses from migrants. Using regression and other statistical tools further analysis will help identify and develop an understanding of any relationships that exist between the variables.

Chapter six will contain the details of the findings of the semi-structured interviews with service users. This chapter will contain a demographic breakdown of the interviewees and also themes that emerged from conversations relating to their personal journey to Northern Ireland, their substance use and their helping seeking.

Chapter seven will detail the findings of the semi-structured interviews with service providers. The chapter will give a brief overview of the services they represent and their role. Within the chapter the main recurrent themes are presented and discussed developing further insight into the complexities of delivering services in an ever changing multi-cultural society.

Chapter eight will draw together the results and findings of the previous 3 chapters and will offer a detailed examination of the objectives set out by the thesis. The results will be compared to international research on this issue and help to examine the current situation here in Northern Ireland. Within this chapter, based on the results provided, recommendations for change will be offered, alongside opportunities for further research.

Chapter 2

Theories of migration, acculturation, substance use
and help seeking.

2.1 Introduction

This chapter sets out to explore some of the theories associated with this thesis. Firstly theories of migration will be explored to help give some insight into the increase in migration to Northern Ireland from 2004 taking into consideration economic theories, structural theories and migration systems theory. In doing so it will endeavour to give a better insight into the often life-changing decision to migrate and try to understand the rationale behind such decisions.

Following the migration section the focus be on the personal journey of migrants by looking at the specific experience of acculturation. Acculturation can be described as the process of 'acclimatising' to a new culture. This section will look at all aspects of the acculturation process and how it affects individuals. These effects can have far reaching effects on an individual's social and emotional wellbeing and often lead to emotional stress. It is the acculturation process and that may trigger or exacerbate mental health problems among migrants.

In the next section of this chapter some of the relevant theories of addiction will be explores. Within this section the discussion around the complexity of substance abuse will be presented therefore gaining a further understanding of how individuals use and abuse substances. There are many theories of addiction however, they can be classified into biological, psychological and social.

The final section of this chapter will focus on some of the theories of health care utilisation and inequalities. This will focus the research on aims as stated in the chapter 1.

2.2 Migration Theory

2.2.1 Economic Theories of Migration

Ravenstein (1885; 1889), produced early scholarly articles titled "laws of migration" in order to explain migration. Ravenstein (1885; 1889) argued that migration was an inseparable part of development, and therefore that the major causes of migration were economic (Skeldon 1997). Skeldon (1997) further argued that migration in terms of Ravenstein (1889) was influenced by factors such as distance and population densities. At the macro-level, neo-classical economic theory explains migration by geographical differences in the supply and demand for labour. The resulting differentials in wages cause workers to move from low-wage, labor-surplus regions to high-wage, labor-scarce regions. This is often referred to as the push-pull theory,

because the understanding is that migration comes about by a combination of 'push factors', impelling people to leave the areas of origin and pull factors drawing them to certain countries. Hugo (1993) states that such pull factors include demographic growth, low living standards, lack of economic activities, and political oppression, while pull factors may include such reasons as demand for labour, good economic opportunities and political freedom. This model is very much an economic perception of migration. It looks at migration in terms of human capital, and how people rationalise between the return of investment and migrating. However, Castles (2003) criticises this model and argues that often people may migrate to more densely populated areas. He further argues that the model fails to identify the reasons as to why certain migrant groups go to one country and not another, for example, Algerians to France or Turks to Germany.

2.2.2 The historical-structural approach

An alternative explanation to migration was offered in the 1970's. The explanation developed from Marxist political economy theory and Wallenstein's World-System Theory (1976; cited in Castles 2003). This explanation focused very heavily on unequal distribution of economic and political power in the world economy. Within this explanation, migration was seen as a cheap way of mobilising cheap labour and capital. Migration was viewed as a means of exploiting the resources of poorer countries to the benefit of the richer countries. Within this approach it is argued that migration has its links with colonialism and is a means whereby domination is secured by first world countries. Castles 2003 states that

"migration was as important as military hegemony and control of world trade and investment in keeping the Third World dependent on the First".

(Castles 2003 p 25).

The World System theory is criticised for falling short in explaining how, very often, migration policies breakdown and that countries often have limited control on migration. It also fails to take into consideration the actions of individuals or groups and their own personal roles in deciding to migrate.

2.2.3 Migration Systems Theory Approach.

Out of the critiques of the previous migration explanations came a new approach, Migration Systems Theory (Kritz and Zlotnik 1992). This approach aims to take into consideration previous theories and tries to explain all dimensions of migration. Firstly, a migration system constitutes two or more countries where the migrant exchange occurs. The tendency is then to analyse the migration system within these two or more countries and try to analyse the reasons; looking at historical events, economic developments, the links between the two countries and also the migrants themselves.

The basic principle is that any migratory movement can be viewed in terms of the interaction of macro and micro structures. The macro structures include, the political economy of states, relationships between countries and the laws, legislation and policies between countries. For example, migrants from Poland coming to the UK were faced with a more welcoming set of legislation because both countries are EU members, and after Brexit there are measures in place to protect their residency status, as opposed to someone migrating from Botswana to the UK where there are more stringent controls.

The micro structures include the informal social networks developed by migrants themselves, such as personal relationships, and family, friendship and community ties. These networks provide vital resources for individuals and groups. Bourdieu (1992) refers to this as social capital. Boyd (1989) states that informal networks bind migrants and non-migrants together in a complex web of social roles and interpersonal relationships. These informal networks form the basis of the development of migrant social and economic infrastructure; places of worship, associations, shops, cafes, lawyers and doctors along with other personal and social services (Boyd 1989).

In between the micro and macro structures of migration there is an intermediate level which has been described as meso-structures (Castles 2003). Here mediation takes place between certain individuals and groups and between economic and political institutions. Massey (1998) states that a migration industry emerges at the meso level, consisting of recruitment organisations, lawyers and often smugglers and other intermediaries.

In conclusion based on the literature available, reviewing policy and legislation, and after discussing migration in Ireland over the last 400years, it would seem apparent

that humans migrate to try improve their lives. This perceived improvement of outcomes is calculated based on a number of factors including current life or lifestyle, future opportunities for improvement at home and ties to home. All these are considered as potential sacrifices. Alongside this are the pull factors of the destination countries and locations. In conjunction with these factors are the current policies and legislation in place in the destination countries that supports the migrant passage and whether it is worth the risk to migrate illegally.

2.3 Acculturation Theory

2.3.1 Acculturation

Acculturation can be described as the process whereby individuals modify and adapt their behaviours when in contact with a new culture. The classical definition of acculturation was given in 1936 by Redfiled, Linton and Herskovits (cited in Berry 1997 P7). Within this it is stated that, "acculturation comprehends those phenomena which result when groups of individuals having different cultures come into continuous first hand contact with subsequent changes in the original culture patterns of either or both groups". Within this definition the concept of acculturation is perceived as a neutral principle, i.e. that change may take place in either or both groups. In practice, and as outlined by many studies (Alianz 2002, Buchanan 2009, Campos 2008, Siavash 2010, Palacios 2008, Yun 2008, Berry 1990, 1997), the change and perceived change is likely to be in only one group and that group is the group who are in the minority or have emigrated to the new host culture.

Bhugra (2004) defines acculturation as the "process by which a minority group assimilates cultural values and beliefs of a majority community". However, it is important to note that a distinction has been made between acculturation as a group level phenomenon, and psychological acculturation which is more about the individual (Berry 1997). It is argued that the distinction between the levels is important because firstly in order to examine the process properly it is useful to consider the individual and then the group and secondly, not all individuals acculturate at the same rate or levels (Furnham and Bochner 1986).

In order to further explain the differences in what has been identified above, at the cultural level, acculturation encompasses the changes in social climate the structures with the society, political structure, social structure and economic climate (Berry, Poortinga, Segall, & Dasen 1992). On the other hand, psychological acculturation focuses in on the changes of behaviours, attitudes and beliefs of individuals (Berry, 1990). In terms of the research within this thesis it is worth noting that Polish migrants who come to Northern Ireland, on a cultural level face changes in the political structure here, the way in which people conduct their social lives, how they socialise, the economy and the services including, social security, health and personal social services. These changes on a macro level are often difficult to understand and comprehend for migrants, especially if both societies are distinctly different. On an individual level, or as referred to as psychological level (Berry 1990), the

acculturation process is distinctively unique as each individual responds to the process in their unique individual way. Oberg (1960) describes the impact on the individual as 'culture shock'. Bhugra (2004) defines culture shock as "sudden unpleasant feelings that violate an individual's expectations of the new culture and cause them to value their own culture negatively" (p15). The concept of culture shock has been around for some time and is used in everyday language. Oberg (1960) identified six aspects of culture shock and how it can have an impact on the lives of migrants. These include, strain, a sense of loss or feelings of deprivation rejection by members of the host culture, role expectation and role confusion, surprise and anxiety, and feelings of worthlessness (Oberg 1960 cited in Bhugra 2004 p15). Culture shock, it would seem, has a strong emotional drain upon the individual and the group. How individuals deal with this stress reaction may often limit their ability to interact in the new host culture's society. Further to this, Ward (2002) argues that many of the models of measuring acculturation are based on a medical model. It is argued that many life changes, whether positive or negative, may invoke stress of different degrees. Migration and cross-cultural relocation will lead to stress. However, Furnham & Bochner (1986) argue that the level of stress is based upon the individual's ability to cope with the new environment and culture, based on the social skills they have. So in understanding acculturation it is important to realise that there are two levels, cultural and the individual. Coupled with this it is pertinent to note that it is not merely a linear process whereby an individual or a group begin a process of change to the new host culture. It is argued that a two-dimensional process exists whereby the traditional or ethnic culture and the new dominant host culture interact playing an important role in the acculturation process. Berry (2002) suggests that within this interaction there are four possible outcomes. The first being assimilation, whereby there is movement towards the host culture, secondly there is integration whereby there is synthesis of the two cultures, thirdly there is rejection, where the host culture is rejected and reaffirmation of the traditional culture takes place, and finally there is marginalisation where alienation from both cultures occurs. In some of these acculturation strategies some conditions need to be in existence. Within assimilation the individual must choose to assimilate into the new host culture. Forced assimilation may lead to failed assimilation or marginalisation (Berry 2004). Also, in terms of acculturation it is important to note that the host or dominant culture must also interact within the process. In the case of integration, the host culture must be prepared to adapt certain

institutions like health and education to better meet the needs of the new migrant groups. But Berry and Kalin (1995) argue that the integration strategy can only be pursued and achieved in societies that are multicultural. They further define a multicultural society as having certain preconditions. These preconditions include cultural diversity, low levels of prejudice, and positive attitudes within each cultural group. However, there is a constraint to some acculturation strategies. For example, if those who wish to assimilate are physically different in appearance then this may set them apart from the society of settlement.

2.3.2 Acculturation Framework.

Within the study of acculturation there is much literature and theories that try to make sense of the complex process. They try to systematise the process and simplify it by illustrating the main influencing factors. It is worth considering these at this point as some of the issues discussed will provide a deeper understanding of the analysis of the data gathered in my research. Olmedo (1979) discusses acculturation from a psychometric perspective, and Berry (1997) built upon this and other writing to conceptualise the framework below (figure 1). This framework helps to visualise all the variables that may influence group and individual acculturation taking into consideration dependent and independent variables. The framework is structured in a way to be considered from left to right. The mainly situational variables and phenomena are on the left-hand side of the framework and these influence migrants at a group level. The individual variables and phenomena are on the right. Another dimension to the framework is the factors or variables which exist prior to acculturation and those which exist during acculturation. From the framework it is clear what the main factors are which influence groups and individuals during the acculturation process. The main aim of the framework as outlined by Berry (1997) is to show the key variables that are present during the acculturation process. When applied to this thesis the research process and outcomes will be informed by this framework. When developing interviews and questionnaires for this thesis the framework has been taken into consideration, particularly how peoples' lives may have changed since coming to Northern Ireland and how different social, political and environmental factors may have influenced the lives of Polish migrants here in Northern Ireland. Although Berry's (1997) model goes a long way to providing an understanding, it has been argued by many writers that it fails to recognise that the

issues faced by migrants in acculturating are not merely down to psychological issues and that of stress and coping, but also lie in the social inadequacies (Ngo 2008). Berry's model follows the approach of psychopathology and is very much medically based. Ngo (2008) argues that Berry's (1997) model fails to recognise existing oppression within society's and structural inequalities, however within this thesis that has been recognised and this thesis does not seek to prove or disprove the framework but use it a basis to build understanding . The model also fails to consider individual circumstances and personality and Furnham & Bochner (1986) argue that difficulties arise because migrants have "trouble negotiating everyday social situations" therefore this would indicate that the problem lies with the lack of social skills. Ward (1996) states that Berry's model looks at psychological adjustment defined in terms of psychological well-being and the model is viewed as a stress coping framework. Ward (1996) further argues that a socio-cultural adaption approach is assessed in terms of skills deficits and social difficulty and is more typically influenced by factors such as length of time in the new country/culture, interaction with new culture and past experience of cross-cultural experience. Some of which are presented in Sluzuki's theory discussed below. In noting the different explanations of how migrants acculturate, the difficulties posed by the acculturation process and using the framework below it helps develop an understanding of the negative impact of migration and acculturation on individuals including a deterioration in mental health.

Figure 2: Berry's (1997) Framework for understanding acculturation
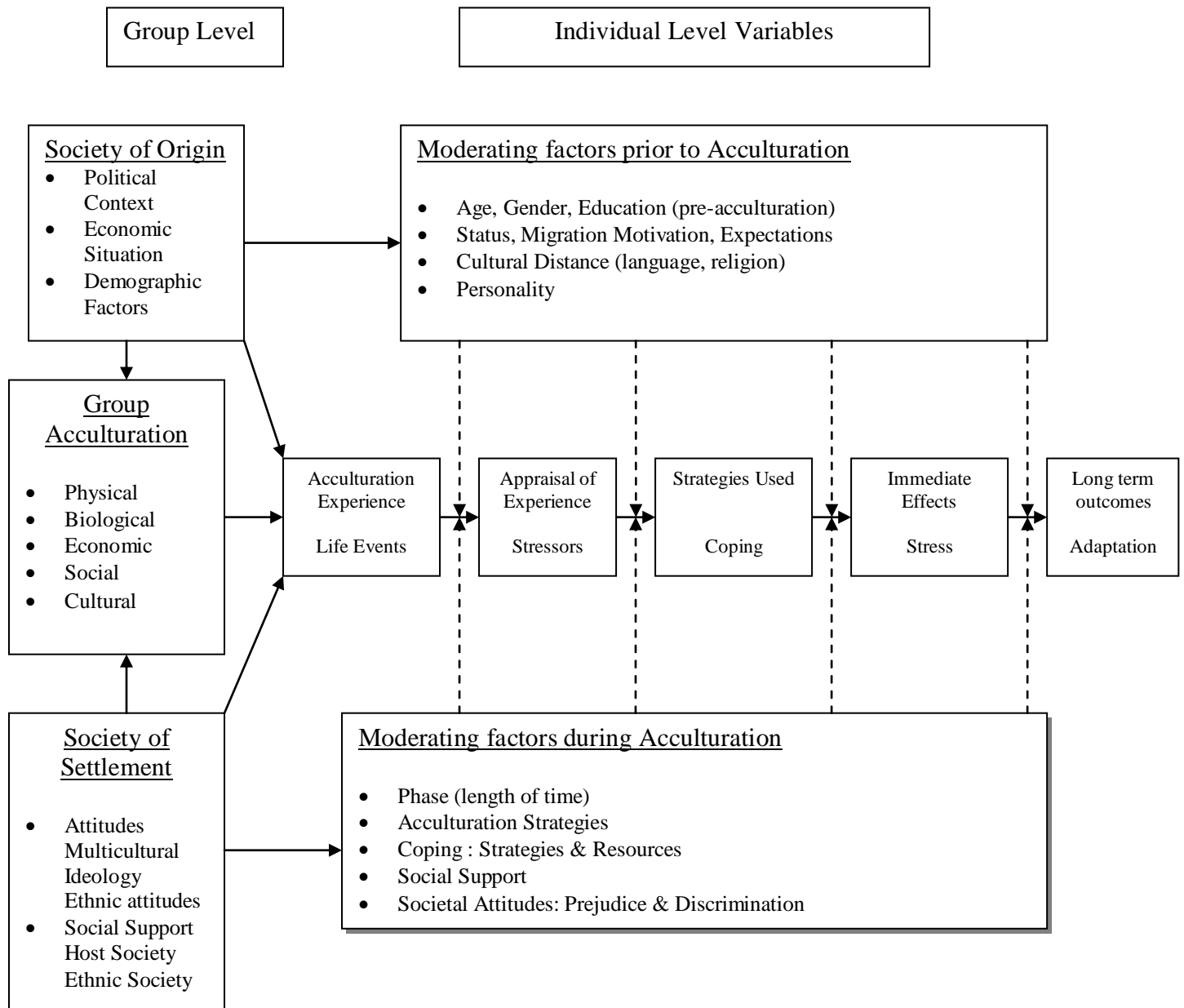
2.3.3 Sluzki's Theory of migratory stress

Sluzki (1986) developed his model from a study in the 1980's. The model is cultureless and states that the migratory process is a continuum, which he breaks down into five discrete steps: (I) preparatory stage; (II) act of migration; (III) period of overcompensation; (IV) period of de-compensation; and (V) trans-generational phenomena.

I. Preparatory Stage

Sluzki describes the stage as 'getting reading' to migrate. It involves plans around route of migration, applying for visas, or maybe researching employment possibilities. In terms of emotions, Sluzki states that in this stage there are periods of ups and downs with periods of euphoria and excitement followed by periods of sadness and dismay and the anxiety of leaving loved ones behind and also the apprehensions of moving to a new country, job or culture.

II. The Act of Migration

Often the actual act of migration may involve a plane trip of a few hours. However, in some cases it can take considerable time involving travelling for many days. In some cases, the act may involve many people, therefore these people may share some sense of solidarity like the displaced Jews after the holocaust, or the Vietnamese boat people. Sluzki (1986) further comments that the act of migration varies considerably and that each individual or family has a different experience of it. Another dynamic of the migration act is that some migrants migrate legally, thus will have access to institutions of the country of adoption, whilst those who migrate illegally may exhibit understandable distrust and alienation from the mainstream institutions. Finally, it is important to note that some people migrate because they want to and choose to do so, while others have no choice and are forced to relocate.

III. Period of Overcompensation

Sluzki (1986) argues that during the first six months, migrants are not fully aware of the stressful impact and the cumulative effect of migration as they take a very task centred approach to survival, concentrating on fulfilling basic requirements, such as food and shelter.

IV. Period of De-compensation or Crisis

In his model Sluzki (1986) states that after the period of overcompensation comes a period of crisis or de-compensation. During this period, the migrant may face problems in coping with the new society after the initial 'honeymoon' period. Many of the migrants' values may be challenged in the new society and also many of the ways in which the migrants coped with or used to resolve situations may not work. Sluzki (1986) described the problems in terms of family migration. He discusses how the families' coping mechanisms in the new culture don't have the same strengths as in their home culture. These include the lack of extended family support or support from friends. Sluzki (1986) adds a further dynamic to this theory in terms of gender roles. He states that within this period males focus on practical activities that entail a connection with the current environment, such as employment and housing. The female on the other hand centres on the emotional tasks of mourning the left-behind culture and keeping in contact with family back home.

V. Trans-generational Impact

This final stage refers to the impact on second generation migrants and the conflicts within families. Sluzki (1986) states that, as families are the main socialisers of children and society reinforces and promotes this socialising, the conflict occurs when the family culture is different from the outside culture. Children interact with the larger society through schools, the media and friends. If the outside influences of society have different cultural norms and values of the family and their society of origin then there is the potential for conflict within the family. This conflict can lead to added stress on individuals within the family.

It is worth considering Sluzki's (1986) theory when examining Berry's model as the time continuum has an impact on the process of acculturation.

Although Sluzki's model gives some explanation to the process of migration it is worth considering the limitations of the model. Firstly the preparation stage does not take account that sometimes people migrate with little or no preparation and can be an immediate decision particularly in the cases of forced migration and war . Sluzki in his explanation of de-compentation or crisis makes reference to the gender roles. These assumptions fail to take account of the fact that

females who have made the majority of migrants in several cultures historically, including Irish, and often migrate alone as single women have been making the decisions and looking for employment, housing, etc just the same as any male. If you're going to stay with Sluzki's point gendered analysis here, then you'd have to make a statement concerning the large amount of evidence that doesn't support his views, not only in the current period, but certainly going back to the 19th century mass migrations where women formed large minorities or even majorities. Evidence of female agency even in early migrations to America in the 17th and 18th centuries is considerable.

2.4 Theories of Addiction

This thesis sets out to investigate the impact that migration has the mental health of Polish migrants and also develop an understanding of the help-seeking behaviour of migrants with drugs and alcohol problems. It is therefore appropriate to develop an understanding of some of the language and theories of substance use , misuse and dependence

West (2006) states that, addiction is an "impaired control over a reward-seeking (usually drug taking, behaviour from which harm ensues" (West 2006). He further argues that it can be assessed in terms of severity, the frequency and intensity of the behaviour and the outcomes and consequences. Gossop (2003) states that, addiction is most often manifested psychologically and behaviourally, in feelings of compulsion to use and a difficulty in resisting urges to use. The NHS states that addiction means not having control over doing, taking or using something, to the point that it may be harmful. The Advisory Council on the misuse of Drugs (ACMD) gives a broad definition of a problem drug and alcohol user as someone "who experiences social, psychological, physical or legal problems related to intoxication and or regular excessive consumption and or dependence as a consequence of their use of drugs or alcohol (ACMD 1982, cited in Gossop 2003 p1). West (2006) argues that addiction is a chronic condition of the motivational systems within a person's life including physical motivations, psychological motivations and social motivations. West (2006) further argues that there are abnormalities which affect the motivation system including, stress and anxiety, withdrawal symptoms when not using the drug or stimulant and the social environment which people are in. Based on this it is safe to argue that addiction may be driven by a number of interacting factors. This section of the chapter will set to explain some of the theories of addiction in order to give a better understanding of addiction. Firstly, the issue of diagnosing and measuring addiction will be explored. Then the issues around user, misuse, abuser and addict will be explored. Finally, some of theories of addiction including, physical, psychological, and socio-cultural will be discussed.

2.5 Diagnosing, Measuring and defining substance misuse problems.

2.5.1 Harmful and dangerous levels of substance use

Substance use may be defined as the use of mood altering substances, a stimulant or a drug for non-medical reasons. Harmful use occurs when there is a direct impact upon

the individuals' physical or mental health. This could for example, be the development of abscesses around injecting sites of intravenous drug users, or damage to the nasal cavity of snorting cocaine users. Long-term users may develop other health issues, such as paranoia, and depression. Increasingly, there is also a focus on the harm caused to others such as the children and/or the family of substance users. The harm can be in the form emotional neglect, financial neglect, lack of interest in the life of the child, or failing to provide in terms of nourishment and physical wellbeing due to lack of finance because of the drug use.

2.5.2 Harmful and dangerous levels of alcohol use.

It is worth pointing out that although an individual may not be diagnosed as having an 'addiction' their levels and frequency of alcohol use may be defined as harmful and dangerous.

According the NHS guidelines there are three main types of alcohol misuse; hazardous, harmful and dependant.

2.5.2.1 Hazardous drinking

Hazardous drinking is defined by the NHS(2016) as when a person drinks over the recommended weekly limit of alcohol which is 14 units for a man and 14 units for a women. The NHS (2016) guidelines also state that individuals may be drinking hazardously within these limits by binge drinking. Binge drinking is defined as drinking eight units in a day for men and eights units in a day for women. The World Health Organisation (2010) defines hazardous drinking as 'alcohol consumption which confers the risk of physical and/or psychological harm'. Mertens (2009) states that this type of drinking is a lot less severe but yet more common. The NHS (2006) in Scotland states that hazardous drinking increases the risk of danger which includes, arguments, fights, and accidents. It also increases the risks of illegal acts such as drink driving and physical violence as well as increasing the risks for young children who are being looked after by an adult drinking at these levels. Further to this is the increased risk of unsafe sexual practices, which may lead to unplanned pregnancies and sexually transmitted diseases (NHS Scotland 2006).

2.5.2.2 Harmful Alcohol Use

Harmful alcohol use is defined as 'when a person drinks over the recommended weekly amount of alcohol and experiences health problems that are directly related to alcohol' (NHS 2011). The WHO (2011) states that harmful use of alcohol has many implications on public health. Globally, nearly 4% of all deaths are related to alcohol. These include alcohol related injuries, cancer and car accidents. When looked at by gender, there is significant difference between men and women, with 6.2% of all male deaths related to harmful alcohol use and 1.9% of female deaths related to alcohol.

2.5.2.3 Dependent Drinking /Substance use

Dependent drinking/substance use is when an individual has a continuous desire to drink or use the substance of choice. The desire may be for psychological reasons or physical reasons. In order to 'diagnose' if someone has an addiction to a substance there is a set of measurement criteria used. The fact there is 'diagnostic' criteria sets the problem of addiction firmly within the medical model of care and more specifically the field of psychiatry. There are two main sets of diagnostic criteria, the World Health Organisation's ICD-10 and the American Psychiatric Association's DSM-V. The DSM-V uses the same criteria to help diagnose disorders but in the manual it does differentiate between the substances, including alcohol, cannabis, opioids, sedatives and stimulants. For the purpose of reference the alcohol use disorder diagnostic criteria is listed here.

Diagnostic Criteria for Alcohol use Disorder (Diagnostic and Statistical Manual V APA 2013)

    A. A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

    (1) Alcohol is often taken in larger amounts or over longer period than intended

    (2) There is a persistent desire or unsuccessful efforts to cut down or control alcohol use

(3) A great deal of time is spent in activities necessary to obtain alcohol, use alcohol or recover from its effects.

(4) Craving or a strong desire or urge to use alcohol

(5) Recurrent alcohol use resulting in a failure to fulfil major role obligations at work, school or home.

(6) Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol

(7) Important social, occupational, or recreational activities are given up or reduced because of alcohol use.

(8) Recurrent alcohol use in situations in which it is physically hazardous.

(9) Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

(10)   Tolerance, as defined by either of the following:

   a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect

   b. A markedly diminished effect with continued use of the same amount of alcohol.

(11)   Withdrawal, as manifested by either of the following:

   a. The characteristic withdrawal syndrome for alcohol (As detailed in DSM-V page499-500)

   b. Alcohol is taken to relieve or avoid symptoms.

In addition, the DSM-V also gives guidance on severity indicating:

   Mild: Presence of 2-3 symptoms

   Moderate: Presence of 4-5 symptoms

   Severe: Presence of 6 or more symptoms

(DSM-V 2013 P490-491)

International Classification of Diseases -10 (WHO 2016)

Three or more of the following must have been experienced or exhibited at some time during the previous year:

   (1) Difficulties in controlling substance-taking behaviour in terms of its onset, termination, levels of use

(2) A strong desire or sense of compulsion to take the substance

(3) Progressive neglect of alternative pleasures or interests because of psycho-active substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects.

(4) Persisting with substance use despite clear evidence of overtly harmful consequences, depressive mood states consequent to heavy use, or drug related impairment of cognitive functioning.

(5) Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses

(6) A physiological withdrawal state when substance use has ceased or been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms.

These two sets of diagnostic criteria are similar and do offer clear criteria to measure if someone does have a problem or an addiction to a specific substance. However the criteria are open to subjective interpretation. One clinician may view the responses from an assessment with a service user as fulfilling certain criteria, whilst another clinician may interpret the responses differently and thus make a different decision. It is also possible that two individuals may be diagnosed as having an addiction to a specific substance however never share the same diagnostic criteria. West (2006) argues that the diagnostic criteria are open to interpretation. He questions the validity of criteria such as 'withdrawal' and specifically the strength of withdrawal symptoms given that individual's ability to cope with withdrawal differ and therefore will be reported differently.

However, these are the criteria that are used throughout the world. Rounsaville (2002) argues that both systems' use disorders are based on the 'dependence syndrome'. He further argues that to change any component of the criteria set would yield large differences in rates and reduce comparability across data gathered with different systems therefore leading to considerable costs related to retraining, changes in record keeping and changes in diagnostic interview schedules.

When examining the theories and explanations of alcohol and substance misuse it is apparent that they can be categorised as being physical, social or psychological.

Under these headings I will set out to explain some the theories of addiction and substance use and misuse in order to enhance the wider understanding of the study population.

2.6 Biological Theories

Biological theories of addiction and substance abuse place the problem firmly within the physiological mechanisms of the individual, those compelling them to continuously abuse and use substances with little regard for the consequences.

2.6.1 The Disease Model of Addiction

The disease model of addiction very much centres on the concept of a medical problem. It sets out to explain the addiction in terms of an abnormality in the function or structure of the central nervous system. At the centre of the disease model is the concept of craving. Jellinek has described this as an 'urgent and empowering desire' to use the substance. West (2006) describes the power of cravings by stating that 'it overwhelms the individual in totality, dominating the thoughts, feelings and actions of the individual to the exclusion of all else' (West 2006 p77).

Within this model there is the compulsive nature of addiction that many individuals report , that is the uncontrollable desire to use whatever substance they are addicted to. People with addiction often report that compulsion to use is often driven by the physical need to quell the cravings and to ease and eliminate withdrawal symptoms. Specifically in relation to alcohol dependence, much research has been conducted in relation to the disease model. Biological theories hold that a physiological or structural anomaly causes the individual to become alcohol-dependent. The most prevalent position is that alcohol dependence is a physical disease. This 'disease model' maintains that the person with the addiction is a victim of an innate condition that, once a small amount of alcohol has been consumed, this then generates a compulsion over which the sufferer has no control. It is a chronic, incurable disease for which the only outcome is death or abstinence. The disease model of alcohol addiction has been strengthened further by advances in other 'biological' theories. Earlier findings suggested that there is a genetic predisposition at least to some "types" of alcohol dependence (Kendler, Heath, Neale, Kessler, & Eaves, 1992; Schuckit, 1987). This evidence comes primarily from family, twin, and adoption studies. The studies have indicated that sons and daughters of alcohol dependent

parents are 4 times more likely to develop the disorder themselves, relative to people whose parents are not alcohol-dependent. In addition, studies of twins show that there is greater likelihood of both members of identical twin pairs having alcohol dependence ("concordance") than of concordance in fraternal twins. Kendler (1992) states that this finding is significant because identical twins are genetic matches, whereas members of fraternal twin pairs have only 50% of their genes in common. Arguments against these findings may be that the environment in which children are raised can be of greater influence. However, studies of adopted children of alcohol-dependent parents counteracts this argument. These studies have indicated that the development of alcohol problems in children is far more influenced by having an alcohol-dependent biological parent than by the adoptive home environment . These findings further add gravity to the disease model of alcohol addiction. Miller and Kurtz, (1994) identify four core assumptions that underline the disease model:

1. Alcoholism is a unitary disease entity that is qualitatively distinct and discontinuous from normality. As with pregnancy there are no grey areas, one is either addicted to alcohol or not.

2. The causes of alcoholism are solely biological, rooted in heredity and physiology. Behavioural, family and personality disturbances are merely symptoms of the underlying physical abnormality in how the body reacts to alcohol.

3. The definitive symptom of developed alcoholism is an inability to control consumption after the first drink. This is an inexorable reaction to the chemical ethanol, resulting in the physical abnormality.

4. This condition is irreversible and cannot be cured,

The disease model of addiction is widely used in a variety of treatment settings including Alcoholics Anonymous and proposes that the only 'cure' is abstinence. The issue with the disease model is that it somehow allows the 'addict' to blame the compulsion on an illness and contend that he/she has little or no control over the situation. Skoog (2000) further argues that the disease model implies that 'addicts' can only be prevented from using by physical constraint. Further to this, the disease model fails to take account of the fact that sometimes people with an addiction decide to stop and cease the addictive activity without any apparent negative physical effects

or withdrawal. The model also fails to take account of other theories and social constructs of addiction including some personality theories which will be discussed later.

2.6.2 Metabolic Imbalance

A second theory in the biological category is that of metabolic imbalance. It is particularly used to explain substance dependence as opposed to alcohol dependence. This theory was developed by Dole and Nyswander (1965). The theory was based on clinical research of heroin dependant patients. The theory argues that heroin dependent individuals suffer from a metabolic disorder and the only way in which the bodies metabolism is stabilised is through the introduction of opiates. Based on this theory, patients with a dependency are never 'cured' and abstinence is not an option. Therefore the way in which it is treated is via a maintenance plan of prescribed substitute opiates, in the form of methadone. Methadone is an opioid and fulfils the body's desire for opiates. It also alleviates the negative physical withdrawal from heroin.

Although the methadone maintenance programme is still used by many drug treatment agencies and is an endorsed method of treatment in UK treatment agencies, the theory of metabolic imbalance does have its flaws. Firstly, no specific biological mechanism has been identified that leads to the 'metabolic imbalance', unlike diabetes for example where the lack of insulin leads to a metabolic imbalance and the identified biological issue is that the pancreas doesn't produce insulin or not enough insulin. Secondly, many heroin users successfully stop using heroin and remain abstinent with no issues of metabolism imbalance. Thirdly, there are other substitute prescribing programmes for the treatment of opiate dependence and the treatment does not involve long – term opiate maintenance. Instead the treatment acts as an opiate blocker thus nullifying the effects of the opiates. Other active ingredients within the treatment medication alleviate the symptoms' of opiate withdrawal.

2.7 Psychological Theory

Psychological theories of addiction may be broken down into two separate categories; those that try to explain the addiction and substance abuse in terms of reinforcement and those which rely on personality theories to explain the issues of substance abuse.

Reinforcement theories of addiction play down the influence of personality in relation to addiction and substance abuse. McAuliffe and Gordan (1980) argue that animals use certain drugs compulsively under experimental conditions. In a previous study McAuliffe (1975) demonstrated that humans who were administered opiates without them knowing did develop a desire for the drug. These results were independent of personality. It is worth exploring further the reinforcement theory along the two distinct axis, the first being positive reinforcement the second being negative reinforcement.

Positive reinforcement occurs when a pleasurable sensation or feeling is experienced by the users and the user is motivated to repeat the use of what caused the feeling. With the use of drugs or alcohol it is the feeling of intoxication or euphoria after ingestion. For the user, the benefits of using outweigh the consequences or potential legal, social or health consequences of using. Additional to this theory is the fact that users don't have to be physically dependent on the substance, thus promoting the theory of psychological dependence.

Negative reinforcement is when someone does something to avoid pain or negative feeling. In terms of addiction and substance misuse, users who are physically dependent may suffer negative withdrawals if they stop using or significantly reduce their intake. Users then use the substance to reduce or eliminate the effects of the withdrawal. Individuals who are alcohol dependent describe withdrawal symptoms of anxiety, shakes, hallucinations and in some extreme cases, seizures.

2.7.1 Operant Conditioning

Within the application of operant conditioning to addiction theory it is theorised that dependence to drugs and alcohol arises from the process of reinforcement. The process can be sub grouped into positive reinforcement and negative reinforcement. Positive reinforcement is the unconscious link associated between a particular behaviour and a positive outcome. In the instance of substance and alcohol abuse the reward seeking behaviour, the locating of the substance and using it gives rise to the good positive feelings the user gets from using. Negative reinforcement is used to explain how there may be no pleasure from using where the only purpose in using is to stop or prevent withdrawal symptoms. This theory also explains the fact that on each occasion of reward seeking the reward is not achieved. Occasional reinforcement explains the fact if reinforcement does not occur on every occasion but occurs on

average every 5-10 occasions then reinforcement increases (West 2006). Within studies of addiction the psychological theories of addiction still have strong links with biological explanations and also a very strong social influence; so therefore cannot be stand alone explanations.

2.7.2 Classical Conditioning

West (2006) argues that classical conditioning plays a critical role in the experience of drug and alcohol addiction. West (2006) further states that it plays a crucial role in explaining cravings and the motivation for the user to continue using. This is explained in terms of how stimulus-stimulus association influences the role and development of cravings and withdrawal symptoms. Drummond (2001) explains that within drug and alcohol use there are environmental stimuli; needle presence, drug paraphernalia, the smell of the inside of a pub or people with whom the user would normally use with. These stimuli then initiate the conditioned effect of craving which leads to use . Based on this theory, a number of studies have set out to try and 'break' the 'cycle of addiction' by exposing users to stimuli in an attempt to disassociate the stimuli with the reward. Wanigaratne (2006) describes this as cue exposure and it is built on the premise that extinction will occur. In a review of studies Wanigaratne (2006) argues that the use of such techniques have proved equivocal and would need further work and investigation to prove worthwhile.

2.7.3 Cognitive Bias Theory

The cognitive bias approach proposes that biases in belief, attention, and biases in the memories linked to those beliefs are the cause of the addiction. The theory focuses in on the memory process of individual's mental processing and how positive memories are linked to positive actions. Current psychological approaches used in addictions treatment tend to use motivational interviewing (Miller and Rollnick 2002) and relapse prevention (Marlatt and Gordon 1985) which are heavily influenced by social learning theory (McCusker 2001). This approach fails to explain all addiction and is selective in its application whereby many individuals who are diagnosed with an addiction do not display the afore-mentioned biases (West 2006).

2.7.4 Tri-dimensional Personality Theory

Cloningers (1987) theory of addiction focuses on the implications of the individuals personality in terms of addiction. Cloninger (1987) argues that three fundamental dimensions of an individual's personality have direct impact on that individual's susceptibility to addiction. The theory tries to explain why individuals may respond to their environment and this explanation is based on personality. Cloninger (1987) proposes three dimensions of the personality; novelty seeking, harm avoidance and reward dependence that interact and ultimately have implications for the dependence on alcohol and drugs. Cloninger's (1987) theory further hypothesised that alcoholism can be defined into to two subtypes, Type I and Type II. Type II addiction has an early onset, and is heavily influenced by genetic factors, environmental factors and gender, whereas Type I addition is typically at later onset in life, more likely to affect women and be influenced less by genetic and behavioural factors. In a review of studies involving Cloningers (1987) theory, West (2006) reports that novelty seeking as an independent trait was found to distinguish those with an addiction to alcohol and those without and also Type II from Type I alcohol dependant individuals. Further to these findings, Howard (1997) concluded from a review of studies that novelty seeking predicts the early onset of alcohol abuse and criminality. He further concluded that Harm Avoidance did have an impact on the intensity of substance use however, reward dependence as a subscale was less consistent.

It is apparent that Cloningers (1987) theory has been used to predict some aspects of addiction but would need further studies and research to increase its validity.

2.7.5 Rational Choice Theory

There are a number of explanations of addiction that fall under the remit of reinforcement. The overarching view is that people do things because they believe that their actions will result in certain benefits and that people are willing to accept the consequences. Within this theory it is important to understand the rationale of the 'addict' and try and change your perception from that of the onlooker to that of the person who is addicted. It is at this point that the idea of using and abusing seems right and that the user has made calculated decisions in order to use the substance of choice. Becker and Murphy (1988) developed the theory of Rational Choice around addiction. They proposed an economic model of addiction. They argued rationality is

defined as a 'consistent plan to maximise utility over time' (Becker and Murphy 1988, p 675). Within this theory the idea is that individuals, as consumers, make informed decisions based or their desire for goods. Based on the consumption and the benefits that it gives them they continue to consume and the benefit reinforces the decision making process. As an economic model of addiction, rational choice theory has some short comings. Vale (2010) argues that the theory fails to explain relapses within addiction. He further argues that explaining how an addiction arises within the theory is difficult. Vale (2010) continues by arguing that intoxicants inhibit cognitive processing, but the rational choice theory relies on clear decision making as the basis of the theory. Becker and Murphys (1988) theory also discounts other theories and research in addiction such as genetic predisposition.

2.8 Social Theories

2.8.1 Self Medication

The self-medication model of addiction proposes that individuals may take drugs as a means of coping with perceived stressful life situations. Gelkopf (2002) argues that individuals intentionally use drugs to treat psychological symptoms from which they suffer. The self-medication model proposes that users and subsequently addicts choose their drug not at random but by the function of the drug and how it best suits their needs. West 2006 argues that 'initiation of drug use and the choice of drug are based on the drug effect sought by the individual' (West 2006 P36). This sets out to explain why some users choose sedatives and others stimulants. Buckley (1998) states that drugs may be chosen based on the fact that they alleviate feelings of anxiety, help to control aggression and also to help control psychotic symptoms. However, West (2006) argues that even though the drug may not alleviate the feelings or problems, as long as the user perceives them to be doing so then this will propel the continued path of self-medicating.

The self medication model does have some failings. It fails to explain the cases of addiction in which there is no underlying psychological distress or psychotic symptoms. The model also fails to acknowledge the knowledge base and research in the area of biological factors which has been discussed earlier in this section.

2.8.2 Social Learning Theory

Social Learning Theory (SLT) (Bandura 1977) adds to psychological processes of association and conditioning by theorising that cognitive processes have an influence on learned behaviour. It describes how goal-directed behaviours within humans are influenced cognitively. These cognitive factors include anticipation, planning, expectancies, attributions, self-efficacy and decision-making (Wanigaratne 2006). Based on this, it is assumed that our social environment influences how we behave. Applied to the field of addiction SLT explains how, through social reinforcement, people use drugs and alcohol, and continue to use drugs and alcohol. Through social sanctioning and positive reinforcement, people use and abuse substances. Marlatt (1985) stresses the importance of cognitive factors in the relapse of substance users and people with alcohol problems. Again, the influence of associated learning is interwoven into the theory of alcohol and substance use and addiction. Added to this is the influence of culture. Soto e.al.(2001) describes cultural differences to substance use and abuse in terms of diffusion and imitation. This adds to the additional perception of alcohol and drug abuse/misuse and labelling within specific cultures, in that what may be accepted in one culture is frowned upon or seen as deviant in another. This will now be discussed below under the heading of social process theories.

2.8.3 Social Process Theories of Addiction/Substance misuse

The social process theory of drug and alcohol misuse and abuse stem from sociological theories of deviance and labelling. Durkheim, from a functionalist perspective interprets drug

and alcohol use as a having a role with in society. These roles all acquire labels which in turn they are associated with a set of behaviours, and identities that comprise a lifestyle, running counter to conventional society in some ways and consistent in others. The 'deviant' behaviour of dependence when considered in this theoretical terms is best understood as a phenomenon that changes over time, with a beginning or entry point and often a desistance or end point. The development of dependence takes on 'dependence'-related roles and identities. The concept of "career" and the lifetime of the deviant behaviour. Using interactionalist and labelling theories to help define and understand substance misuse, use and dependence

there is a belief of social escalation in a drug or alcohol lifestyle or career via

labelling, stigma, role-taking and identity change (Combs-Orme 1988).

In sociological terms interactionalists argue that negative social reactions though labelling or stigma facilitated more, drug and alcohol use because individuals would likely internalise the negative labels applied to them and persist in deviant activities and behave in ways expected of the role and label. This self-fulfilling prophecy (Lemert 1951) and internalisation of negative labels leads to adopting deviant roles and behaviours associated with the name of being an addict, an alcoholic or a drunk .

Labelling theory and its facets does help explain some of the process's in dependance development however the theory offers little explanation in how individuals start to use or abuse substances.

2.8.4 Social Structural Theories

The previous theories set to offer some explanation in relation to substance misuse and dependence on an individual level, however social structural theories set to give some insight into the impact of the social structures in a society, community or neighbourhood. They range widely and can include dimensions of stratification including disparities in status and power by race or ethnicity, class and gender; environmental characteristics such as poverty, job availability, and institutions like schools and community and finally government organisation including, practices policies and legislation. This theory argues that external social forces play an important part in causing and/or shaping the manifestation of drug and alcohol abuse. As opposed to the individual as discussed in social process theories. Poverty, social inequalities and health inequalities are argued to have an influence on substance use and misuse and ultimately dependence. Social structural theory promotes different questions about substance use and abuse than social process and social learning theory. These questions include how drug and alcohol use and abuse varies culturally by race and ethnicity or between societies, over time and by geographic location such as rural and suburban or inner city differences. It concludes that the wider structures in society create and influence the settings in which substance use and misuse exist.

2.9 Conclusion of theories of addiction

In conclusion there are a number of theories in relation to use and misuse, subsequence dependence and addiction to substances and alcohol. From the theories

listed above it is apparent that the theories set out to explain the issues in terms of either the biological, psychological or psychosocial. From the different theories and subsequent research there are conflicting results. Each individual theory falls short in explaining each individual persons experience with alcohol and or substance dependence. With this in mind it is wise to consider all aspects of individual's lives when discussing their addiction and drug use as all theories can be applied to some degree. It is also pertinent to note that some theories take into consideration wider societal influences

2.10 Theories of access to services for migrants including care pathways

As this study looks to investigate migrant service users perceptions' of care offered is important to consider how and why people seek help for health conditions particularly mental health.

There are many reasons why individuals may access help and support for health issues and alternatively there are many reasons why people may not access support. This will now be explored using a number of theoretical models. The first of these is the Health Belief Model (HBM). This model of health was developed in the 1950's to explain and predict health behaviours and originated to explain the failure by some individuals to take up immunisation against certain diseases (Rosenberg 1966, 1974). The model is based on a socio-cognitive perspective and was further developed during the 1970's and 1980's by Becker (1977), Janz and Becker (1984). The theory bases people's outcomes in terms of health care on five core beliefs or perceptions:

- Susceptibility to illness – This is when an individual perceives that they develop or contract an illness or susceptible to a mental health problem.
- Severity of illness – This is how the individual perceives the severity of the illness to be and how it will impact upon their daily life.
- Cost of change – This is when the individual perceives a behavioural cost or social cost to addressing the perceived illness
- Benefit – This is the perceived benefits of addressing the illness or health issue
- Cues to action – This could include deterioration of the condition or increased symptoms and knowing how to address the health issue.

(Henshaw 2006)

Henshaw (2006) further argues that the fifth element listed above is often omitted from studies of the HRM, and is an important factor in relation to mental health utilisation because of the social factors associated with it. In addition, components of social cognitive theory (Bandura 1977) were added to the HBM by Rosenstock, Stretcher and Becker (1988). They argued that self-efficacy, the belief that you can influence outcomes, is an important aspect of health behaviour.

In addition to this model a number of other models exist which are similar to HBM. These include Theory of Planned Behaviour (Ajzen 1991) and the Self-regulation Model (Leventhal, Nerenz, & Steele, 1984).

2.10.1 Theory of Planned Behaviour

Ajzen's (1991) theory developed over a number of years from previous writings by Ajzen (1985. 1988, Ajzen and Madden, 1986). Central to the theory is conceptualising that intentions are 'plans of action in pursuit of behavioural goals' (Ajzen & Madden, 1986). It is further explained that these goals result from the following beliefs. These include whether the behaviour will be of benefit, the behaviour will get approval from significant people in our lives, including family and friends, a belief that one can engage within the behaviour and receive the benefits (Ajzen 1991). This theory can be applied to individuals who have mental health issues and even abusing alcohol in that if they believe that reducing the alcohol use or eliminating it will be a benefit, that significant people in the lives of the individual approve and support the behaviour, and the individual feels that that they can control or eliminate their alcohol use because of learned experiences of relapse in the past. Although in theory it can be applied to utilisation of health care Henshaw (2006) states there has been little research into its use predicting mental health care utilisation. One of the explanations for this has been that the model places emphasis on a individuals representation of their illness and mental health can be difficult to measure particularly among migrant groups as it is culturally defined (Bhugra 2006). Similarly the self-regulation model has little empirical evidence in predicting health care utilisation in mental health. This model and associated theories have been designed to be exclusively used in health care utilisation, but have been used to explain learning and organisation behaviour. It is applied to health care utilisation by firstly accepting that people have an ability to apply control over different aspects of their lives including health. This control is exerted though behaviour and decision making to achieve a goal and in this instance

the goal is health related. As with the previously discussed theories the SRM is a socio-cognitive model that does assume a rational decision making process (Henshaw 2006). This can be omitted sometimes if someone is suffering serious mental health problems.

A number of additional models of health care utilisation may give more insight in the study group researched in this thesis as such models highlight the importance of social networks and social support when seeking help. These models include Andersons Sociobehavioural Model (Anderson 1995) and Pescosolido's Network Episode Model (Pescosolido 1992).

Andersons' Sociobehavioural model was developed during the 1960's in the US to test hypotheses in relation to the inequalities of healthcare access (Anderson 1968). The model focuses on the belief that members of ethnic minorities, whether living in inner cities or rural areas, avail of less health care provision compared to rest of the population. (Andersen & Newman, 1973).The model assumes that three predictive factors determine health care utilisation. These factors are; the predisposition to use services, the ability to engage and use services, and the need to use services. These will be explained more clearly so that this model can be somewhat used to explain the access to services by the migrant group in question during the discussion section of this thesis.

Predisposition to use services:

Anderson (1968) argues that individuals and their family's propensity to use health services can be predicted from a set of personal characteristics which are in place prior to illness. These characteristics can be divided into three sets: family composition, social structure and health beliefs (Andersen, 1968). Specific variables include age, sex, family size, ethnicity and social class. These indicate the position of the family in society which could influence their lifestyle and their physical and social environments. Anderson (1968) states that in order to utilise services, there needs to be a perceived need by the service user for support or help. Anderson (1968) breaks this down further by stating that there are two types of 'need' factor; illness variables and response variables. This translates into an interaction effect whereby not only does the family or individual recognise that there is an illness but they respond appropriately to the illness including accessing services.

Andersons (1968) model had identified ethnicity as a predisposing factor to health care utilisation inequality. More recent studies (Bradley, et al., 2004) have focused more on the influence of ethnicity on inequalities. Bradley et al (2004), reported that ethnicity is the primary independent variable in terms of predicting health care utilisation inequalities.

2.11 Theory of Change

Within substance misuse, in order for individuals lives to improve or prevent them from deteriorating, change may need to happen. There are a number of theories that set to explain t change. Within this thesis understanding theories of change help to understand some of the issues discussed with services users, particularly when they present at different stages in their recovery or at a time when they believe that change is not necessary. The most relevant theory of change in terms of substance misuse and addiction is Prochaski and DiClememntes Trans Theoretical Model (TTM)of Change (1983). The model differs from other models in that it sets to explain change as a cyclical process. The TTM explains that change occur in stages;

1. Pre-contemplation is the stage at which there is no intention to change behaviour in the   foreseeable future. Many individuals who are in this stage are unaware or under aware of their   problems or a need to change

2. Contemplation is the stage in which people are aware that a problem exists and are   seriously thinking about changing but have not yet made a commitment to take action.

3. Preparation is a stage that combines intention and acknowledgement of the behavioural   change that is needed. Within this stage there is a plan to change and consideration is given to   the factors that will enable change to occur .

4. Action is the stage in which individuals modify or change their behaviour to achieve the   goals planned. The changes can include changes to where they socialise whom they socialise   with, lifestyle and environment .

5. Maintenance is the stage in which people work to maintain the changes they have made and   also to prevent relapse .

6. Relapse is considered a stage although often part of the change process is not a necessity.　　　If relapse occurs it is often used as a learning opportunity to improve

This theory of change maybe somewhat clearer illustrated in the diagram below
Figure 3: Stages of Change Model (Outowa University 2017)
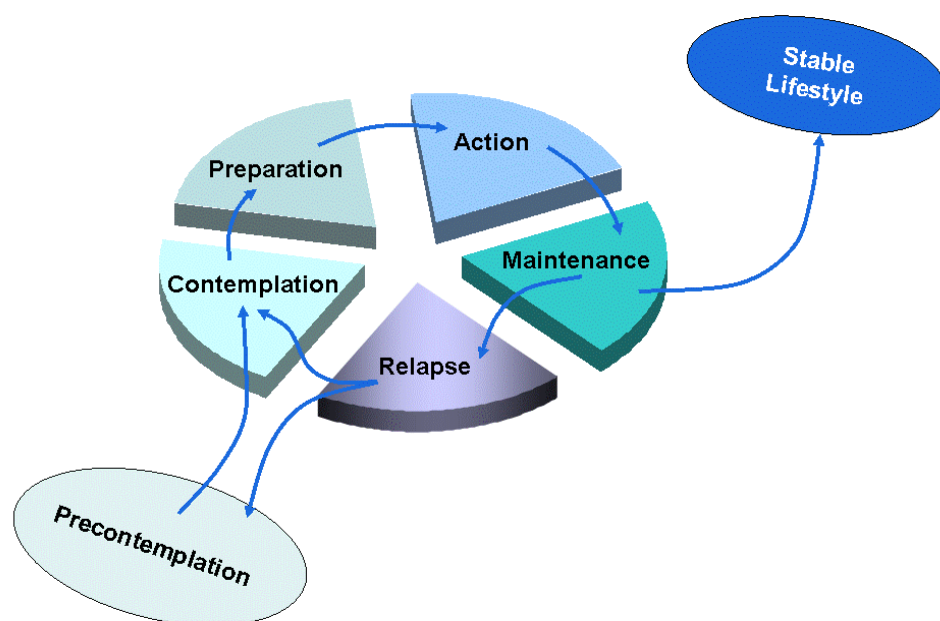
The Transtheoretical model of change does give a clear insight into how change can be achieved however it does have its limitations. West (2013) argues that the model was developed from studies in relation to smoking and not alcohol dependence. Many writers have critiqued the model stating that the stages are quite arbitrary in nature. In addition, the model has been argued to be too rigid in explaining change in peoples' lives as sometimes individuals make a spontaneous decision to change and stop. Larabie (2005) in a study looking at smokers found that over 50% quit attempts involved no planning or preparation. Additionally, the model has be critiqued for failing to consider human psychology around reward and punishment when making decisions (Baumeister et.al. 1994).

Considering these arguments, the TTM is a good starting point to help individuals visualise change and it is important that the change and facets of it consider all aspects of the individual's life.

2.11.1 Motivational Interviewing

The cycle of change is a way of helping understand health behaviour change. Bundy 2004 argues that health promotion alone does not motivate health behaviour change. She also argues that making people aware of the risks does not inhibit change and in fact when their unhealthy behaviour has physical, emotional and social problems these consequences still do not evoke change (Bundy 2004). It is therefore argued and in fact promoted to use motivational talking therapies to elicit cognitive behavioural change in clients and service users. The use of these techniques is promoted by the National Institute of Health and Care Excellence (NICE 2007) Motivational Interviewing (MI) is technique of therapeutic engagement developed by Miller & Rollnick (1991) to support behavioural change. Within motivational interviewing the client is responsible for change and the therapist, counsellor, social worker or health professional facilitates that motivation and response using very specific communication skills and techniques. Miller and Rollnick (2002) state that there are four guiding principles of motivational interviewing; expressing empathy, developing discrepancy, rolling with resistance, and supporting self efficacy.

Expressing Empathy.

Miller and Rollnick (2002) argue that the ability to express empathy is the foundation on "which clinical skilfulness in motivational interviewing is built" (Miller & Rollnick 2002 p37). Expressing empathy involves active listening to understand how the client is truly feeling in the context of their life.

Developing discrepancy

This principle of motivational interviewing seeks to broaden the distance between the clients current unhealthy life choice, such as excessive alcohol use, and their wider positive life goals. Developing this discrepancy and helping the client see it will more likely to promote change (Miller & Rollnick 2002).

Roll with Resistance

In any behaviour change there may be resistance. Miller and Rollnick (2002) in their explanation of the skills and principles of motivational interviewing state that resistance is inevitable, however resistance should not be met with resistance, and that

argument should be avoided. Therefore when using motivational interviewing practitioners should roll with resistance and help the client see and articulate different perspectives.

Support self-efficacy

Self-efficacy is the belief or the ability that change can occur. This belief is both held by the practitioner and the service user/client. The ability to convey this belief is both through action, reassurance, verbal and non-verbal communication. Miller and Roolnick (2002) argue that the practitioner can through this belief build the client's confidence in their ability to change.

Motivational Interviewing is a method of being with the client to promote and evoke change. It requires the use of communication and counselling skills to develop an understanding of the feelings and emotions that clients have around a particular behaviour. The use of empathy is the cornerstone of the interaction and again requires the use of complex counselling skills to convey the understanding. Motivational Interviewing is used with substance misuse services in Northern Ireland.

2.12 Conclusion

In terms of the thesis this content helps develop a further understanding of the complexities that impact upon individuals' lives. The content helps understand why some people migrate, and when they do, the impact that the process has on their lives and how they may or may not react, emotionally or socially. This theory chapter gives further insight into how substances are used, can cause problems and how dependence can then develop. Finally there are also theories to help understand the help-seeking behaviour, or lack of. It provides insight into the complexities of making decisions around seeking helping and once those decisions are made the added complexities of access and care pathways are then uncovered. Theory in relation to health behaviour change is also presented in the context of substance misuse along with the therapeutic techniques used to support change. All these theories enhance the methodology and the questions asked in order to gather the data necessary to deliver the findings of the thesis to aid understanding and gain insight. The theory's also will help in the discussion chapter to help explain and develop an understanding for the implications of the findings within a local and global context.

Chapter 3

Literature on migration & mental health &

substance abuse.

3.0 Introduction

This chapter will examine current and recent literature in terms of the aims of the research. It will specifically focus on mental health and migration. The content will examine the process of acculturation and assimilation and how this influences the outcomes for migrants, in particular mental health. Migration specifics and mental health will then be discussed in order to help understand some of variables that may influence positive outcomes for migrants. This in turn will put into contrast looking at specific groups and the influences of gender and also how culture does influence mental health, in terms of how it is expressed and also how it is treated and acknowledged. The chapter will then focus on addiction, substance misuse and migration as the overarching theme of this thesis is in relation to substance misuse among a particular migrant group. Finally in line with the aim of service access the relevant research in relation to mental health service utilisation by migrants will be explored. These literature themes are directly linked to the aims and objectives of the thesis. The research reviewed will focus on a studies globally then try and be specific to Europe and then finally the UK.

3.1.Methodology of Literature review

The literature review in any study has a purpose, which is to investigate what is already known about the topic. The literature review also can inform direction and guide in the methodology. Within this study the literature review was conducted with these aims in mind. Within this section the process of conducting the literature review will be discussed. Kemtes (2003) argues that there are a number of key components of a successful literature search, including efficiently searching the appropriate databases, using target keyword searches, reviewing the found articles, and organising the found articles in a methodical manner.

3.1.1 Data Base Searches

The search for literature involved using the electronic databases located within the Ulster University's electronic databases. With consultation and guidance from academic and library staff around the topic and research, the databases used were;
ARK; Northern Ireland Access Research Knowledge
ASSIA: Applied Social Sciences Index and Abstracts
BioMed Central

CINAHL : Cumulative Index of Allied Health Literature

Cochrane

Medline

Ovid

Psychinfo

Web of Science

3.1.2 Search Criteria

The scope of the search criteria was wide at the beginning, with title words or key words including 'migration' & 'mental health'. The reason for this was to try and get a better understanding of the general concepts, research and findings attributable to the research topic. The search also included research from 21 years previous from 1996-2017. The reason for this was it is such a specific topic, and research was limited. Also, there were periods in time when there was an influx in migration and research may have focused in on these migratory influxes. The results did present a lot of varied research looking at the impact on individual's mental health, the migration paths, including forced migration, the mental health of refugees and also the process of acculturation and assimilation. The review of research also found various analysis of tools to measure acculturation and assimilation. From the varied results from the literature search it was realised that a more structured literature search strategy would need to be employed. Kemetes et.al. (2003), explained that literature searches can either be limited and narrow in nature or extensive and broad. Within the literature search employed in this thesis it is best described as funnelled, in that initially searches were broad and extensive and as certain key themes and articles were discovered then the search became quite narrow and specific.

A search criteria matrix was used to reduce repetition and also focus on the research required to facilitate this thesis. This model was designed specifically for this piece of research

Table 1: Search Criteria Matrix

	Migration	Immigrants	Immigration	Migrants	Polish/Poland
Mental Health	X	X	X	X	X
Mental Illness	X	X	X	X	X
Substance Misuse	X	X	X	X	X
Substance Use	X	X	X	X	X
Addiction	X	X	X	X	X
Alcoholism	X	X	X	X	X
Alcohol	X	X	X	X	X
Drug Use	X	X	X	X	X
Depression	X	X	X	X	X
Anxiety	X	X	X	X	X
Acculturation	X	X	X	X	X
Assimilation	X	X	X	X	X
Polish	X	X	X	X	
UK	X	X	X	X	X
Mental Health Services	X	X	X	X	X
Northern Ireland	X	X	X	X	X
Service Access	X	X	X	X	X
Health Services	X	X	X	X	X

Some of the searches did use multiple search words in order to narrow down the results for example, Polish & migrant & mental health .Also from the results lists certain authors appeared multiple times indicating a significant interest in the chosen

field. Therefore searches were also conducted using the specific author and the key word, for example, Berry and Acculturation. Searches include title and keywords.

The articles were selected from peer reviewed journals. The articles were reviewed and catalogued by the type of research, the content and which area of the research they were appropriate to. Some manual notes were recorded against each article. Within the literature review below the articles reviewed were discussed and presented to the thesis supervisors in a format that replicated the funnel searching and also the facets and tangents that developed.

3.2 Migration and Mental health

People migrate generally to improve the quality of their life, either through escaping persecution, improving their economic well-being or moving to countries with better social systems and political stability (Castles 2003). However, it has been extensively documented that migration can affect the mental health of those migrating. Bhugra & Mastrogianni (2004) state that in relation to migration and mental health there are both positive and negative results and it is likely to create both losers and winners. Levitt et.al (2005) states that the process of migration and settlement is inherently stressful .The deterioration in mental health in an individual is sometimes a consequence or the symptom of the trauma of migration. Bhugra and Arya (2005) argue that the "extraordinary stresses" often associated with migration can lead to increased mental illness. There are many reasons as to why people who migrate can suffer 'extraordinary stress' and ultimately suffer mental health problems. Stress is considered to be a major risk factor for a variety of diseases including mental illness (Health Canada 2008). Fenta et al. (2004) argue that migrants may be exposed to a variety of stressors including separation from family, unemployment and poverty. The mental health of migrants "might be undermined by their acculturative stress, in the course of uprooting, relocation, and adaptation" (Lou and Beaujot 2005, p3). In order to understand the issues more in-depth, it is worth considering the two distinct processes involved in migration for individuals. Shimahara (2012) states that the two processes are the migration of 'bodies' and the migration of 'selves'. Horenczyk (1996) argues that the natural response by societies when faced with increased migration is to deal with and respond to the migration of bodies, and this tends to be the provision of housing and provision of jobs. Very often the complex issues of the

migration of identities and 'selves' is somewhat overlooked (Horenczyk 1996). Historically there has been interest in the mental well-being of immigrants and as far back as the late 1800's it is evident that the US government was concerned about the mental health of migrants to the extent that a policy was implemented to 'check' new arriving migrants' mental health status (Odegaard 1932). There were further discussions around migration and mental illness among particular migrant groups. In one of the first robust academic studies in this field Ornulv Odegaard (1932) published a paper reporting that Norwegian Immigrants in Minnesota in the US had a much higher incidence of mental health problems than Norwegians back home. Odegaard (1932) also reported that the Norwegian migrants as a minority group in the US had much higher incidence of mental health problems compared to other migrant groups. In his study the two main questions proposed were;

1. Does the immigrant population of the United States, or certain parts of it, represent an inferior stock which is constitutionally inclined to mental diseases and defects?

2. What is the effect upon the immigrant of the sudden transplantation to an environment which is fundamentally different from what he has been accustomed to? Does the mental and physical stress of readjustment lead to mental disorders in certain cases?

The study came about as there was reported physical degeneration of Norwegians in the US, some theories related to the change in climate and poorer quality of food along with increased alcohol use which led to a notable rise in insanity. Arnesen (1917 Cited in Odegaard 1932 p47) found that higher proportion of returning migrants to Norway had mental health problems. Additional studies found similar outcomes however Odegaard (1932) found that the previous studies looking at migrant groups were mainly a statistical comparison of two groups using official data. In his study his methodology focused on the diagnosis process and to reduce error he used notes and records from psychiatric hospitals in Norway and the US. Odegaard chose one hospital in Minnesota in the US, as the region had a high number of Norwegian migrants, to compare to one hospital in Norway, the control group. The records examined spanned 40 years so there was large amount of material to compare. Within Odegaards' (1932) analysis he found that there was a higher incidence of schizophrenia among the Norwegian migrants compared to the Norwegian population at home and also for every one case of affective disorders in the migrant population

there were more than 3 case of schizophrenia. Odegaard (1932) set to explain this in terms of the influence of environmental factors on mental health and how they may increase the likelihood of schizophrenia. Odegaard (1932) further explained, that climate, food, language and the 'culture shock' all may have influenced the increase in mental illness. Overgaard's (1932) research is very pertinent in that it was the first extensive study into migration and mental health. It also set to explain some of the reasons why migration can have a huge impact on mental health and therefore lead to further research. Although the methodology of case reviews is not as effective as using live data or face to face interviews, it does give some insight into the experiences of the population.

As outlined by Odegaard (1932) in his pioneering study, when people migrate their personal and social identities change and this may lead to detrimental consequences in terms of individuals' health and wellbeing. Many writers have often defined this process of leaving one culture and embracing a new one as a process that can cause great upset and mental stress in peoples' lives. The process is often referred to as acculturation. The concept of acculturation, which was discussed more in-depth in the previous chapter, aims to examine individuals' behaviour when they have developed in one cultural context and attempt to live in a new cultural context.

3.3 Acculturation and Mental Health.

The process of adjusting to a new culture can have an impact on individuals and they can respond both behaviourally or psychologically to the culture that they have moved to. The relationship between acculturation and mental health has been studied by many researchers. Linking findings to Berry's (1997) process of acculturation, it is argued that migrants face more difficulties if they retain their native culture (Griffith, 1983). However research has indicated conflicting results indicating that separation from the native culture and assimilation of the mainstream culture may lead to greater stress and adjustment difficulties (Bhugra 2004). A further take on the influence of acculturation on the mental health of individuals is that migrants who are bicultural may be 'healthier' (Smokowski 2008). By reviewing literature it is apparent that that there are reasons for conflicting results in the studies examining migration mental health and acculturation. Firstly, there is the issue of measuring acculturation. Ward (1997) argues that there are two distinct approaches to measuring acculturation. Firstly, there is the psychological adjustment which is viewed in terms of a

psychological well-being and a stress coping framework. Secondly, there is socio-cultural adjustment which is viewed in terms of social skills and social difficulty. Therefore in terms of measuring acculturation, the research reviewed uses either or both approaches to determine the impact of migration on individuals. At this point it is worth noting that much of the research presented in literature is comparable only to a certain extent as different acculturation measures have been used. The reason why there are different systems of measurement is that cultures are fluid and cultural practices differ so baseline behaviours and attitudes differ.

Moyerman and Bruce (1992) compared sixty different studies to try and divulge key 'adjustment' types. Each study looked at different migrant groups in different locations around the world. Moyerman and Bruce (1992) found that acculturation measures often have a wide variety of psychometric properties and have also been applied in various adjustment situations. In their meta-analysis, Moyermand and Bruce (1992) used 49 reports and from these reports compiled 11 acculturation and adjustment classes. These classes included addiction, anxiety disorders/stress, and psychosocial/health problems. From this study it is evident that various studies use different measuring criteria, however correlations and meta-analysis have indicated that different studies are comparable. In a more recent review Wallace et. al. (2010) looked at acculturation measures in the use of promoting Latino health. They found twenty six articles with acculturation scales that met their study group, which was Latino populations in the United States. In their review they recommended that the use of theory driven model of acculturation will benefit studies into acculturation. They also stated that there are many acculturation implications of health and help seeking among migrants including.

Taking into consideration the theory of acculturation as discussed in the previous chapter it is apparent that people can suffer stress and additional mental health problems. The process of moving and living in a new cultural setting can have a negative impact on mental health (Bhugra 2001), although often people migrate to improve their well being (Bhugra 2001). The World Health Organisation (2007) has stated that "usually migration does not bring improved social well-being; rather it often results in ...exposing migrants to social stress and increased risk of mental disorders" (WHO 2007 p2). However it is important to note that some studies have indicated that migrants' mental health maybe improve because of the new found sense of wealth (Foliaki 1997). To further explore the idea of migrants' mental health

improving it is important to discuss findings from Pernice and Brooks' (1996) research. Within their study they asked the question "Is there a Euphoric Period followed by a mental health crisis. Pernice and Brooks (1996) based the study on Sluzki's (1986) mental health model of the migratory process discussed in chapter 2. Taking into consideration Sluzki's (1986) model, Pernice and Brook's (1996) research set out to examine the impact that migration had on individuals mental health, seeking to identify variables contributing to poor mental health and also to see if length of time since the beginning of the process was a significant variable. The study sampled 129 south-east Asian refugees, 57 Pacific Island immigrants and 63 British migrants in New Zealand. This mixed methods study firstly collected demographic data via a questionnaire which also asked participants about their migration experience, employment status, social networks and discrimination experience. Participants were then asked to complete another questionnaire, the Hopkins symptom Checklist -25, which is a symptom inventory that measures symptoms of anxiety and depression. Finally participants were interviewed around some of the questionnaire items and their own experience. The results of the study did not support Sluzki's (1986) model. The study reported that both migrants and refugees who were in New Zealand for less than six months had symptoms' of anxiety and depression. Pernice and Brook (1996) also found that those who were in the country between 6 months and 6 years did not exhibit symptoms that would indicate a deterioration in mental health, however it was reported that those who lived in New Zealand for more than 6 years had a slightly lower mean depression level compared to those who had lived less than 6 years. This could be interpreted that mental health may improve with time. Pernice and Brook (1996) did find that post-migration factors such as being unemployed, discrimination and not having close friends as a being significantly correlated with anxiety and depression. When analysed further, British migrants reported no discrimination however other groups within the research felt discriminated by employers, health care services and the media. Unemployment was considered a significant post immigration factor influencing anxiety levels amongst all groups. It was reported that 43% of the refugees, 40% of Pacific Island migrants, and 80% of British migrants who suffered high levels of emotional distress were unemployed (Pernice and Brook 1996). It is further suggested by the authors that the stigma of unemployment may affect British migrants more than their south-east Asian

and pacific Island counterparts who would experience high unemployment (Pernice & Brook 1996) in their own society.

Mental health deterioration or improvement over time is difficult to measure unless participants are involved in a longitudinal study. One such study, although not specifically designed to measure mental health, is the Longitudinal Study of Immigrants to Canada (LSIC cited in Trew 2013). The study was commissioned as there was a growing need for information on recent immigrants to Canada. The study gathered a variety of data over three waves starting in early 2000's. The survey gathered information on language proficiency, housing, education, foreign credential recognition, employment, health, values and attitudes, the development and use of social networks, income, and perceptions of settlement in Canada. The method employed involved interviewing candidates at three different times after their arrival in Canada, which were at 6 months, 2 years and 4 years and described as waves. The data in relation to mental health was presented in 2012 and the findings indicated that 29% of migrants reported having emotional problems with 16% reporting high levels of stress after 4 years (wave 3). When analysed by migrant group it was found that refugees reported higher emotional problems and stress over the three waves than family class migrants. The report also highlighted migrants from the US, UK and Western Europe suffered less emotional problems than their Asian or South American counterparts; a finding similar to Pernice & Brook 1996. One overall finding from the LSIC is that for immigrants, as time spent in Canada increases, health decreases (Newbold 2009, Zhao et al. 2010). Newbold (2009), states "new arrivals experience a rapid decline in health as measured by self-assessed health, mental health, and physical health problems" (p325).

Other research has focused on the ability of migrants to cope with migration as opposed to factors such as length of residency. Kosic et.al. (2006) discusses the process of migration in terms of adaption. In her 2005 study she examines the relationship between migrants' adaption and acculturation strategies. These were measured alongside individual characteristics such age, educational background, and language proficiency. The participants of the study were Polish migrants living in Rome, Italy. The majority of the participants were women, 66%. The participants were recruited through a Polish ethnic centre and a Polish religious gathering in Rome. Participants were asked to complete a questionnaire, in Polish, which took about 45mins to fill out, it was then returned to the researcher. The questionnaire

elicited demographic information including age, gender, marital status and length of time in Italy. The questionnaire also included different measures of adaptation including acculturation strategies, self monitoring scale, psychological adaption and socio-cultural adaption. In order to aid understanding it is worth briefly explaining the measures. Self monitoring measures the 'ability to modify the self presentation' in social situation (Lennox & Wolfe, 1984). Acculturation strategies were measured using a scale to measure the quality of social relationships and also the number of friends among co-nationals and host nationals. This scale was developed by the author and based on previous scales developed by Berry (1994). The author also developed a scale of psychological adaptation which focused on respondents reporting feelings such as happy, nervous and anxiety and how often the experienced such emotions in the past month. The socio-cultural scale was again developed by Kosic (2004) and was developed using tools used in earlier studies by Berry (1988) and Ward and Kennedy (1999). The 6-item scale was designed to measure the success of social adaption to Italian society. The items measured were having a work permit, being registered within the national health insurance system, satisfaction with accommodation and fluency in Italian. From the study it was reported that there was a significant positive correlation between self monitoring and assimilation (r=0.22, p=0.05), which the authors felt would indicate that migrants high on self monitoring would tend to gravitate towards host nationals. A positive correlation was also reported between self monitoring and socio-cultural adaptation (r=0.53, p=0.05) and psychological adaption (r=0.35, p=0.05) suggesting that Polish migrants with high self monitoring were more successful in adjustment. The researchers also found that there was a significant positive correlation between assimilation and socio-cultural adaption (r=0.67, p=0.05), and between integration and psychological adaption. Added to these findings was the reporting of a significant negative correlation between separation and socio-cultural adaption (r=-0.49, p=0.05), and between marginalisation and psychological (r=-0.47, p=0.05) and socio-cultural adaption (r=-0.33 p=0.05). When analysed further it was reported that adaptation to Italy was better for those who had an increased capacity to modify their behaviour in terms of situational demands based around the measure of self monitoring (Kosic et. al. 2006). This research would indicate that social interactions act as a protective factor in terms of acculturation in migration.

Having looked at the theories of acculturation and some models of acculturation and also a model of migration and mental health there will now be a review of particular literature that examines particular migratory groups and the implications for their mental health.

3.4 Migration specifics and Mental Health

Scores of international researchers have studied the issues surrounding the mental health of migrants including Berry (1998), Kosic (2006) and Pernice & Brook (1996). Stilman (2009) argues that to truly understand the effect of migration on mental health then there would need to be a comparison of the mental health of migrants before migration and then after. Few studies actually do this however one study in 1997 by Foliaki did. In his study, 'Migration and Mental Health the Tongan Experience', the author found that those who migrated from Tonga had poorer mental health prior to migrating however, the experience had improved

their mental well-being. However if Slukzi's (1986) research and the LSIC findings were considered and applied to the Tongan experience it is pertinent to ask at what point was the migrants' metal health measured. If it was measured before the end of the six month 'honeymoon period' or as other research has indicated the two and half year 'honeymoon period' then the results may give a false indication of the true scenario. The research failed to indicate at what stage of migration the mental health of individuals was measured. In a further study Pernice et al. (2009) studied three migrant groups in New Zealand from South Africa, China and India. The researchers investigated employment status, length of residence and mental health. The research involved face to face interviews with 107 respondents. Demographic and employment data were collected in the interview and the GHQ-12 was used as measure of mental health. In the first series of interviews with the newly arrived migrants, the benchmark data was collected and subsequently every 12 months over the next four years respondents were revisited and interviewed again. From the study there were a number of hypotheses posited. The first related to employment status and mental health, and the second related to mental health and duration of residency. The results of the study were presented vaguely and there were no pinpointed definitive results. In terms of the first hypothesis, the link between employment status and mental health, there was no significant difference between the mental health of those who were unemployed or employed at the first interview. During the last three phases of the

study the number of those who were unemployed had fallen to numbers that comparative analysis was not possible. However, in a more general analysis amongst all migrant groups there was a significant improvement in the mental health, (lower GHQ-12 score), across time for those who were employed.

The second hypothesis proposed by Pernice et al. (2009) was that employment status and mental health among the three migrant groups would differ. This hypothesis was based on the fact that South Africans would have a predominately European and English-speaking background therefore would have a higher rate of employment success and better mental health than the Chinese and Indian migrants. The hypothesis was accepted in part, in terms of the employment prediction but that was as far as it went. There was no significant difference between the three groups in terms of mental health.

The third hypothesis stated that the mental health of migrants will improve with duration of residence. There was no consistent annual downward trend in the GHQ-12 score in any of the study groups however there was a difference from the baseline data to the fifth collection of data. This study had a number of failings. Firstly, the sample size seemed very small considering the statistical tests that were to be conducted and the differences that were to be observed. Furthermore, as will be discussed later in relation to this thesis study, migrant population sizes are fluid. This has even greater bearing on a longitudinal study in this instance. Another issue with the hypothesis stated is that there is a heavy reliance upon the dichotomous variable of employment status. With this variable there are two possible outcomes, employed or unemployed. If the team had broken down this variable into socioeconomic status by income then there would have the opportunity to analyse this further and realise that employment doesn't necessarily mean freedom from poverty and increased mental wellbeing. It is worth noting some of the discussion points that Pernice et al (2009) noted, firstly that in terms of mental health and duration of residence Pernice et al (2009) discussed the fact that overall the mental health of migrants improved over time however the mental health scores stayed in an elevated range, between 9-15. This study was the second such study lead by Pernice. In 1996 she had conducted a previous study in New Zealand, where she along with Brook (1996) examined the associated variables among ethnic groups that lead to increased anxiety and depression scores. In this study the Hopkins Symptom Checklist -25 (HSCL-25) was used to measure anxiety and depression. Within this study there were 259 participants,

129 of which were South-East Asian refugees, 57 Pacific Island immigrants and 63 British immigrants. Data was gathered using a questionnaire which looked at certain demographics, such as age, gender, education level, and marital status. The questionnaire also included questions in relation to post immigration factors including knowledge of English, job satisfaction, income, discrimination, friendships, and interaction with their own identified ethnic group. The Hopkins Symptom Checklist - 25 was also administered along with the questionnaire.

From the results it was determined that only the South-East Asian refugees and the Pacific Island immigrants had experienced discrimination. In total 30% of these two groups reported discrimination by work colleagues and 10% reported discrimination by health care officials by over diagnosis or inappropriate treatment. It is worth noting that the discrimination is self reported and the other arguable factor is that 'over diagnosis' can only truly be argued by a fellow health care professional. Again, the over diagnosis was self reported. It is pertinent to note the biggest grouping, South-East Asians, were in fact refugees, and their legal status may have had an impact upon their access to services and employment rights thus making them feel discriminated compared to other residents and employees. However, in multiple regression analysis, anxiety and depression was significantly dependent upon post- immigration factors such as experience of discrimination, being unemployed, and not having close friends. Within this study Pernice and Brook (1996) found little or no influence of demographic variables on stress, however post-immigration factors had a significant influence. Current socio-cultural factors would seem to play an important role in the level of anxiety or stress. There were similar findings reported by Griffin & Soskolne (2003) in their study of Thai migrant workers in Israel, which set out to examine the association between migration stressors and psychological distress. The researchers also took into consideration the contribution of socio-economic factors upon the psychological distress of migrants. The study used a qualitative approach whereby two hundred and twenty-one male Thai male workers were interviewed using a semi-structured questionnaire. The study focused in on Thai migrants for a number of reasons. Thai migrants make up 26% of the total migrant population in Israel therefore access to respondents was easier. Secondly the researchers state that migrating to Israel involves profound changes in Thai migrants workers' social environmental and cultural context. Many migrate without their families or existing social networks, so the stress of migration on the individuals may be increased. The

respondents were sampled using a convenience sample from 14,000 legal Thai agricultural workers. The final sample was 221. The tool used in this study was a structured questionnaire which was translated from English into Thai and was again translated back into English to ensure no discrepancies in the translation process. The questionnaire was designed to measure migration stressors and psychological distress. The migration stressors included duration of migration, previous migration experience, whether the worker had migrated on their own or with family or friends, and also language proficiency, and finally feelings of homesickness. Psychological distress was measured using a nine-item scale originally developed to address the major forms of distress and anxiety among Thai migrants. The items were individually scored using a Likert scale. A number of control variables were also included such as age, marital status and educational attainment.

From the analysis of the data collected two migration stressors were reported to be associated with psychological distress. Respondents who felt that migration would be difficult or very difficult, reported greater psychological stress that those respondents who felt that migration would be easy. It was also concluded that workers who were homesick frequently reported higher levels of stress than those who did suffer from homesick on a less regular basis. From the study it was also concluded that cultural and social intervening factors played a significant role in the levels of psychological distress. The authors reported these to be poor social relationships, drinking patterns and health beliefs.

The reporting of homesickness was one particular variable that had a very strong association with psychological distress. However, it could be argued that homesickness is a symptom of psychological distress among migrants. The level of homesickness among the respondents was not measured in any objective format therefore it could be argued to be a subjective measure and open to differing interpretation. One measurable variable that could be attributed to higher levels of psychological distress was alcohol consumption. Those who reported higher psychological distress were recorded to be heavy drinkers as opposed to moderate drinkers. Another significant point highlighted by this study was that the self image of being a heavy drinker was significantly associated with psychological stress. Respondents reported to be feeling bad about drinking. The authors concluded on the point that the occupational hazards faced by the migrant workers also had an impact upon the psychological distress. The study on this point maybe have benefited from

using a control group of non-migrant farm workers. Another criticism of the study was that all participants were male.

The study was well conducted and the results highlighted some important issues around the mental health of the migrant group in question. However, the measures used maybe some what subjective. Another point to note is that the relationship between dependant and independent variables measured may be argued not to valid particularly in the case of the 'homesickness being dependent on psychological distress. What the study does highlight is focal role of the specific migration context on the psychological wellbeing of the migrants (Griffin & Soskolne 2003). Ghaffarian (1998) conducted a similar study in the United States examining the implications of migration on mental health among a sample of Iranians. Ghaffarians' (1998) study reinforced the argument about this in relation to specific migration context. In this study the study group, Iranians, emigrated from a Totalitarian regime to a capitalist regime, so the diversity between the homeland and the destination was considerable. The tool used in this study, a structured questionnaire, was similar to that used in the Israeli study in that it set to measure anxiety stress and depression and link this to the migration process and acculturation. It was available both in English and Persian. The Persian translation was obtained through the method of back translation which was the method also used in Griffin & Soskolne (2003) study. The participants were all Iranians living in the Los Angeles area in 1998. The sample was a convenient sample and was made up of 130 men and 108 women aging between 25 to 72 years. The researcher set out to measure the impact acculturation has on individuals' mental health. The measure of acculturation was conducted using Mendozas' (1989) Cultural Lifestyles Inventory (CLSI). Within Ghaffarian's (1998) study, the CLSI measured the process of acculturation with three different components; cultural shift, cultural incorporation and cultural resistance. The researchers used regression analysis to analyse the relationship between acculturation and mental health. The results indicated that those respondents who found it difficult to acculturate into the new society and culture reported increased levels of anxiety and psychological distress. This was further analysed by under four demographic variables; age, socioeconomic status, sex and educational attainment. In terms of age the researchers reported that as age increased so did 'cultural resistance', 'cultural shift 'and also cultural incorporation. When analysed by sex using t-tests, analysis indicated a significant difference between males and females on two of the three CLSI components. From

this section of analysis it could be concluded than males had acculturated better and they also achieved higher mental health scores than their female counter parts indicating that they were less affected by the migration process. However, it is pertinent to note that in research females tend to report more openly about their feelings.

In terms of educational attainment, the researchers reported a positive, statistically significant correlation with acculturation as a process. In other words, as level of educational attainment increased so did the ability to acculturate. However, it is worth noting that the reported correlation figures were low, $r = 0.29$ (p=0.05) and $r = 0.17$ (p=0.05). The study concluded that those immigrants who adopt the US culture and to some degree accept the new host culture tend to have better mental health than those who have resisted the US culture.

In addition to mental health measures prior to and after migration researchers have also investigated subject specific variables such as gender.

3.5 Gender, migration and mental Health

Within the LSIC study there were differences observed in emotional problems between men and women. In wave 2 of the LSIC study, 27% men and 33% women reported having emotional problems, two years later in wave 3 the gap widened with 24% men and 33% of women reporting emotional problems. Women and men do suffer mental health problems but some problems are more common in women than men. The Mental Health Foundation (2016) reported that 25% of UK women will require treatment for depression at some time while the figure for men is 10%. The Mental Health Foundation (2016) also reported that women are twice as likely to experience anxiety disorders as men. It is worth considering whether the process of migration and the hypothesised effects manifest in women differently than in men. Cordero & Kurz (2006) in their study of acculturation and mental health specifically examined the mental health of migrant women from Latin America. Their study developed out of premise that Latinas (Latin American Women) are more often diagnosed with depression than Latinos (Latin American Men) (Koss –Chioino 1999). Other studies have shown that socioeconomic status as having an influence on depression, however Meyers et.al (2002) proved that immigrant Latina Spanish speaking women had a higher prevalence of depression than did non-Latina Whites of the same socioeconomic status. Ghaffarian (1998) supported previous studies in terms

of acculturation and implications for mental health. Ghaffarian (1998) found that as cultural resistance increased, scores signifying better mental health decreased; as cultural incorporation and cultural shift increased, scores signifying better mental health increased. What was also significant about this study was the gender implication. Within the study three acculturation components were measured and in two of the three components there was a significant difference between male and females. The female measures indicted lower levels of acculturation than their male counterparts. There was also a significant difference between mental health scores with men scoring better.

Mirsky (2009) in her study also found that gender was a significant attribute in the psychological distress. Mirsky (2009) examined the mental health implications of migration among former Soviet Union migrants in Israel by reviewing a number of community studies on the topic from 1985-2005. The Israeli studies have attributes that make it possible to have increased insight into migration and mental health. Firstly Israel grants citizenship to all migrant Jews, thus creating a population of recorded migrants accessible for research. Secondly, the registration is updated to continue citizenship rights thus allowing follow-up in research. Thirdly in 2002-2003 the Israel National Health Survey was carried out which looked at a number of health issues including mental health. An immigrant sub-sample was included in the study thus comparisons can be made with previous studies and within study analysis.

In the review by Mirsky (2009), three distinct studies were compared and the results were discussed. The first study was performed between 1983 and 1985, whereby a representative sample of 273 immigrants was included in the study. The study focused on psychological distress such as anxiety, depression and not on psychological disorders. The tool used to measure psychological distress was the demoralisation subscale of the psychiatric epidemiologic research interview (PERI-D). The study found that there was a statistically significantly higher level of psychological distress, mean score of 1.2, among the migrant sample compared to the non-migrant respondents who had a mean score of 1. This study was replicated in 1990, with similar findings and when analysed further it was reported that immigrant women reported higher levels of psychological distress, mean of 1.3, compared to Israeli women who scored 1.0. There was similar reported findings for the males subgroups, with migrant men mean scores of 1.0 while their Israeli counterparts having a statistically significant score of 0.8. In 1995 there was a follow-up study with the

same sample group and their levels of reported psychological distress had increased compared to the reports in 1990 with the mean score for women now 1.4 and men 1.1. The third study in the review was Israel National Health Survey, which included a sample of migrants. The findings of the study were reported by Ponizovsky et.al (2009). The study measured the level of psychological distress using the General Health Questionnaire (GHQ-12). The questionnaire was translated into three languages for the research, Hebrew, Russian and Arabic. The results compared the mean GHQ scores between three groups of respondents, veteran Israelis, Former Soviet Union (FSU) migrants and other migrants. The FSU migrants scored consistently significantly higher scores compared to the other sub groups with a mean score of 21.5 versus 18.8 of Israeli Respondents and 18.4 of other migrants. Ponizovsky et.al (2009) described the FSU migrants as in 'severe distress' based on the >20 score. When analysed further by demographic subgroups it was reported that factors associated with psychological distress included being aged above 50, being divorced or widowed, being unemployed or not working and being female. As with many other international reports gender was very apparent (Zilber 1996, Ritsner et.al. 2001). Mirsky (2009) also makes the point that it is unclear whether the fact that women report higher psychological distress reflects their higher vulnerability, or is their higher readiness to admit psychological distress and ultimately seek help.

3.6 Culture and Mental Health

As detailed within the concept of acculturation, culture has a huge impact upon the mental health of migrants. Bhugra & Jones (2005) argue that cultural congruity acts as a contributing factor to the deterioration of mental health of migrants. However cultural differences in relation to mental health have been long researched. Since Odegaards' (1935) study that reported the rates of schizophrenia among Norwegians who had immigrated to the USA were higher than the rates for the illness reported in Norway, a plethora of studies have investigated the links between stress of migration and mental health. Some writers have argued that migration impacts the mental health of each cultural group differently. Sashidharan (1993) argued that the stress of migration suffered by African-Caribbean's cannot be considered as the same as that suffered by white migrants. Bhugra (2005) states that in the UK, higher rates of schizophrenia were recorded amongst migrant groups and in particular African –

Caribbean's. These higher rates have not only been compared to rates in the host country but also to rates in the country of origin. In studies in Trinidad (Bhugra etal. 1996), and Barbados (Mahy et.al 1999), levels of schizophrenia were lower compared to their expatriates in the UK. In more recent studies Qassem et.al (2015) found that there was higher prevalence of psychosis among black ethnic minorities in the UK. So do certain cultures or migrant groups have an increased predisposition to certain mental health problems?

Much research has indicated that psychological distress can manifest itself in different forms across different cultures. Bhugra (2016) states that, culture affects all aspects of mental illness, including; generation of symptoms, expression of symptoms, experience of symptoms and coping. Very often studies concentrate on the biggest migrant groups available for research. In the US many studies focus on Mexican, Peurto Rican and other Latin American migrants because they are the largest migrant groups and ultimately the biggest consumers of health care. In the UK much focus has been on West Indians, Bangladesh migrants and Irish migrants. In order to understand further the cultural implication for mental health issues it is appropriate to focus on research and literature concerned with such groups. Then the focus will shift to examine the use of alcohol and drugs as a manifestation of the problems associated with migration as this is line with the main crux of the thesis.

Mental health problems have been identified as an often negative consequence of migration. But why is there a cultural difference in the way in which these problems manifest themselves. In one paper Leavey (1999) examined the suicide rates for Irish-born people in Britain. The rates appear to be greater than those of the Irish in Ireland. The rates also appear to be higher than the indigenous population and any other ethnic group (Burke, 1976: Balarajan, 1992). One of the reasons is the link with mental health problems and migration. Durkheim (1967) identified three types of suicide-, egoistic, altruistic and anomic. All three relate to a single social factor, that is the internal cohesion and integration of the social group.

Leavey (1999) argues that for the Irish in Britain, a lack of social cohesion and integration plays a big part. He further argues that this is compounded by the inability to establish an authentic identity. Maynard et.al. (2012) state that other contributing factors are, lower social class, high levels of deprivation and anti-Irish racism. Another highly influential contributing factor is the use of alcohol. Research has

indicated that there are high rates of alcohol abuse and alcohol related problems among Irish migrants in Britain (Tilki 2006) which will be now be discussed.

3.7 Addiction, substance misuse and migration.

There is further evidence that this may be attributed increased alcohol use after migration to Britain amongst Irish people (Harrison & Carr-Hill (1992). Leavey (1999) suggests that perhaps more so than other groups, alcohol use is culturally sanctioned as acceptable response to stress by the Irish. Tilki (2006) states that there is a relationship between the use of alcohol as a means to coping with psychological distress among the Irish. Erens et.al. (2001) highlights the point that higher levels of alcohol consumption are not confined to Irish migrants but are evident in many deprived groups. Tilki (2006) further comments that culture sanctions the use of alcohol as a coping strategy and a form of release. In terms of the Irish migrants in the UK it is argued that Irish people indulge in excessive alcohol use, which is health harming, because it is pleasurable. It also gives them a sense of control in a world where they have little influence (Sanchez 2015).

One very interesting point that defines culture is the identity of religion. Walls (2005 cited in Tilki 2006) locates the tolerance of and misuse of alcohol in Catholicism. However, it is important to note that this link is in the context of a piece of research which looks at sectarianism and class. Needless to say, the religious theory does have some grounding in terms of the idea of alcoholism as a disease and 'God have pity' on the sufferer, so that forgiveness may justify to a certain extent the abuse of alcohol. This idea draws some parallels with this chosen research group as 95 % of the Polish population are Catholics. However, the belief is that this is where the similarity ends because Poland has had a somewhat different history than Ireland and a different promotion of alcohol use which will be discussed later. In conclusion when comparing drinking patterns to the host nation and the resident population back in Ireland the key theme as stated by Harrison and Carr-Hill (1992) was that alcohol problems worsened upon migration to England. It is worth noting that the context of the Irish drinker does lie very much with the migration path as Irish workers, particularly men, who met in pubs to find accommodation, find work, socialise and at the end of the week the place where they met to get their wages (Tilki 2006).

Other countries around the world have experienced similar problems to alcohol and substance misuse in terms of migrants. In a US study the focus was on Mexican

migrants in the United States. Within this study conducted by Borges et.al (2009) aim was to examine the impact of migration to the United States on substance use. The study found a link between migration to the United States and increased substance and alcohol abuse. What triggered the study was that along the northern Mexican border with the US there were a significantly higher number of people with alcohol problems. When investigated it was discovered that the increased amount of people with alcohol problems was made up of a significant number of returning migrants. The study discovered that people reported that the stress of migrating, difficulty in finding a job and prejudice as contributing triggers to alcohol and substance abuse. This study counter argued the results of a US wide study in 1997. The study used data from the US National Health Survey where by self reporting of substance abuse behaviours was analysed for 21,000 adults. The study found that immigrants to the US are less likely to use alcohol and other drugs than those people born in the US. However, the study has limitations in that it categorised the migrants into 5 subgroups, black, white, Hispanic, Asian and other. By doing this it failed to take into consideration the specific cultural aspects of migration and substance misuse. Cheung (1991) states that culture and gender interact to influence substance misuse patterns among migrant groups. The US study also failed to take account of the strict immigration laws within the US. For instance, laws prohibit entry to anyone to the US how has a criminal conviction, or who has had a substance dependence. Further to this, new migrants to the US may be less likely to report substance misuse problems via the use of a self reporting questionnaire for fear of consequences. Cheung (1991) also reports that immigrants have tried to conceal alcohol and substance misuse problems from their families in an effort to avoid bringing disgrace on the family and to avoid the risk of deportation. In a further study at the same time by the same author, VanGeest (1997, p879), he stated that that "substance misuse has become a major health and social problem within the immigrant community in the United States". He further explored an additional facet of the impact of migration and focused on homelessness and substance misuse. Van Geest (1997) found that migration is seen as a chronic strain as opposed to an acute strain and therefore leads to ongoing stress. The stress then triggers the misuse of substances which is a maladaptive coping response to the stress of migration. Some studies have linked specific substance misuse as a cultural adaptive response as discussed earlier. It is therefore argued that specific migrant groups may be more prone to alcohol or

substance misuse. In a study by Rios-Bedoya and Gallo (2003) the prevalence of alcohol use studied among Puerto Ricans living in the United States. One of the findings was that high levels of depressive symptoms were associated with alcohol use. Again, this may be linked to the stress and strain of migration. In a more recent study Sanchez (2015) found that one third of Latino migrant workers in the study in Florida reported heavy drinking in the past 30 days. Although more males than females reported abstinence, there was a high proportion of males who drank daily. Many research studies have focused on alcohol however one study by Haasen et.al. (2004) in Germany focused on opiate dependence among Turkish migrants. Previous studies in Germany found that out of all migrants who were treated for psychiatric disorders 15.6% were being treated for substance dependence (Lazardis 1988). This study was specifically designed to sample Turkish migrants in Hamburg who have an opiate dependence. Turkish migrants were targeted within this research as they make up the majority of migrants in the city. This quantitative study focused on socio-demographic data and data concerning the experience of migration and the course of addiction. Additional to this, a part of the questionnaire asked respondents about their experiences of discrimination and interpersonal conflicts with family and partners. The study found that the average age of first contact with illicit substances was 16.1 years and mean age at initiation of regular drug use was 19.7 years, however the average age at first contact with the addiction service was 27.2 years. Although this study did focus very much on the experiences of substance dependence migrants it looked also at access to services and the cultural differences in dealing with individuals who have a dependence on drugs. Haasen et.al. (2004) highlighted the fact that many German opiate addicts have severed theirs ties with their family, however there were indicators of strong family ties among the sample with most of those interviewed living with their families. However, although family can be a protective factor, Haasen et.al. (2004) found that the severity of dependence correlates with migration specific stress. Brown et.al. (2005) would argue similarly by stating that there is an increased risk of substance misuse problems, especially during the first few years in a new country, among those who experience cultural pressures, economic difficulties, prejudice and discrimination. In an additional study in Germany focusing in on migrants from the Former Soviet Union, Lindert (2008) found that migrants who had a drug-dependency showed significantly higher levels of anxiety, depression and negative stress-coping strategies, independent of differences in education or

employment status. This study used a group of migrants who were not substance dependent to compare to. The research highlighted some interesting findings in terms of negative stress-coping among substance dependants, however it failed to differentiate whether these were attributable to migration or a consequence of the substance dependence.

Again, additional research would indicate that cultural perceptions of the use of alcohol have an impact on levels of consumption. Branka et.al. (2016) in a study of seven ethnic communities in Ontario found varying degrees of alcohol acceptance from total prohibition in the Somali community to wide acceptance in the Russian and Polish communities. In these communities, alcohol was seen as part of their cultural tradition. One Russian participant stated that "in Russia we drink after work to relax, to warm up in cold weather and to take part in social activities. In Canada we drink mostly because of homesickness, loneliness and depression" (cited in Branka et.al. 2016 p121).

Branka et.al. (2016) stated that 'social exclusion, discrimination and poverty disproportionately impact upon ethnic minority groups and increase their vulnerability to alcohol problems'.

Although this research has identified some key issues in terms of migration, mental health and alcohol consumption the research is limited in that focus groups, which were used with this study, are not a representative sample.

3.8 Mental Health Service Utilisation by Migrants

One of the goals of this study was to investigate access to services by migrants and also their perception of services. Therefore within this section of the literature view it is pertinent to look at the international literature with relates to migrants accessing mental health services.

It has been evidenced in previous sections of this chapter that when people migrate they can indeed suffer mental health problems. It has also been evidenced that mental presentation and symptoms can be culturally defined. So with a population who are at risk of mental health problems, and have been identified with the Bamford Review of Mental Health in Northern Ireland (2007) as an 'at risk group', are they accessing services. Within the Victoria area of Australia, a report by the Victoria Transcultural Psychiatry Unit in 2008 reported that migrants from Non English-Speaking Countries comprise of 20% of the adult population yet only 13% of the population of mental

health services. Maybe they have 'better' mental health. This is not the case because the report states that higher proportions of migrants are diagnosed with psychosis, and a higher proportion of this population group were admitted to acute psychiatric hospitals than their Australian counterparts, this also the case in the UK (mental Health Foundation 2017). There were similar findings in a study the Netherlands in 2009. Fassaert, et.al. (2009), investigated the uptake of health services for common mental disorders such as anxiety and depression by first generation Turkish and Moroccan migrants in the Netherlands. The study found that migrants report more psychological distress than the ethnic Dutch control group within the study. It also reported that the uptake of mental health services was lower among Moroccan migrants compared to ethnic Dutch citizens and Turkish Migrants. The authors believed the reason for this was the associated stigma and taboo around mental health problems and the difficulties in communication when attending GP's. The study is relevant to this research in that the Netherlands operates a similar system of 'referral' like that in the UK, whereby service users attend their GP first and then are referred to specialist services. In another study from the Netherlands in 2000, the research focused on a particular migrant group, Ghanaians. The study again focused in on reporting of mental health problems and access to services. This study found that migrants do access services however they were more likely to seek help firstly from traditional supports such as clergy and family. The study also reported that new migrants to the country were less likely to be aware of how to utilise mental health services and has had increased difficulties in disclosure of mental health problems and also discussing them mainly due to reporting of symptoms and language barriers (Knipscheer, et.al. 2005). Kirmayer, et.al (2011) also reported in their study in Canada that recognising and reporting mental health problems is complicated because of language differences, culture and patterns of help seeking. The problem of accessing services has also been researched in the US among one of the biggest migrant groups, Mexicans. Vega (1999) reported that there were gaps in service utilisation among Mexican Americans. What prompted the researcher to investigate this was the fact that other research he had reviewed cited cultural differences in the perception of mental disorders as a barrier to service utilisation. What the researcher also noted was that there was an assumption that, because there was a lower rate of utilisation by Mexicans compared to US Nationals and African Americans, they were suffering less mental health problems and therefore not seeking help of mental health services. The

researcher also considered that maybe Mexicans didn't experience the same mental health problems. In order to eliminate this discrepancy, he focused the study on patterns of service utilisation by Mexican Americans, i.e. those Mexicans born in the US and also Mexican immigrants who had recently had a mental health problem. The results looked at service utilization by socioeconomic class, by residential location and the type of service accessed. The greatest difference was the fact that 15.4% of migrants who had a diagnosable psychiatric condition had used some form of care for mental health problems in the previous 12 months, whereby 37.5% of US-born Mexicans had used some type of provider (Vega, et.al 2009). In this research the team further explains that the low levels of utilisation can be primarily influenced by cultural beliefs about mental health problems, belief in the effectiveness of therapies, access to culturally sensitive and linguistically appropriate services and the belief in the ability to deal with problems within the family network (Vega, et.al 2009). However, it has been argued that the provision of services does not necessarily mean that people will access them (Szczepura 2004). In a recent study in the UK the authors wished to investigate the experience of accessing mental health services among African and African Caribbean services users in the UK. Within the study by Rabiee Smith (2014), qualitative data was gathered through nine focus groups so that both carers and services users' experiences could be shared. Researchers used a topic guide developed from a literature review to use during the focus groups. The areas asked about were accessibility, cultural appropriateness of services access, positive and negative issues faced, and how and why their needs were not met, and finally suggestions for service improvement. From the research the two main themes that emerged were, understanding mental illness and contributory factors, and experiences of using mental health services. Respondents discussed issues such as grief and loss, social stress and trauma in the form of racism as contributing factors to mental health problems. In terms of the experiences of using the services, the findings were themed into two groupings, positive experiences, and negative experiences. Under the heading of positive experiences, carers and service users felt that they were understood and that there was a lot of support available particularly in non-government organisations (NGO's). In terms of negative experiences respondents felt that their mental health issues were not considered in terms of a social model of care. Other issues included a feeling of lack of equality in accessing services, and negative attitudes from staff. From this study the researchers' main recommendations were that

in order to engage more with ethnic minority groups, then services need to be flexible in providing alternative interventions in line with cultural beliefs, work closer with spiritual leaders and also with voluntary organisations.

In terms of more specific mental health services, the research looking at accessibility to addiction services will now be discussed. Although some of the research discussed already focuses in on addiction and migration, it has not discussed the important issue of help seeking, which is an aim of this research.

Mills (2010) investigated the drug treatment needs of A8 nationals in London. Mills (2010) in her study rationale stated that 'little is known about substance misuse among A8 nationals in the UK (p854). Mills also states that there are many unclear areas including, the prevalence and nature of substance misuse, the impact of migration on substance misuse and access to services for A8 nationals. Mills (2010) states that research in the UK based on A8 nationals focused largely on labour trends and public service provision, and that this research has limited direct application to substance misuse treatment provision. To date there has been no other research in the UK focusing in on this. In Mills' (2010) research, the focus was to gather qualitative data from 'key informants' via semi-structured interviews on the access to treatment, level of provision and the need for substance misuse treatment services for newly arrived A8 Nationals. Key informants included managers and commissioners within Drug and Alcohol Action Teams, Drug Arrest Referral Workers, Drug treatment service managers and staff, workers from the voluntary sector and service users. The face to face interviews were recorded with the consent of the participant and then transcribed. Mills (2010) elected to use a Framework Analysis (Ritchie & Lewis 2003) in order to analyse the data collected. Mills (2010) stated that the main reason for using this technique of analysis was to ensure that the pre-set of aims and objectives were investigated. From this research Mills (2010) identified three groups of A8 Nationals. The first group are well prepared for transition to a new country, have developed networks within the UK and are working. The second group are less prepared, have little English skills, little financial backup and are vulnerable to exploitation. Mills (2010), states that this group, unless they gain employment, may fall into destitution. The third group identified, smaller in numbers, was those who were presenting to homeless organisations with mental health and addiction problems. It was suggested that members of this group may have had a pre-existing problem prior to arriving.

In terms of findings from treatment agencies Mills (2010) stated that it was clear that information needed to manage and develop services for new A8 arrivals was not being collected. It was also reported that no data was being offered by government agencies in terms of treatment requirements. From the research it was reported that access to services varied across London Boroughs. It was highlighted that some A8 nationals were being denied access to treatment based on resource constraints. In other areas where treatment was available in the form of substitute prescribing, GP referrals, detox and counselling, however one service provider expressed a fear of creating a 'magnet' drawing new service users into the area base the availability of support. However, this was found not to be the case within Mills (2010) research, and she actually found that one service user actually returned home to Poland to access treatment. Mills (2010) also reported that the there was the quandary by service providers of letting A8 nationals into services and ultimately taking up a space that could be used for a local resident. This was also reported in the form that service providers didn't mind letting A8 nationals into group treatment as there was spare capacity. Mills (2010) did discover how local Drug and alcohol treatment services reacted to the perceived emerging problems by an increased uptake of local walk in centres where GP prescribing was based. There was also evidence of responsive services whereby Polish workers were employed as translation workers, and also leaflets were translated into some of the A8 languages in order to engage with marginalised groups. In conclusion the research found that there were no exact numbers of those in need of drug and alcohol treatment services and the level of their needs. Due to this Mills (2010) suggested that overestimation of numbers of vulnerable A8 migrants may lead to a panicked response from service. The restriction to services was also observed in criminal justice Drug Intervention Programmes, and homeless charities. Mills (2010) suggests that greater collaboration between Drug and alcohol treatment services, homeless charities, and community groups may offer the best solution to the problem.

This research is significant in terms of the research goals within this thesis in that it uses semi-structured interviews to gather data from a number of key informants. The key informants are similar as Mills (2010) gathers information both from service users and service providers. It is also similar in that Mills (2010) and her team focus in on both voluntary and statutory service.

The research does have its limitations in that it was limited to a few London boroughs and does not make distinctions between each borough therefore nullifying the opportunity to compare between boroughs. The research also fails to identify the country of origin of the service users interviewed. This would have been beneficial as the research could have compared treatment systems in the UK to A8 country of origin. Finally, the research did not indicate the main substances of misuse, although identifying substitute prescribing as the services accessed gives an indication that it may have been opiate dependence, however there was no indication of alcohol services or other mental health service involvement. In 2006 Homeless Link conducted a piece of research within London and it specifically examined the numbers and needs of A8 nationals who were using homeless services and agencies within London. The research found that out of 43 of the hostels and night shelters surveyed, over 75% had supported A8 nationals. For a one-week period data was collected and it was reported that 15% of service users were A8 nationals. When the figures were analysed further it was reported that nearly 70% of service uses were Polish. In addition to the demographics, the perceived needs of the service users were also recorded. The service providers reported that over 40% of service users had Alcohol misuse problems, additional to these problems there were housing issues, employment issues and mental health issues. The research further explored some of the barriers to engaging with services users from A8 countries. Service providers were asked to rank in order some of the main issues. In repose over 70% stated that language barriers were the main issue, this was flowed by lack of knowledge about referral routes and entitlement of A8 nationals. The limited access to services and support is stipulated in statute with A8 nationals not eligible to access housing benefit or social security benefits for at least 1 year after full employment. The research concludes with recommendation based on its findings including that the UK Government take the lead in addressing the multiple complex issues faced by a small but significant number of homeless A8 nationals. Secondly it recommends that services are available for migrants to learn English, understand how the social security systems work and access to accommodation. Thirdly it recommends that there should be a joint working relationship between European countries so that a directory of services is available for migrants. In terms of appraisal of this piece of research it has identified a number of issues of concern, however it is limited in that the issues reported are perceived from the point of view of the service provider. For

example, with the identified issue of alcohol misuse there is no measure of the alcohol use. This is also the case for the issue in relation to mental health, there is no recorded diagnosis or indeed assessment or reason as to why mental health services would be required. Therefore, the issues identified are at the discretion of the workers.

Selten (2007) states that population-based studies of the risk alcohol and substance misuse problems among migrant groups in Europe are scarce. These included studies focusing in on hospital admissions due to alcohol and drug problems and studies looking at out-patient treatment services. This is further backed-up by Specka,. et.al. (2010) when they argue that immigration is a factor which affects treatment response for substance misuse disorders and that there is little consistent data regarding outcome for patients within migrant communities. In their study Specka,. et.al. (2010) investigated the outcome of inpatient treatment for opiate dependence among migrants in Germany compared to German natives. In their review they found that the national health care system in Germany is not in line with the specific needs of immigrants. It was also reported that in 2006 migrants made up 10% of drug related deaths in Germany yet they only make up 5% of the population, and they are proportionally underrepresented in treatment services. Such specifics would indicate that this would lead to health inequalities. In a recent review of literature in 2017 pertaining to drug use and access to services by migrants, asylum seekers and refugees, the EMCDDA found limited new research into the access of substance misuse services in Europe. In an additional search to complement this research there was a systematic review by Maciagowska & Hanley (2017) that looked at the mental health needs of Polish migrants in the UK. In this review there was limited research found and only two pieces of research actually focused on mental health and the others looked at socio political influence on migrants and the use of culture as a coping mechanism to settling in a new country.

3.9 Conclusion

In conclusion, there has been varied research using both quantitative and qualitative methods. Some research has also used a mixed methods approach investigating the impact of migration upon individual's mental health.

The aims of the research discussed range from investigating the impact of migration upon a specific cultural group to developing measures of the impact of migration

upon migrant groups. Some research has examined the coping mechanisms of specific nationalities when they develop mental health problems.

 Results have indicated that when people migrate they can suffer mental health problems. Comparison of the impact upon an individual's mental health can be influenced by the way in which the mental health is measured. Other measures such as individual's ability to develop skills to cope, their ability to find work, prevention of poverty, development of support mechanisms, and the length of time within the host nation are all measured variables used to compare individuals' different experiences. The way in which these problems are presented, how they are reported and how they manifest themselves can be influenced culturally. Furthermore, how individuals cope with mental health problems is culturally defined. Some of these coping mechanisms may have a negative impact upon the individual's health and their life. In addition, the international research has also highlighted the impact of help seeking behaviour and individuals' ability to access and utilise services. This is particularly important to aims of this thesis

Taking into consideration the research reviewed including the aims, methods and results it is important that it is acknowledge the strengths and limitations of the research and also the impact upon the results. By applying the knowledge to the aims and methods of this thesis it will enhance the research in order to ensure that the goals set out are investigated thoroughly taking into consideration up to date policy and legislative changes.

Chapter 4

Methodology of quantitative phase and qualitative
phases

4.0 Introduction

Within this chapter the methodology of the research will be discussed. In chapter 3, discussion took place in relation to the rationale for conducting the research with needs indentified via previous international research findings and the change in migrant population in Northern Ireland. This chapter will firstly discuss the research paradigm. Creswell (2003) refers to 'elements of enquiry' which are; knowledge claims, strategies and methods which then inform the research method.

The methodologies will then be discussed and an explanation given as to why the methods were used. The design of the research will then be discussed incorporating the chosen methods. Then each individual methodology within each phase will then be discussed. This discussion will include the data collection tools, the reason for choosing the tools and how the tools were administered. Specific details will also highlight the sampling methods and data collection points for each phase. The methods of analysis will also be discussed. Finally the process of ethical approval will be detailed including discussion in relation to the internal ethical approval process and ethical approval from ORECNI (Office for Research Ethics Committee Northern Ireland). The ethical considerations are also highlighted detailing procedures in the event of disclosure during the research.

4.1 Research Paradigm

Within social sciences there is much debate about how research should be conducted, what perspective should be taken in relation to the research question and what are the most effective tools for conducting the research and analysing the results.

In order to conduct research there are certain philosophical assumptions held by the researchers. Crotty (1998) argued that when proposing a research study there are four questions taken into consideration:

1. What epistemology informs the research? This question helps to distinguish the knowledge embedded in existing theories and helps identify the source of the knowledge and whether it is objective or subjective.
2. What theoretical perspective is behind the chosen research methodology? These perspectives may include positivism, interpretivism and critical theory.
3. What methodology/plan of action is chosen? The methodology may include survey research, experimental research or enthnography.

4. What methods are to be used? This includes the tools available for data collection and accessibility to the information required.

Similarly (Guba 1990) argues that three questions need to be applied to;

1. Ontological: What is the nature of reality

2. Epistemological: What is the nature of the relationship between the inquirer and the known.

3. Methodological: How should the enquirer go about finding out knowledge (Guba 1990).

Creswell (2007) summaries these considerations into 'elements of enquiry' which are; knowledge claims, strategies and methods. Creswell (2003), states that by using this approach a researcher can then identify that either qualitative, quantitative or a mixed method approach as being the most effective option.

The first part of any research process is understanding the theoretical perspective that guides the research. This is referred to as the paradigm. Paradigms may be defined as the worldviews or belief systems that guide researchers (Guba & Lincoln, 1994, cited in Tashakkori, 1998 p3). Guba (1990) states that there are many paradigms that we use in guiding our actions and within social sciences research it is those paradigms which guide disciplined enquiry. In order to understand further and to highlight the process of this research there will be three distinct paradigms discussed; the positivist and the constructivist/interpretivist and pragmatism.

4.2. Positivism/Postpositivism

Positivism is rooted in the belief of realism, that there are answers to the true nature of reality. These answers are found by objective means, by proposing questions and hypotheses (Guba 1990). Johnson & Onwuegbuzie (2004) state that quantitative purists believe that social observations should be treated as entities in the same way that scientists treat physical phenomena. The purists of quantitative methods would further contend that the observer is separate from the entities being observed (Johnson & Onwuegbuzie 2004). At the centre of this approach is the need to be objective and the belief that absolute truth is achieved through enquiry.

In recent years there has been a further advancement in this paradigm with the emersion of postpositivism. It focuses on the thinking after positivism (Creswell 2007) and challenges the notion of absolute truth (Phillips and Burbules, 2000). Postpositivists focus on the causes that influence outcomes and focus very much on objective measures. In terms of social research postpositivst researchers develop relevant true statements in terms of measurement criteria. The measurement systems are therefore required to be valid and reliable.

4.2.1   Constructivism/Interpretism

Positivists and postpositivists examine theory and claim knowledge theory by a set of measures and analysis. However, others claim the knowledge and understanding of the world in which we live in is gained through individual experiences. Creswell (2003) states that individuals develop subjective meanings of their experiences. He further explains that these meanings are varied and complex. This paradigm is called constructivism or interpretism. With this understanding the goal of the research therefore is to depend on the participants view and interpretations of the studied situation. This is achieved by asking broad and general questions so that participants are enable to construct their meaning of the situation.

Constructivism has its meaning in the interaction between variables. This paradigm does not prove theory by testing or questioning however it allows for interpretation of answers through theory. Guba (1990) argues that 'Reality can be seen only through a window of theory'(Guba 1990 p25). Through this paradigm it is argued that much of what is observed or witnessed through social enquiry is determined by many variables. Reality is influenced by the social context and there is subjectivity from the inquirer and the inquired. Creswell (2003) states that

> "researchers recognise that their own background shapes their interpretation, and they 'position themselves' in the research to acknowledge how their interpretation flows from their own personal, cultural, and historical experiences" . (Creswell 2003 p8)

Crotty (1998) in his understanding of constructivism identified a number of assumptions:

1. Meanings are constructed by human beings as they engage with the world they are interpreting

2. Humans engage with their world and make sense of it based on their historical and social perspective.

3. The basic generation of meaning is always social, arising in and out of social interaction with a humans community.

With these assumptions it is understandable to realise how qualitative research focuses very much on the individuals at the centre of the enquiry and how their unique experiences and their interpretation and meaning is at the forefront of the research.

4.2.2 Pragmatism

A recent development in social research has come in the form of pragmatism. Due to conflicting theoretical debates there has been discussions about the incompatibility of using qualitative and quantitative methods in research.

The debates have been referred to as wars with the two separate paradigms labelled as wrestlers, (Datta 1994, Cited in Tashakkori 1998).

However, over the years, an increasing number of researchers have embraced both research methods and have argued that they complement each other and are compatible (Howe 1988, Reichardt & Rellis 1994). Tashakkori and Teddie (1998) state that this compatibility thesis is based on a different paradigm, that of pragmatism. Recognising that all methods have limitations, some researchers felt that biases inherent in any single method could neutralise or cancel the biases of other methods (Creswell, 2003). Merten (2010) argues that what pragmatist have achieved is to put the research question at the fore front as opposed to the method. So instead of methods being important, the problem is most important.

Research which contains elements of both qualitative and quantitative approaches has been referred to as mixed methods. Bryman (2004) refers to this as a multi-strategy approach. The emerging shift towards the use of a mixed methods approach has been labelled as 'the third wave of research methodology' (Tashakkori and Teddie 2003). Despite its widespread utilization across disciplines especially in nursing, education, and in the health service, the field of mixed methodology is still evolving. It has been proven to work effectively and many authors have reported on the success of a mixed

methods approach (Brewer and Hunter 1998, Creswell 2002, Newman and Benz 1998, Tashakkori and Teddie 2003).

Creswell (2003) states that pragmatism is not committed to any one system of philosophy or reality. By using mixed methods research the researcher draws on both qualitative and quantitative techniques to conduct the research. By doing so researchers have the freedom to choose methods and techniques which best meet their needs and purposes. With this approach investigators, by using quantitative and qualitative data, provide the best understanding of a research problem.

A number of writers state that there were several viewpoints as to why quantitative and qualitative methods can be used in combination. Haase and Myers (1988) state that the two methods share the goal of understanding the world in which we live, while Sale et.al. (2002) states that the two methods are united by a shared commitment to understanding and improving the human condition. Reichardt and Rallis (1994) argue that the methods share a common goal of disseminating knowledge for use within society. Further, it is argued by Clarke and Yaros (1988) that due to the complexities of the phenomena being investigated there is a requirement for data from a number of perspectives. Howe (1988) states that the pursuit of truth seems to be the prevalent attitude in mixed-methods research. Johnson and Onwuegbuzie (2004) state that mixed methods research recognises the strengths of qualitative and quantitative research methods. They further argue that the goal of mixed methods is not to replace either of these individual methods but to minimise their weaknesses and capitalise on their strengths. In their 2004 article, Johnson and Onwuegbuzie summarise the strengths and weaknesses of the mixed methods approach.

Strengths:

- Words and personal experience can put meaning to data and figures
- Figures and data can be presented to add precision to words and personal experience.
- A broader and more complete range of research questions can be answered.
- Different methods can be used to compensate for the weakness in particular method.
- Conclusions can be stronger due to the stronger evidence being provided.

- Can add insight and understanding that may have been missed if only a single research method had been used.

- Can increase the generalisability of results

- More complete knowledge is produced that may inform theory and practice.

Weaknesses:

- Can be difficult for a single researcher to carry out mixed methods as a number of approaches to data gathering are uses.

- More expensive

- More time is needed

- Some paradigm purists would argue that if a specific single method is used properly then it should be suffice.

<div align="right">Johnson and Onwuegbuzie (2004)</div>

In a recent review of mixed methods research undertaken in health services in the UK it was reported that the use of mixed methods is driven by pragmatism rather than principle and motivated by the perceived limited number of quantitative methods available to investigate the complexities of health care research (O'Cathain, Murphy & Nicholl 2007).

4.2.3   History of Mixed Methods.

There always has been much debate about the interpretation of information and whether qualitative or quantitative measures provide the best conclusion for the question answered. In the early part of the 20th Century sociologists and anthropologists would have used qualitative and quantitative data (e.g Gans 1963, Hollingshead 1949, Lynd & Lynd 1929. Cited in Tashakkori&, Teddlie. 2003) however the label of mixed methods would not have been applied until a number of years later. Campbell and Fiske's (1959) article is sometimes argued as the formalising of mixed methods as a research method (Johnson and Onwuegbuzie 2007). Within the article by Campbell and Fiske (1959) the concept of triangulation was introduced referring to multiple operationalism whereby more than one method is used within the research process. With the use of two or more methods, comes the idea of convergence of findings which "enhances our beliefs that the results are valid

and not a methodological artefact" (Bouchard, 1976 cited in Johnson et.al. 2007 P114). With the development of a multi-methods mix, researchers have developed strategies and procedures for using the mixed methods approach. The most popular are sequential, concurrent and transformative.

4.2.4.Design

For this research a sequential process was chosen. This process allows the research to be expanded and elaborated from one method after the other. The beginning of the research, phase 1, focused on the general Polish population in Northern Ireland with a quantitative tool being used to data the gather. Then two specific phases of semi-structured interviews were conducted with a specialist specific client group. The qualitative data gathered gives an insight into their personal experiences.

Figure 4: Sequential Mixed Methods process

The sequential process is illustrated below. Cresweel (2003)

Research Question

(to guide study)

QUAL (Phase 2) ←————— QUAN (Phase 1) —————→ QUAL (Phase 3)

Data Collection   Data Collection   Data Collection

(semi-structured interviews   (questionnaires)   (semi-structured interviews

Service users)   providers)

Synthesis and interpretation of findings across all three phases of data

collection
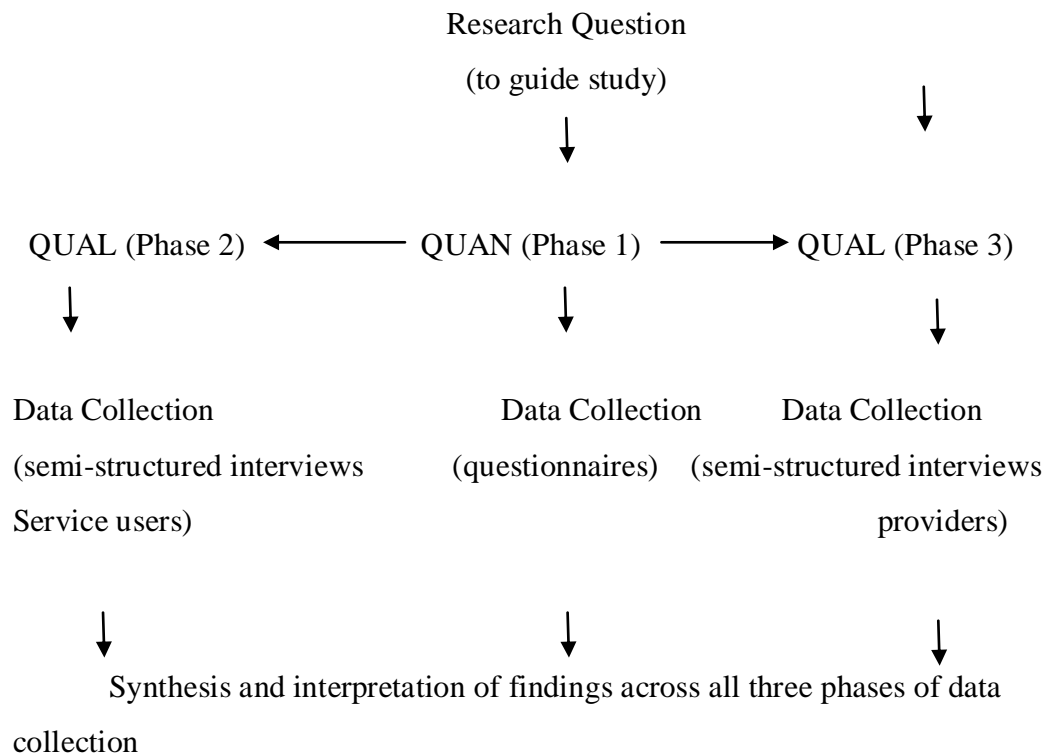
This has been adapted from Creswells (2003) interpretation of the sequential

process within a mixed methods study.

4.3.   Methodology Framework

As detailed, this research used a mixed methods approach, primarily because it was the best method to answer the research questions. A methodological framework is illustrated below. This shows the complete components of the research.

Figure 5 : Methodological Framework

Methodological Framework

Phase 1 Quantitative study of Alcohol and substance use among the polish population	**Phase 2** Qualitative study of Polish individuals	**Phase 3** Qualitative study of service providers
Questionnaires translated into Polish and distributed to sample points including online questionnaire. April 2009 – September 2009	Semi –Structured interviews with Polish individuals who have alcohol and or substance misuse problems. October 2009 – February 2010	Semi –Structured interviews with service providers who have provided service to Polish migrants. October 2009 – February 2010
Data Analysed October 2009	Data Analysed March 2010	Data Analysed March 2010

4.3.1   Methodological framework – The three phases of the study

The three phases used were very much interlinked and were conducted over a two year period in various locations throughout Northern Ireland.

Phase one, the quantitative questionnaires were completed in privacy and returned to the sample point, returned via a stamped addressed envelope to the researcher, or the online version was completed and returned electronically.

Phases two and three of the research used the qualitative method of semi-structured interviews because these parts of the research were designed to explore individual's unique experiences. So therefore it is the quality and depth of the information that was important not the quantity.

4.3.2   Structure of the three phases

4.3.2.1 Phase 1; Quantitative investigation into the nature and extent of alcohol or substance use.

This phase of the research related specifically to aim number 1 of the study. A quantitative method was employed as large amounts of data were required. Bryman (2004) defines quantitative research as

"entailing the collection of numerical data and as exhibiting a view of the relationship between theory and research as deductive, and as having an objectivist conception of social reality" (Bryman 2004 P266).

Quantitative methods such as questionnaires and experiments have been used to find out about the 'who' and 'what' of social behaviour. Patton (2002, p.140) noted that these methods require the use of standardised measures so that the varying perspectives and experiences of people can fit in to a limited number of predetermined response categories to which numbers are assigned. One of the major advantages of the quantitative approach, is that it allows the researcher to generate responses to a number of pre-determined questions from a large amount of people over a prescribed period of time. May (2001) states that this data can be easily analysed via statistical tools and computer software and statistical comparisons and generalisations can be made about specific social realities thus adding validity and reliability.

4.3.2.2   Phase 2: Qualitative investigation into Service Users' Experiences and Perceptions of Drug and Alcohol Services in Northern Ireland.

Qualitative research is a research strategy that usually emphasises words rather than quantification in the collection and analysis of data (Bryman 2004). Qualitative research seeks to understand social reality in its own terms: 'as it really is'. It seeks to understand society more than numerical representation, and exhibits a concern with subjectivity and gaining access to 'inside' experience, (Gubrium and Holstein 1997).

Lofland (1971 p7) reinforced this thinking by claiming that in order "to capture a participant 'in their own terms' one must learn their categories for rendering explicable and coherent flux of raw material" (Cited in Patton 2002, p 21). Qualitative techniques allow the researcher to generate a wealth of information about an individual's perceptions, thoughts, emotions and unique experiences. This provides an understanding of the meanings people attach to their experiences. The difficulty with qualitative research is that it deals with a smaller amount of people because interviews can be in-depth and be time consuming. Furthermore due to the wealth of information gathered, analysis can be also tedious and time consuming (Patton 2002).

4.3.2.3 Phase 3 Qualitative Investigation of Service Providers Experiences and Perceptions of Drug and Alcohol Services in Northern Ireland for Members of Migrant populations.

Within this phase of the research, 2 service providers from each health trust were invited to take part in a semi-structured interview. The interview set out to explore with the service provider the complexities and issues in providing a service to members from different migrant groups. The tool had been designed using themes highlighted from the literature review with specific reference to accessing services and engaging with patients from a different culture and also delivering services via interpreters.

The service providers were given the opportunity to decline from the interview process at any time.

4.4 Data Collection Tools

4.4.1 Phase 1of the Study: Self-Administered Questionnaire.

A questionnaire was administered at a number of sample points (see sampling 4.4.2). The questionnaire is extremely effective in reaching a larger population group. The information asked for was very specific in that the questions are not open. Bryman (2004) also states that with self-administered questionnaires there is the absence of interviewer effects and respondents can complete the questionnaires at their convenience. Survey Questionnaires, as methods of data collection do have their strengths and weaknesses. Questionnaires are inexpensive to administer, they produce quick results, respondents can complete on their own without guidance and thus giving increased anonymity. The information is factual and there is little opportunity

for interviewer bias both when questioning and interpreting results. However, questionnaires do have their limitations. They do not offer much opportunity for expanding on answers. Partial response is often possible and thus all information is not gathered (Sarantakos, 1998).

4.4.1.1 Questionnaire Design

The actual tool used to gather data in this phase of the research is a questionnaire. The questionnaire is an adaptation of a prevalence questionnaire used in Northern Ireland by the Drug and Alcohol Information and Research Unit and in the Republic of Ireland by National Advisory Committee on Drugs 2006. The questionnaire is based on the EMCDDA (The European Monitoring Centre for Drugs and Drug Addiction) model questionnaire (EMCDDA 2004).

When adapting the questionnaire a number of factors were taken into consideration. Firstly thee was the need to be able to compare different age categories and sexes, therefore a section on demographics was included. Secondly, there is the specific aim of the questionnaire, and that was to determine the extent of alcohol, and substance use/misuse among a sample of the Polish population in Northern Ireland so specific questions were included to ask about pre and post migration substance use. Anecdotally, after speaking with a number of voluntary agencies and health service staff, it is understood that currently, the specific substance use/misuse problems are in relation to alcohol. Therefore, the questionnaire was streamlined and tailored to be focused on alcohol use/misuse with some questions on other drug use/misuse.

One of the advantages of using an endorsed tool was the ability to compare findings of other research using the same tool.

4.4.1.2 Questionnaire Coding

Another consideration was how the questions were to be answered. Questions were structured so that all answers could be coded. Answers were therefore categorical, discrete or continuous data. If the question was measuring attitudes then Likert scales were used so that respondents could easily record a measure of their attitude, for example, for the question "since coming to Northern Ireland has your alcohol use increased, decreased or stayed the same; a scale of 1-10 was used, 10 being the upper end of the increased side of the scale. By using Likert scales it is argued that this data

can then be used in parametric statistical procedures that require interval data, such as Linear Regression, ANOVA, and Factor Analysis. Jamieson, (2004) argues that as ordered categories, the intervals between the scale values are not equal. Any mean, correlation, or other numerical value applied to them is invalid. Only nonparametric statistics should be used on Likert scale data. However while technically the Likert scale items are ordered, using it in parametric tests is valid. Lubke & Muthen (2004) found that it is possible to find true parameter values in factor analysis with Likert scale data, if assumptions about skewness and number of categories were met. Likewise, Glass et al. (1972) found that F tests in ANOVA could return accurate p-values on Likert items under certain conditions.

Coding was used so that data input for analysis was easy. The other reason why coding was necessary was that the questionnaires would be in Polish and coding would disregard the need to translate upon completion which was a huge benefit.

4.4.1.3 Question Format

Within the questionnaire there were various types of information required including factual, attitudinal and behavioural. The types of questions asked to gather this information included closed questions, filter questions and Likert scales. Closed questions offer the respondents a set of fixed alternatives. Bryman (2004) states that closed questions make to it easy to process the answers, that they enhance the comparability of the answers that they may clarify the meaning of the question by offering the answers, and they reduce the possibility of variability. One of the huge advantages within this study was the fact that the questionnaire was in Polish and with coding, the data was easily analysed. Sarantakos (1998) argues that closed questions have limitations in that there is difficulty in covering all possible answers and that there is a restriction in freedom to be expressive.

Filter questions were used to illicit specific information in relation to the research topic. For example, question 5, do you drink alcohol? Contingency questions were then used to elicit more specific information in relation to the research topic, for example Question 6 asks "During the last month on how many occasions have you consumed alcohol?

Likert scales were used to measure respondent's attitudes to certain topics or issues.

4.4.1.4 Alcohol use

As one of the main aims and objectives of the research was to examine alcohol use a complete section of the question focused in on alcohol use. There was a combination of questions used to determine the levels of alcohol use and also the frequency. The reason why this information was gathered was that the Department of Health Northern Ireland has clear guidelines about what are safer levels of drinking and what are harmful levels of drinking. The guide lines at the time of the research stated that safe levels would be 3-4 units a day if you're a man 2-3 units a day if you're a woman. Binge drinking is defined as drinking more than 8 units a day if you're a man drinking more than 6 units a day if you're a woman. This has since changed where the levels for men has dropped to equal that of females.

Another pertinent issue was the impact of migration upon individuals' mental health and alcohol consumption. As discussed within the literature review chapter there is widespread international research highlighting the link between migration and a deterioration in mental health. Therefore, within the questionnaire there were scales included to measure the impact that migration has had upon peoples alcohol use. Within this section there were also questions designed to assess individuals' behaviour around alcohol use.

4.4.1.5 Drug use

As stated, anecdotal information indicated that substance misuse was not a huge problem among the Polish community, this was subsequently backed up by ECDDMA information, therefore it was decided to reduce the DAIRU tool down and omit much of the questions associated with drug use. It was decided however to include questions around cannabis use, and prescription medication which would be seen as more commonly available in Northern Ireland as opposed to heroin.

4.4.1.6 Help seeking Behaviour

Another aim of the research was to investigate the behaviours of the population group in terms of their understanding of how to access services or support if they required. As discussed in the literature review chapter, international research has indicated that when people migrate they find it difficult to acculturate into the host society and often

do not have an understanding of welfare provision and how to access local services. It was therefore necessary to ask a question in relation to this population group.

4.4.1.7 GHQ Scale - Factor analysis

One additional measure incorporated into the questionnaire was the General Health Questionnaire (GHQ). The GHQ is a tool designed to measure individuals' current mental state and is not a diagnostic tool. The tool was designed in the 1970's by Goldberg and was originally a 60-item instrument however over the years a number of shortened versions have been developed and validated including the GHQ -30, the GHQ -28, the GHQ-20 and the GHQ-12. The GHQ-12 is brief and easy to complete and its application to research settings as a screening tool has been widely incorporated (Montazeri 2003). The tool has excellent psychometric properties as a screening instrument for psychiatric disorders in non-clinical settings (Goldberg & Williams1988). Within the tool there are twelve statements describing a particular symptom or behaviour. Respondents are required to rate each statement by circling one of the four points; less than usual, no more than usual, rather more than usual, or much more than usual. Each point is statement response is scored using a likert scale of 0-1-2-3.

4.4.1.8 Phase 2 & 3 Semi – structured interviews

The second and third phase of this research, as stated involved a qualitative approach. These phases of the research were designed to investigate individual experiences. The most practical way to conduct this part of the research was to conduct interviews. Interviews can be structured or unstructured. Within this research semi-structured interviews were used. Semi structured interviews lie somewhere between structured and unstructured interviews. Semi-structured interviews are flexible, allowing new questions to be brought up during the interview as a result of what the interviewee says (Flick 2007). This is extremely beneficial in exploring sensitive issues that may not be covered in questionnaires. However, the semi-structured interviews did have a theme and questions will be asked in relation to the overall research goal. This permitted greater flexibility and permitted a more valid response in relation to the informant's perception of reality. Burns (2000) states, that one of the main advantages to semi-structured interviews, as opposed to structured interviews, is that the

informants' perspective is provided rather than the perspective of the researcher being imposed.

Flick (2007) states that semi-structured or semi-standardised interviews are very beneficial in studying subjective theories. He argues that interviewees have a complex stock of knowledge about the specific topic under study. With open questions this knowledge can be expressed in an immediate and spontaneous answer.

The interviews were conducted through a Polish interpreter.

4.4.2 Sampling Phase 1

4.4.2.1 Sampling Method

Within the first phase of the research the aim was to ascertain the levels of alcohol and substance use/misuse among a sample of the Polish population here in Northern Ireland. Because of the sampling technique and statistical tools used to analyse the data, general trends can be inferred to have a bearing on the overall population. Within research it is often difficult, time consuming and exhaustive to try and gather data from all members of the population so therefore a representative sample was taken.

The purpose of sampling is to use a relatively small number of cases to find out about a much larger number. Another reason for sampling is that many of the statistical tools used in the analysis of the data are based on sampling theory (Gorard 2003). The group to be studied is referred to as the population, and the group actually involved in the research is the sample. Within this phase of the study, the population was those Polish people who used community support centres and Polish welfare associations. Ideally, the population would have been the Polish population within Northern Ireland. However, access to sampling points to gain a representative sample were difficult to determine. Also for ethical reasons it was not appropriate to access some sampling points that were identified, such as places of worship or places of work.

For the purposes of this research, the sampling points were those community development organisation that give support and advice to members of the Polish community. So therefore the population was those members of the Polish Community here in Northern Ireland who used these services.

Table 2: Population Calculation Phase 1

Services:	Visit per month
Ballymena Community Forum –	20
Ballymoney Ethnic Minority Support Association-	10
Kilkranny house Coleraine	10
Omagh Ethnic Communities Support Group	20
Polish Welfare Association	20
Polish Association N.I. (via Web site)	1000
Step Dungannon	20
Total	6600

In total over a six month period there is the potential to access 6600 participants. This is the total population. From this population a sample was to selected.

A sample size is determined to be representative of the overall population. There are number of ways to do this. Firstly, the size of the sample could be determined by the statistical testing that is to be carried out and the variables we want to measure. To do this however would be very specific and time consuming to cover all proposed statistical testing that may be conducted. The other method is to use a sample size calculator that has been developed specifically for the purposes of social science research. These tools require some information in order to determine sample size.

The first is confidence level. Most social research works on the assumption of 95% confidence level. If the confidence level was to increase to 99% the information would be more accurate, however a larger sample would be required. For the basis of this study, and many social science research studies, a confidence level of 95% is sufficient (Santakos 1998).

The second piece of information required is the confidence intervals. When analysing data there will be variation in respondent's answers. When using inferential statistics it is the sampled population results that will be used to make assumptions of the total population. Confidence intervals factor in variation. The bigger the confidence intervals the less accurate the assumptions may be, and the smaller the sample size required. For example, if we use a confidence interval of 3% within this study, when analysing the data we may find that 81% of Polish men consume alcohol regularly. Because we have a confidence interval of 3% we say that the true figure is between 78% and 84%. We would not know exactly unless all Polish people are questioned in Northern Ireland.

The final piece of information required is the overall population size from which the sample is to be taken. For the purposes of this study the population was defined as these members of the Polish Community here in Northern Ireland who used community support services. This figure is when people first make contact with the support centre and is not how often they attend. Here is a table of the sample size calculation.

Table 3: Sample Size Calculation Phase 1

Determine Sample Size

Confidence Level: 95%

Confidence Interval: 3

Population: 6600

Sample size needed: 919

4.4.3 Re-calculation of sample

Reduction in Population

After a number of months of sampling it was realized that the desired sample targets were not being met. When this was further investigated it was realized that due to economic downturn that the number of Polish people migrating here to Northern Ireland had reduced significantly, therefore the number attending and seeking advice from the support centres had reduced. To give some insight into the reduced numbers the following comparisons were made. In the period from April 2006 to March 2007 there were 5,660 polish individuals who registered for the WRS. In the period April 2008 to March 2009 this had dropped to 1,445. When looking at National Insurance applications in the period from April 2006 to March 2007 9,937 applications were made in Northern Ireland by Polish Nationals, from April 2008 to March 2009 this had dropped to 2,553. Another important note to make is that although it is not officially recorded the number of Polish Nationals returning back home or leaving Northern Ireland to find work elsewhere had also risen. The Office for National Statistics in Poland stated that many Poles have returned home in the wake of the economic crisis, as potential benefits of returning to Poland exceeded the cost of

living in the UK . The Migration Policy Institute (MPI) claimed that more than half of those Polish migrants who came to the UK since 2004 had returned home (MPI 2013). The MPI report states that "the United Kingdom has witnessed a rapid turnover of workers from the eight Eastern European countries and a significant drop-off in A8 immigration – particularly from Poland." The claims of Poles returning home has been substantiated by the Warsaw-based Centre for International Relations, when it reported that half of the estimated one million British-based Poles were expected to return home (2013).

Because of these factors the population had to be re-calculated based on the decline in numbers seeking help and support for the first time from the identified sampling points. The recalculated figures were as follows

Table 4: Population Re-Calculation Phase 1

Services:	Visit per month
Ballymena Community Forum –	5
Ballymoney Ethnic Minority Support Association-	2
Kilkranny house Coleraine	2
Omagh Ethnic Communities Support Group	4
Polish Welfare Association	8
Polish Association N.I. (via Web site)	200
Step Dungannon	8
Total (Monthly rate x 6)	1380

Table 5: Sample Size Re-Calculation Phase 1

Confidence Level:	90%
Confidence Interval:	3
Population:	1380

Sample size needed:	227

Due to the reducing population of Polish people coming to Northern Ireland and therefore a reduction in the number attending support centres this did led to increasing difficulty in achieving the required sample form the hidden population the confidence level was reduced to 90%. This is still effective in statistical calculations as a lower number of responses is required to have power in the statistical analysis (Hazelrigg,2009). This therefore allowed the sample size to be reduced to an achievable level within the sampling parameters determined and agreed under the research protocol and the ethics committee.

4.4.4 Online questionnaires.

Web Survey: One of the questionnaire distribution points is the Polish Association Website http://www.polskibelfast.pl/. The website had 1000 new visitors per month which then reduced to 200 per month. On the home page an icon was placed where visitors can chose whether or not they want to complete a questionnaire. If they click the icon they were given the opportunity to complete the questionnaire on line. Once completed, the coded questionnaire was returned directly to the University of Ulster. There are some advantages to using web based surveys. Bryman (2004) indicates that web surveys/questionnaires can be designed to factor in filter questions and maximise the use of drop down boxes. Another advantage is that answers are automatically coded for analysis.

One of the disadvantages of online methods is that of sampling. Firstly internet users are a biased sample of the population in that they tend to be better educated and younger (VanGelder 2010). It is difficult to apply any type of sampling frame to a web site as often users cannot be seen and often log onto websites more than once. Because of the difficulty in obtaining randomisation this sample will be determined as a saturated sample, i.e everyone who visits the web site will have an opportunity to complete the questionnaire (Sarantakos 2012).

Because there is two sampling points there is the opportunity for replication. Therefore respondents will be asked not to complete the questionnaire if they have already done so.

4.4.4.1 Probability Sampling

Community support organisations: In this research every fifth person who uses the services was asked to complete a questionnaire. If declined then the next person was asked. Once someone agreed then the fifth in line again was asked, and the process was repeated. The questionnaire was completed in the centre that they were visiting and then placed in the envelope provided or if respondents preferred they took the questionnaire away with them and complete at their own leisure and return it via post with the stamped addressed envelope provided.

4.4.4.2 Sampling Technique

Once the sample size was determined a method of selection was employed. This is referred to as probability sampling. Probability sampling is used due to its high reliability, degree of representativeness, and high generalisability of the results (Sarantakos 2012). The method of probability sampling used in this research was stratified, systematic random sampling.

It was stratified in that sampling occurred across different geographical locations. The systematic random sampling occurred by the fact that every fifth person who used the services was asked to complete a questionnaire.

4.4.5 Sampling Semi-Structured Interviews

Phase 2 Sampling

This part of the research did not intend to make any overall general conclusion, but it did intend to understand the unique experiences of those individuals who have received treatment or support for alcohol or other substance dependence. Therefore, the sampling was purposive. Within purposive sampling individuals are chosen who are relevant to the research topic. Sarantakos (2012) argues that in the case of purposive sampling researchers judgment is more important than obtaining a probability sample. The sampling within this section was structured to a certain extent. It did seek to recruit interviewees by geographical regions/ health trusts then by statutory and voluntary agencies.

Northern Ireland has five health trusts; Northern, Southern, South Eastern, Belfast and the Western. Within each Trust there is an addiction service which works on a multi-disciplinary level. One of the main roles of the service is to provide treatment and

support to those who have an addiction to alcohol or other substances. This treatment is delivered in the community via GP's and community addiction workers, or in hospital settings through inpatient treatment. It was at these points of treatment that interviewees were identified by service managers. Service managers and practitioners were briefed on the research project and were provided with the criteria for inclusion and exclusion. Potential interviewees were asked, by service managers, if they would like to take part in an interview after their treatment. The details of the interview were explained and they were made aware that the interviews would have been conducted in Polish with the support of translators. If they agreed, a date and time was arranged at their convenience.

Within each Trust the non-statutory support/treatment services were identified and again with the support of service managers potential interviewees were approached and asked to participate. Again the same process of set up was used.

It was envisaged that four interviews per Trust were to be conducted, two within the voluntary sector and three within the statutory sector, however based on low take-up of statutory services in some trusts this was not achievable. In the end a total of 18 in-depth semi-structured interviews were completed.

The interviews were prepared and structured with the research question in mind.

4.5 Ethical Approval

4.5.1 Ethical Considerations.

Within this research as with all research projects involving individuals the ethical considerations were always at the forefront when decisions were made. Denzin (2008), states that traditional ethical concerns revolve around the topics of informed consent, right to privacy and protection from harm. Sarantakos (2012) clarifies these issues by stating consent should be informed and that the researcher should be concerned for the welfare of participants including their metal wellbeing, physical well-being and legal status.

Within this specific research further ethical issues arose around the areas of translation and the interviewees' physical and mental health, particularly in relation to alcohol and or substance misuse. These issues had to be addressed further and were challenged rigorously by the ethical approvals committee.

4.5.2 Ethical Approval

Initially the study had to be presented to the Ethics Committee within the University of Ulster. Once approval had been granted within the University, approval was then needed form the Office for Research Ethics Committee Northern Ireland (ORECNI). Approval was granted in March 2009. Details of the application are contained in Appendix 4.

4.5.3 Ethical Approval by Trust

After initial approval by ORECNI each Health Trusts' Ethics committee had to be approached and provided with details of the research and they subsequently made a decision on the research. Each Trust gave consent for the research to be conducted within their jurisdiction.

4.5.4 Translation

In order to explore all the issues in a comprehensive manner it was only logical and ethical to use a translator. However there are issues around the use of a translator that needed to be considered. Collecting data in one language and presenting the findings in another involves researchers taking "translation-related decisions that have a direct impact on the validity of the research and its report" (Hatim 1997).

Factors which affect the quality of translation in social research include: the linguistic competence of the translator; the translator's knowledge of the culture of the people under study; the autobiography of those involved in the translation; and the circumstances in which the translation takes place (Song 1995).

When the researcher and the translator are not the same person, the quality of translation is influenced mainly by three factors: the competence, the autobiography and what Temple (1997:p610) calls 'the material circumstances' of the translator, which is the position the translator holds in relation to the researcher

As Temple (1997:p614) points out, the use of translators and interpreters

> "is not merely a technical matter that has little bearing on the outcome. It is of epistemological consequence as it influences what is 'found'".

She suggests that there are 'three basic problems which arise from the use of interpreters: a) the interpreter's effect on the informant; b) the interpreter's effect on the communicative process; and c) the interpreter's effect on the translation'. Temple (1997:608) further argues that researchers who use translators need to acknowledge their dependence on them 'not just for words but to a certain extent for perspective'. In doing so, researchers need to constantly discuss and 'debate' conceptual issues with their translators in order to ensure that conceptual equivalence has been achieved (Temple, 1997:616).

A decision was made early in the research that translators were needed on all three phases of the study. The decision was based on the fact that from the literature review it had been highlighted that many migrants fail to engage successfully with health services because of the language barrier. Within the literature review it had also been identified that individuals usually articulate their emotions and feeling and discuss difficult concepts better in their own language. This research wanted to explore those difficult emotional issues such as moving to a new country and dealing with a problem in relation to substance misuse.

The process of recruiting identifying and selecting interpreters took into consideration the impaction that interpreters would have on the research process. Therefore it was decided that the interpreters would be Polish so that they would understand and be

aware of the Polish culture. Through the process of contacting Polish support organisations at the early stages of the research process, approximately 10 potential interpreters were identified. They had all a good standard of English and showed some insight into the issues that were to be researched. From the ten, two had regularly translated written documentation from Polish to English and back to Polish as part of the job role. They agreed to work together to translate the questionnaires from English to Polish for an agreed fee.

From the other eight identified candidates 2 had experience in working with Polish migrants with mental health problems. One person in particular was currently working within a mental health charity and had good insight into mental health problems, and alcohol problems. The person was also aware of the support available and the care pathways here in Northern Ireland and in Poland. This individual was chosen to fulfil this role within this phase of the research. It was also decided that in order to reduce variation in the semi-structured interviews that the same translator would be used for all semi-structured interviews however there needed to be a back-up translator. The reason for this was to ensure that a translator was always available, however because this is such a small community there may have been the issue that the translator and participant knew each other, so for reasons of confidentiality the translator may need to have been changed.

Additional training was delivered to all translators on drugs and alcohol and how the services work in Northern Ireland. The additional training also covered areas such as units of alcohol, street drugs and their effects and the link between mental health and drug and alcohol use.

The interpreters selected for the interviews were given additional training on suicide awareness, self-harm and child protection. This was in case during the interview the interviewees made any disclosure in Polish.

4.5.5 Confidentiality & Anonymity

In the covering letter of the questionnaire respondents were made aware that the information would be treated in confidence. They were also informed that the information gathered will be used for the sole purpose of this research. In order to maintain anonymity the written presentation of data did not identify the respondents.

4.5.6. Referral to services

As this research was working with a vulnerable group of the population who may not have beeen aware of the services available for people who have an addiction to alcohol or other substances, there was a duty as a researcher and a Social Worker to make people aware of the services that were available. At the end of the questionnaire a sheet was attached giving the details of both statutory and voluntary services available to people. The information detailed points of contact for both voluntary and statutory services. Telephone numbers were also provided.

4.5.7 Disclosure

During the interviews if any of the interviewees disclosed any information that deemed them to be at risk from harm then the detail would have been passed on to the support providers whom the interviewee is in contact with.

4.5.8 Storage of data

Data was stored in a secure server within the University of Ulster. This was accessible by password only by the researcher.

4.5.9 Informed Consent

For the qualitative study written informed consent was obtained.

1.   A summary of the research was presented in a 'reader friendly format'.

2.   The participant was asked to sign confirming that he/she understands.

3.   The participant was assured that they can withdraw from the research process at any time.

4.6 Method of Analysis

4.6.1 Phase 1 Data Analysis

The analysis of the data gathered in research maybe primary, secondary or met analyses. Primary analysis is the original investigations of the findings by the researcher who conducted the study. Within this study the analyses are primary. Bryman (2015) states that often within research, the data analysis is not thought about until after the data is collected. He further argues that this a mistake in that you should fully aware of the types and nature of the statistical testing you wish to carry out. The

reason for this is that questions within the questionnaire need to be structured within a way as to provide the information for specific analysis. Bryman (2015) continues to state that you cannot apply just any technique to any variable. Techniques have to be appropriately matched to the types of variables that have created through the research.

In order to analyse the data thoroughly statistical software (SPSS) was used, however the raw data needed to be coded and the laborious task of inputting was carried out. One of the aims of this research was to find out about the nature and frequency of peoples alcohol consumption. Other variables needed for fuller analysis to be able to compare and contrast are age, sex employment status and geographical location. Other variables taken into consideration were length of stay in Northern Ireland and where people consume alcohol.

Basic statistics will be presented in chapter 5 to outline the demographic make-up of those questioned. From the presentation of the statistics, and ultimately drawing conclusions from the presented data, a number of different statistical tests were conducted. T-tests were used to identify any statistical differences in the drinking habits of men and women, or those who are unemployed or employed. Proportion tests were used with categorical data. Regression analysis and correlations were also carried out to identify any relationships between variables and subsequently the strengths of those relationships.

T- tests: A t-test is used to compare the means of distributions to indicate whether or not the same.

Proportion test: These statistical tests are used to compare proportion data. Usually proportion data is expressed as a percentage, therefore the proportion test takes into consideration sample size and indicates whether or not two samples are statistically different.

Regressions analysis: Regression analysis develops an estimating equation (formula) that relates the predictor(s) to the response. It determines the strength of the relationship between the predicator, for example age, to an output, for example units of alcohol consumed per week. Binary logistic regression can also, be used where the output is categorical

In addition the GHQ 12 scores analysed within themselves and re-categorised. Graetz 1991 proposed a three factor analysis the GHQ12 whereby certain questions were clustered together in analysis to create new factors. The new factors are anxiety/depression, social dysfunction and loss of confidence. In a recent study by Kashyap and Singh (2017), they found that the use of Graetz (1991) factor analysis was still the be best fit compared to other modelling of the GHQ12.

4.6.2 Phase 2 and 3 Data Analysis

The data collection occurred at the interview stage, and with written consent of the participant, the interviews were recorded via an mp3 digital recorder for later transcribing and analysis. The interviews were then transcribed verbatim by listening back via the digitally recorded interviews. Textual data from the transcribed interviews were explored using variant of content analysis. Simple counts were used to provide a summary of some aspects of the analysis. In this analysis the data was indexed to generate analytical categories.

The analytical categories were then used to describe and explain some of the issues in relation to the research question.

Initially the data was read and reread to identify and index themes and categories. The analysis of the qualitative data was conducted by analysing the data thematically. As each interviewed was transcribed themes and topics were grouped so that specific themes which were trending were visible. These themes were used to highlight key issues during the discussion.

During phase 2 of the research involving interpreters, the interviews were again recorded. The interpreters interpreted in-process and this was recorded for transcribing. Also after the interviews the interpreter listened back and transcribed additional content that may have been omitted during the interview.

4.6.3 Proposed Outcomes

From this research it is envisaged that would be a better understanding of the mental health needs of ethnic minorities in our community specifically in relation to alcohol and substance misuse. With this understanding service provision can be adapted to meet their needs. Migrant workers play an integral part in the economic development of Northern Ireland and the economic development of Europe. It is therefore vital that

health and well-being of these groups is monitored, understood and provided for as is the case in Canada under the LSIC. Within Europe at a macro level there is provision for the understanding of drug and alcohol use and misuse. However, much of the work is country specific. On a micro level, which this research is about, there is less understanding.

4.7 Conclusion

In summary, the research was conducted using a mixed methods approach, combining quantitative and qualitative tools. The rationale for using this methodology has been discussed and justified. The methodological framework demonstrates the research process used and helps visualise the process. Each of the components of the methodology has been discussed including the ethical considerations and the process of achieving ethical approval.

Chapter 5

Literature on migration & mental health & substance abuse.

5.1 Introduction

This chapter will focus in on the results of the quantitative data. The data was gathered through a questionnaire which was distributed at various sample points and also via a website targeted at Polish people residing in Northern Ireland. The data was coded and inputted into an SPSS database whereby the statistical analysis was carried out.

The total population was 997. This population was calculated based on the number of Polish migrants who visited support centres over a six month period. The total sample was n= 231, n=29 of which completed the questionnaire online. This was calculated to be an error margin of 5.66% with a 90% confidence level.

The structure of this chapter will be a step by step analysis of the data at different levels. The first section will present descriptive statistics of the demographic data gathered. Demographics maybe described as the information that gives a general overview of a population, including gender, marital status, age, employment status, home ownership and income. These variables allow for within study analysis between certain subgroups and also allow for comparisons to other similar studies.

The second section of the chapter will focus on data by subgroups in the form of crosstabs. Crosstabs are used to display the relationship, if any, between two variables measured using categorical data (Pallant 2007)

The third section of the analysis will focus on the differences, if any, between specific independent variables. The differences investigated will be the mean of the distributions. The fourth section will investigate the strength and direction of relationships between two variables. The statistical tests used to determine the relationships are correlations.

The conclusions of the this chapter help construct findings of the thesis in conjunction with the conclusions from the qualitative phases and further lead to the recommendations and also guide further research.

5 2 Descriptive Statistics regarding demographics

The descriptive statistics presented in this section will detail the demographic makeup of the sample population. There were 231 respondents to the survey. Of those who

completed the questionnaire, 63% (n= 145) were male and 37% (n=86)were female.

The chart below details the employment status of the sample .

Figure 6; Employment Status
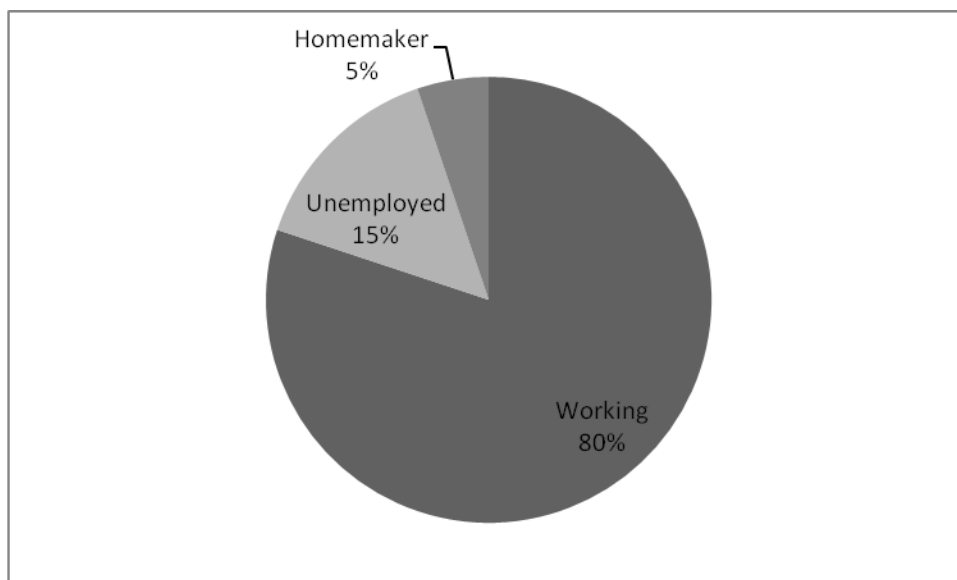
In terms of marital status 52% (n=120) of respondents were married, while another 7% (n= 16) were co-habiting. Figure 7 below details the marital status of the sample.

 Figure 7. Marital Status
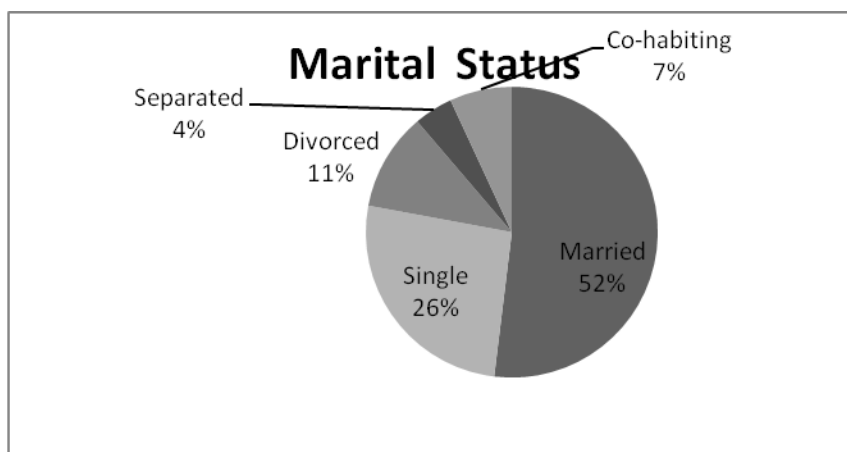
Of those questioned 83% (n=196) live in privately rented accommodation with only 3% (n=6) owning their own home. .

Figure 8. Accommodation Status
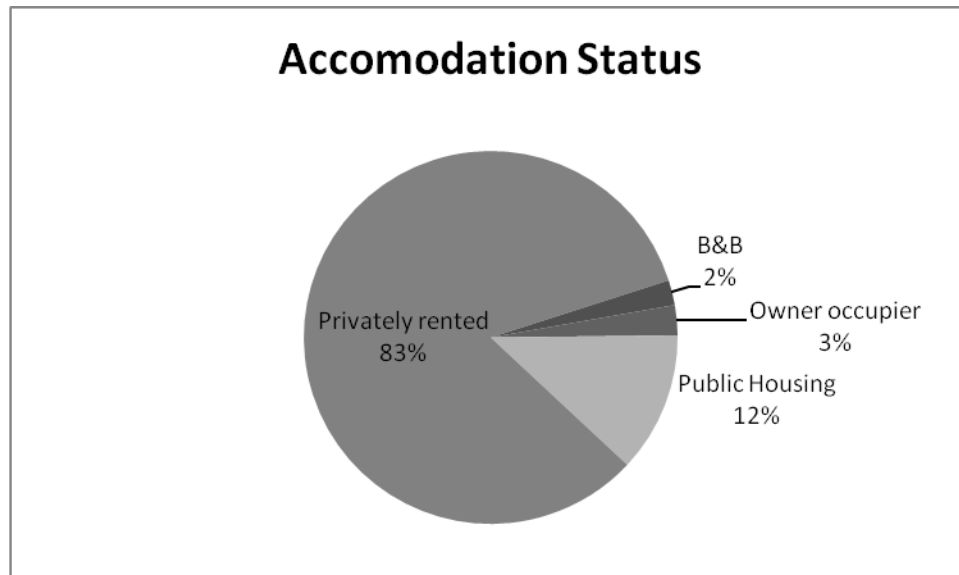
The population sample have been educated to a number of different levels. Over one quarter of respondents, 26% (n=59) reported having a degree, 31%(n=72) have been educated to A-level equivalent, whilst 37% (n=85) have a skilled trade. 6 % (n=15) of the sample respondents have been educated up to the age of 16years of age. (see figure 9)

Figure 9. Educational Attainment
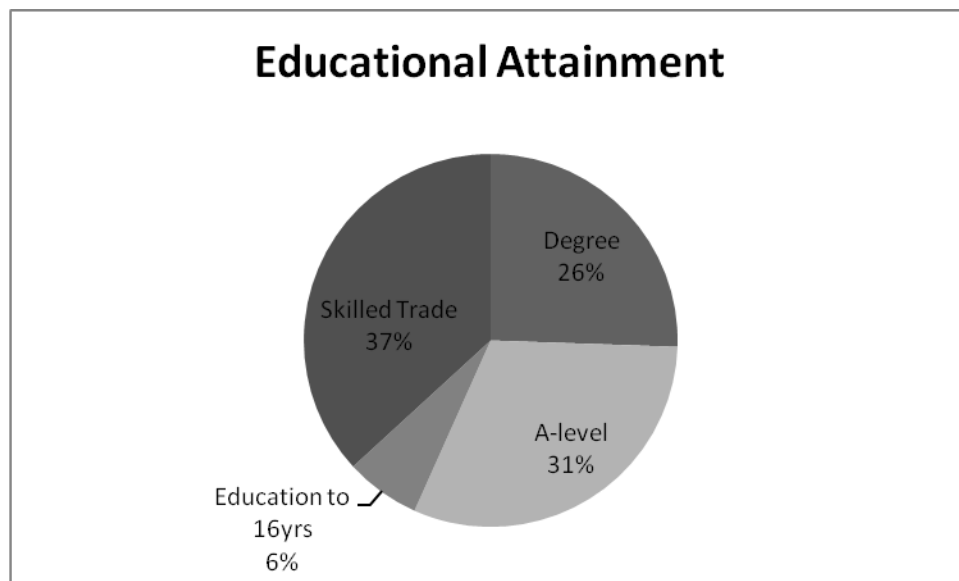
In terms of income, 41% (n=95) of respondents earn between £10,000 and £15,000 a year and 32% (n=73) of respondents earn less than £10,000 per year. (see figure 10)

Figure 10. Levels of Income
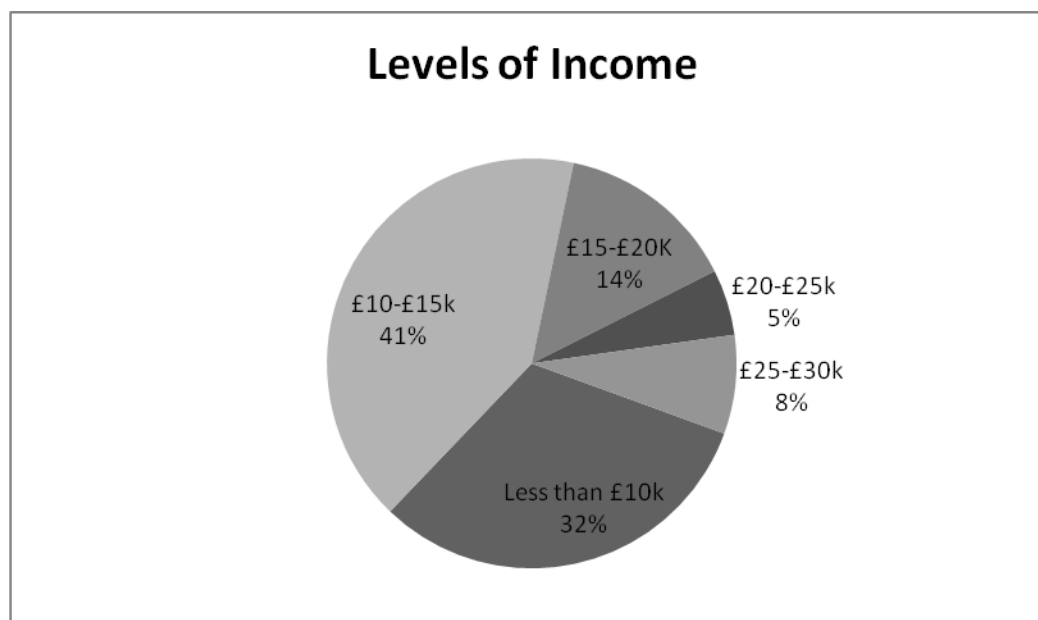
5.3 Descriptive statistics regarding alcohol and drug use

In terms of alcohol use 98% (n=227) stated that they drink alcohol, 2% (n= 4) stated that they do not drink alcohol. In the last twelve months 98% (n=227) stated that they

drink alcohol, 2% (n= 4) stated that they do not drink alcohol. 84% (n=193) stated
that they drank alcohol in the past 30 days, 16% (n= 38) stated that they did not drink
alcohol in the past 30 days. Figure 11 details the past 30 day level of consumption.

Figure 11.   Alcohol Use in last 30 days
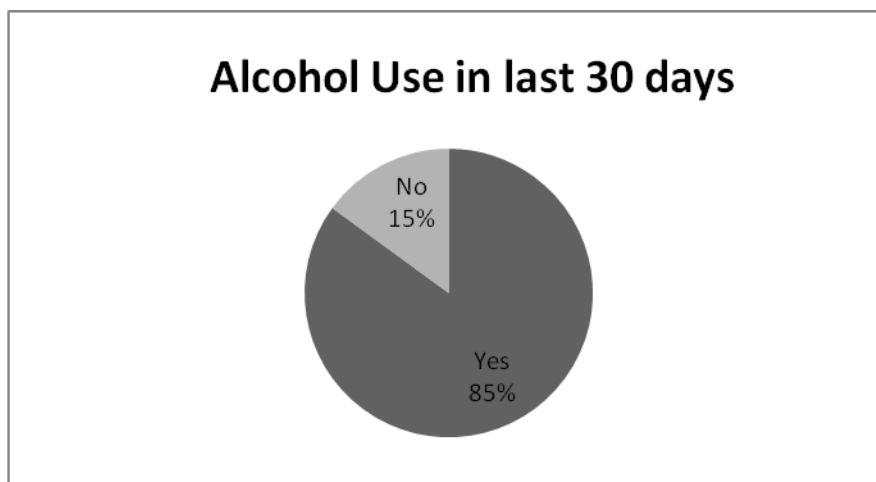
Of those who consumed alcohol in last 30 days 27% (n= 52) consumed alcohol on 4
days or less. 20% (n=37) drank alcohol between 5 and 8 days. 6% (n=12) drank on 10
days, while 8% (n=15) drank on 15 days. 5 %(n=10) drank alcohol everyday in the
past month. Figure 12 below details the alcohol consumption for the past 30 days

Figure 12 Alcohol consumption for the past 30 days
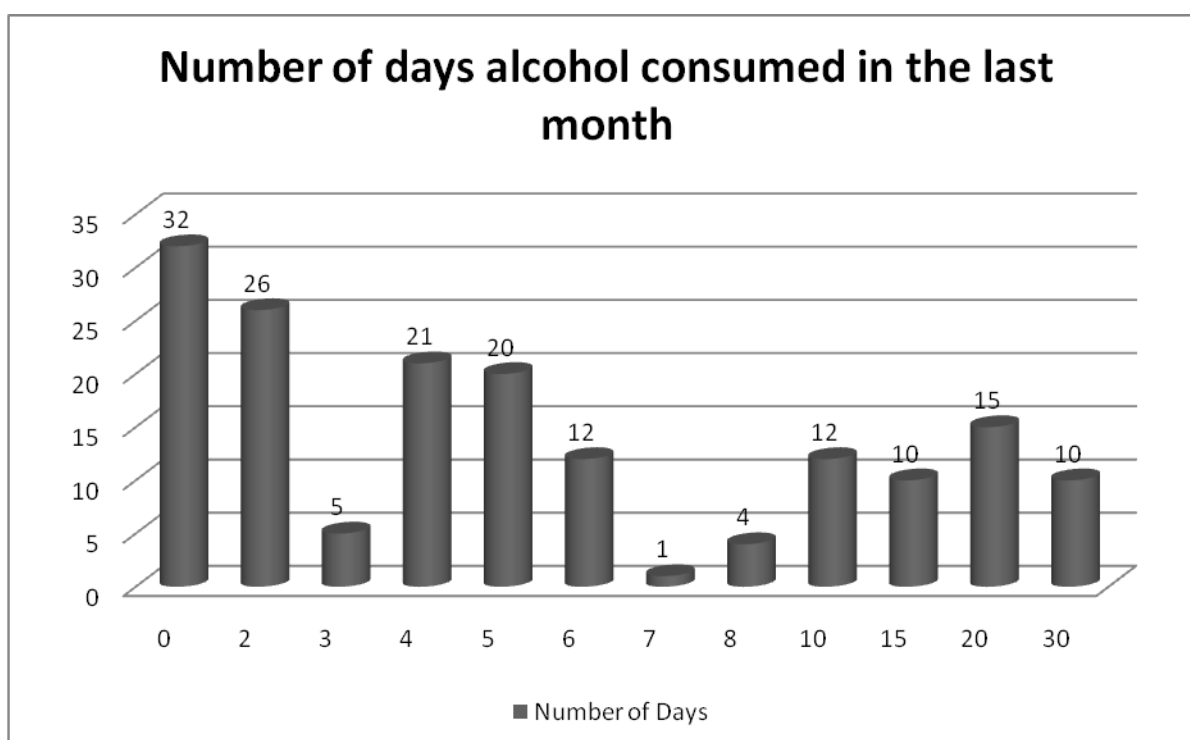
The number of times that respondents drink alcohol was further explored by asking participants what was their pattern of consumption.19% (n=43) stated that they would consume alcohol on a daily basis while 41% (n=93) stated that they would consume alcohol on a weekly. 13% (n=29) state that their alcohol consumption is monthly and 26% (n=60) described their alcohol consumption to be rarely. The figure below displays the information.

Figure 13. Pattern of Consumption for alcohol.
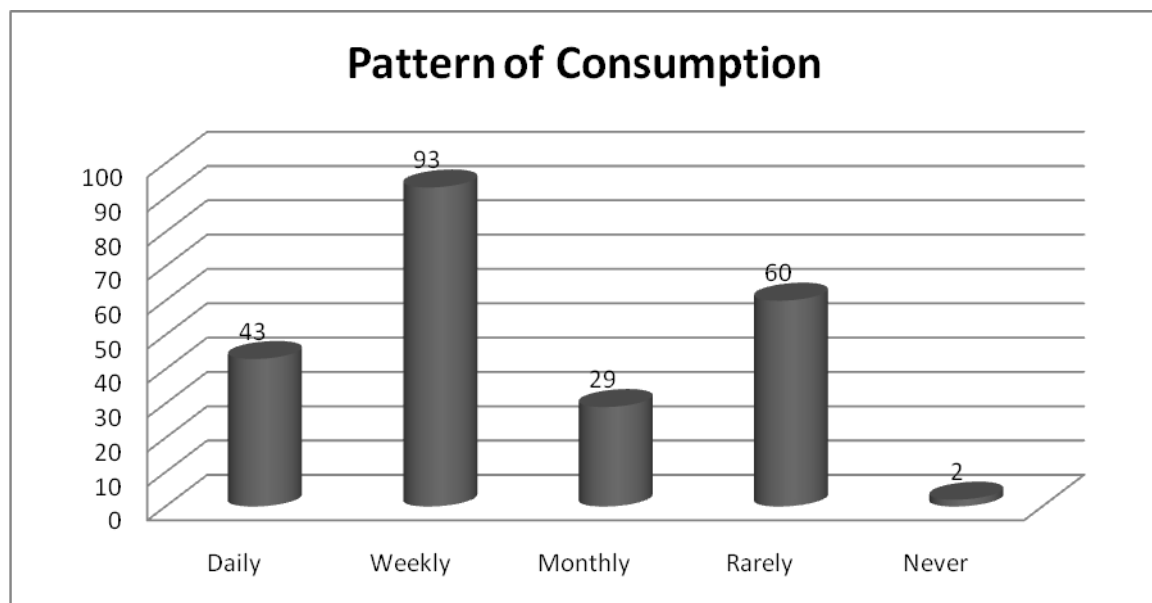
In terms of alcoholic drinks 69% (n=156) of those sampled indicating that they drink beer. Cider was the second most popular drink with 12% (= 28)indicating that this was their drink of choice, 8% (n=18) stated that spirits was their drink of choice. Wien was the drink of choice for 2% (n=4) of those sampled. Figure 14 below displays this information in pie chart form.

Figure 14: Alcoholic drink of choice.
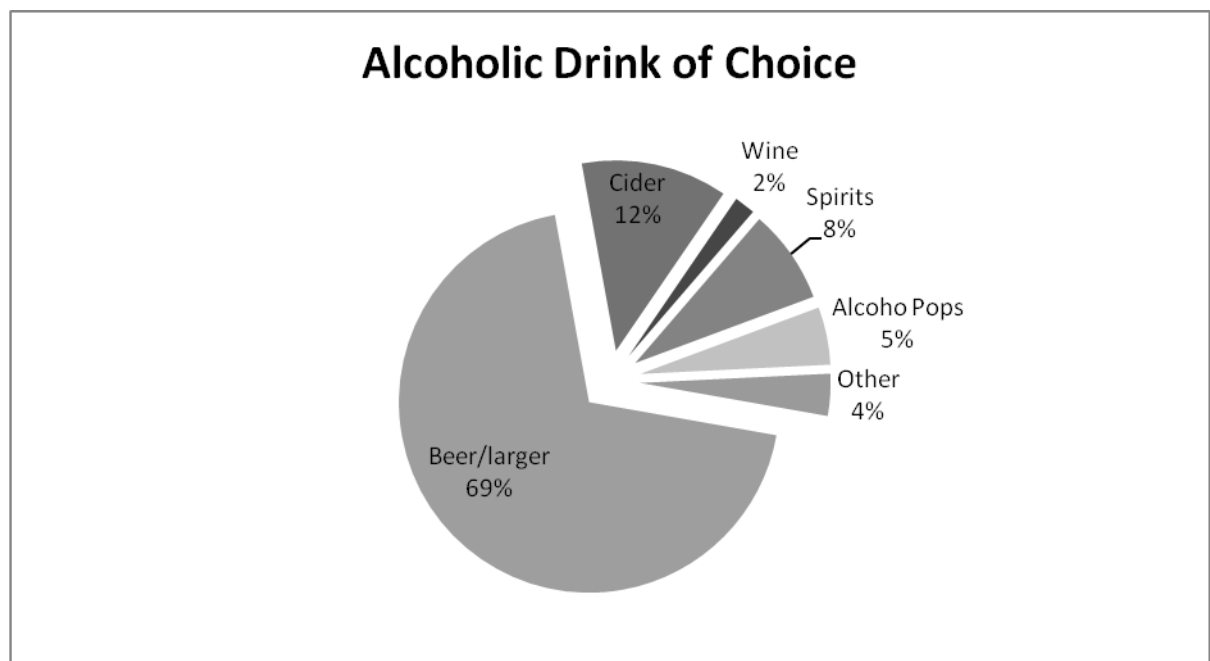
Where and who Polish people drink with is also a reflection of the socialising habits. When asked where they normally drink 70% (n= 157) of those sampled stated that they drank alcohol at home , 18% (n=40) stated that they drink at a friend's house. 6% (n= 13) of those sampled stated that they would normally drink at a pub or a bar. A further 6% n=15 stated that they drink at a combination of the of the above. Figure 10 below shows the information in graph form.

Figure 15: Where do people drink.
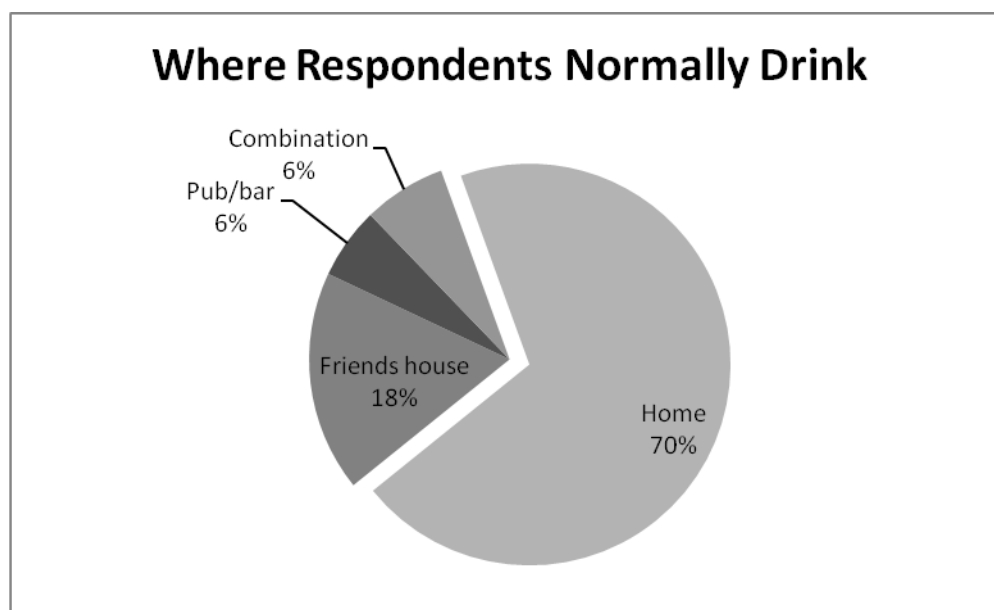
When with whom do they drink alcohol with 97% (n=217) of the Polish people sampled stated that the drink with family or friends and fellow poles.(3% n=8)stated that they drink alone. Figure 16 below displays the information regarding who those in the sample drink with.

Figure 16: Who do you drink with?
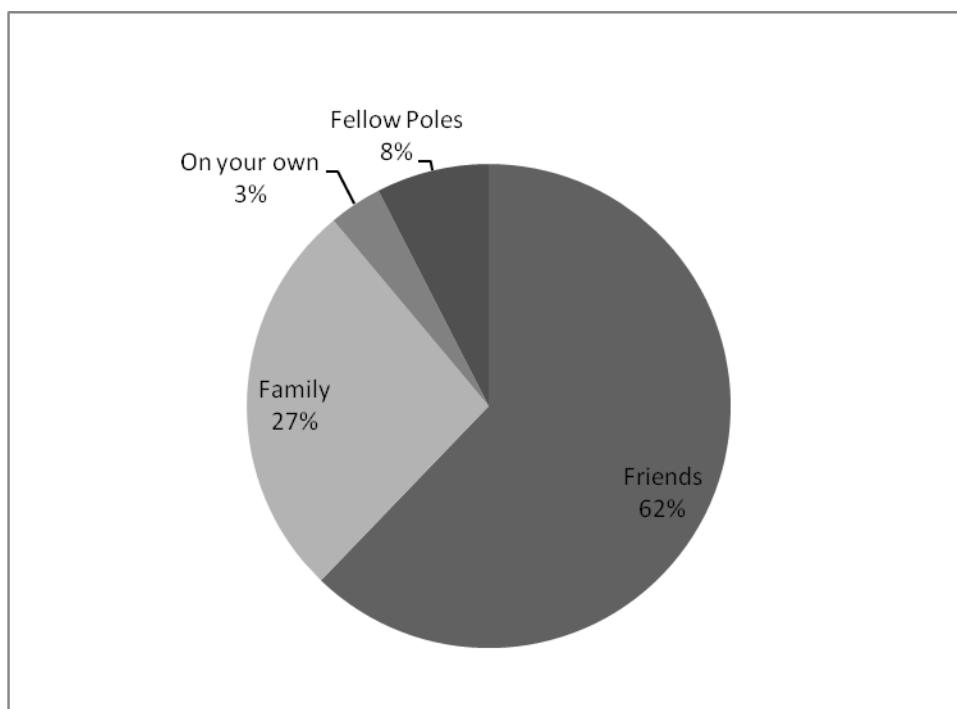
One of the aims of the research was to determine if migrating to Northern Ireland had contributed to an increase in alcohol consumption. Respondents were therefore asked, 'Since coming to Northern Ireland has your alcohol use increased, decreased or stayed the same?' 68 % (n=156) of respondents indicated that their levels of alcohol use had stayed the same or decreased since coming to Northern Ireland, however 32% (n=75) of respondents stated that their alcohol use had increased. Figure 12 below shows percentages of respondents who stated that their alcohol consumption had increased, decreased or stayed the same since coming to Northern Ireland.

Figure 17 Level of alcohol consumption since coming to Northern Ireland.
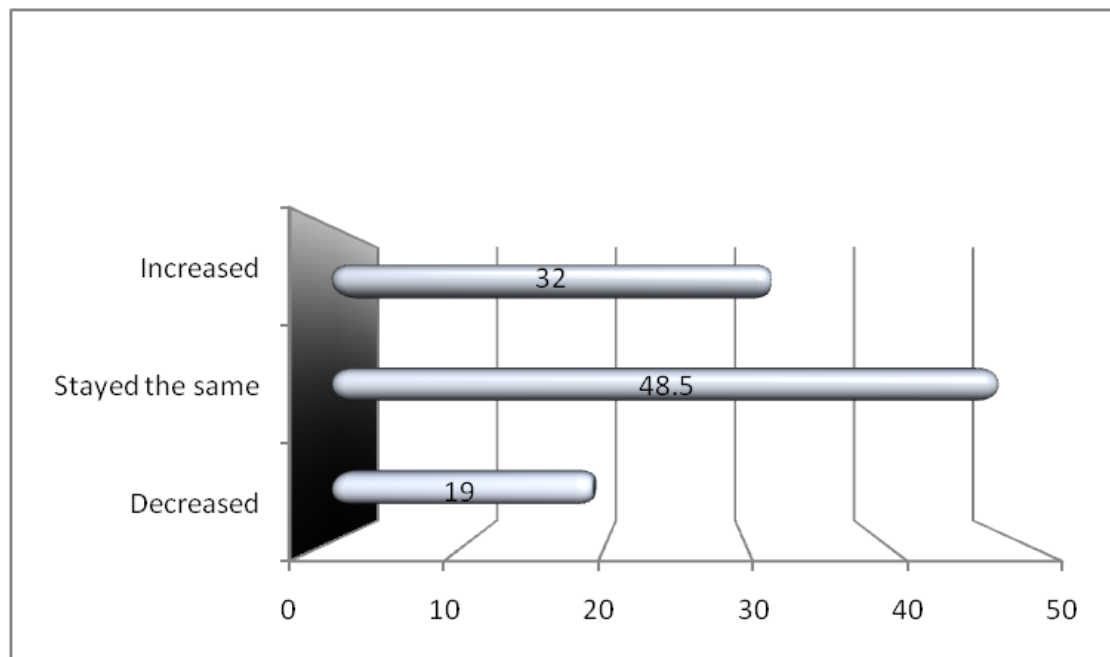
In terms of cannabis use, when asked, 98% (n=226) of respondents had heard of cannabis or one of the street names given to it. Over half, 52% (n=120), personally know someone who takes cannabis, 18.6% (n=43) have taken cannabis themselves. Out of those who have taken cannabis in their lifetime (n=43), 63% (n=27) have smoked cannabis in the last 12 months, however only 33% (n=14) have smoked cannabis in last 30days. Of those who have smoked in the last 30days no one smoked more than on 5 occasions with 92% (n=13) of cannabis smokers only smoking on two occasions. All respondents who smoked cannabis smoke it in the form the form of a joint and 81% (n=22) of smokers smoke cannabis in the form of grass. When asked about their level of cannabis use since coming to Northern Ireland 58% (n=19) of cannabis users stated that their use had decreased or stayed the same while 42% (n=14) indicated that there was a slight increase in their use. Figure 18 below details the percentages of level s of cannabis use

Figure 18: Levels of cannabis use since coming to Northern Ireland.
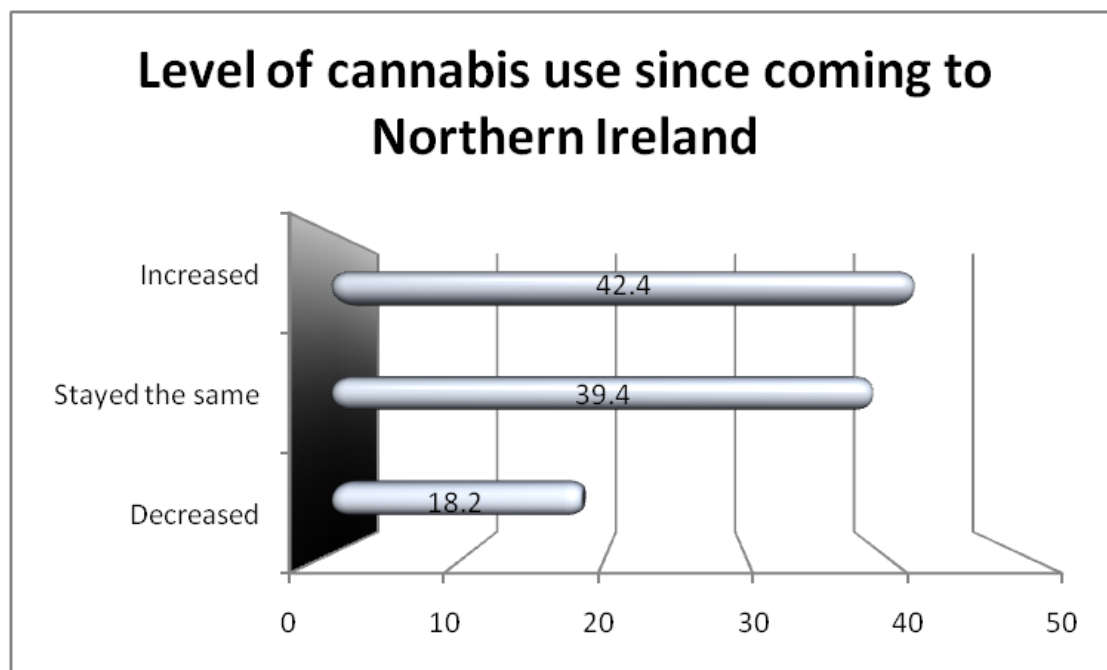
Respondents were also asked about prescription drug use. 5% (n=12)of respondents stated that they were currently using prescription drugs such as sleeping tablets or benzodiazepines. All respondents (n=12) currently using these are prescribed them from their GP. Of those respondents using prescription medication, 50% (n=6) have stated that since coming to Northern Ireland their use has increased, while 50% (n=6) state that their use had decreased since coming to Northern Ireland.

Help seeking behaviour was measured within the survey and it was found that not one person had looked for help for either drug or alcohol problems and when asked who they would turn to for help 77% (n=179) stated that they would turn to their friend or partner, while 17% (n=40) stated that they would go to their GP. Figure 19 below details the makeup of the response.

Figure 19: Point of Contact for help and Support
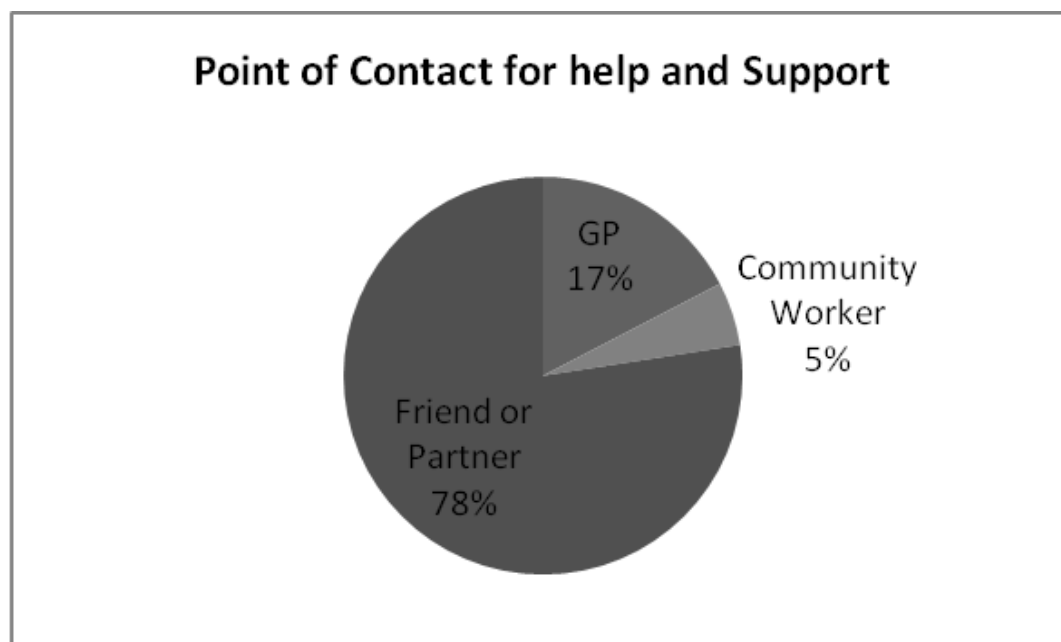
5.4 Analysis of categories by alcohol and drug use

Cross tab analysis of gender, socio historic factors and consumption of alcohol and drugs

Gender is an important factor that influences alcohol and drug consumption and ultimately mental health. They were analysed along with the other factors to identify any differences between men and women in their social and family circumstances and then to explore gender differences in alcohol and drug taking behaviours. Chi-squares are used to explore the significance of the relationship between two categorical variables and the Cramer's V used to measure the strength of the association between the two variables.

The Chi-square and Cramer V analysis was conducted with gender and the following; employment, marital status, accommodation type and the alcohol / drug consumption patterns;

A Chi square statistic was used to determine the relationship between gender and employment. From the chi-square it was found that there was a significant relationship between gender and employment status, (X^2 (2, n= 231)= 23.17 , p=0.00). From the cross tabulation. 17.4 % (n= 15) of females are not working while 13.1% (n=19) of males are not working .The Cramer V statistic indicates a medium strength relationship between the two variables; Cramer V = .317 (p=0.00).

A chi square statistic was used to determine the relationship between gender and marital status. From the chi-square it was found that there was a significant relationship between gender and marital status, (X^2 (2, n= 231)= 13.68 , p=0.05). From the cross tabulation. 64 % (n= 55) of females are married while 44.8% (n=65) of males are married .The Cramer V statistic indicates a medium strength relationship between the two variables; Cramer V = 2.43 (p=0.05).

A chi square statistic was used to determine the relationship between gender and levels of income. From the chi-square it was found that there was a significant relationship between gender and levels of income, (X^2 ,(n= 231)= 30.70 , p=0.00). From the cross tabulation   48.8 % (n= 42) of females are in the lowest income bracket of less than £10,000 pa while 21.4% (n=31) of males earning less than £10,000 pa .The Cramer V statistic indicates a medium strength relationship between the two variables; Cramer V = .317 (p=0.00).

When analysing alcohol use there was no significant difference between sexes for consumption in the past twelve months however when asked have you consumed alcohol, in the past 30days there was a significant difference in sexes. A chi square statistic was used to determine the relationship between gender and whether alcohol was consumed in the past 30 days. From the chi-square it was found that there was a significant relationship between gender and levels of alcohol use in the past 30 days, (X^2,(n= 227)= 18.1 , p=0.00). From the cross tabulation. 27.9% (n= 24) of females had not consumed alcohol in past 30 days while 7.1% (n=10) males had abstained

from alcohol in past 30 days. The Cramer V statistic indicates a medium strength relationship between the two variables; Cramer V = 0.283 (p=0.00).

There was also a significant difference between sexes for the frequency of alcohol consumption. Respondents were asked was their pattern of consumption, daily, weekly, monthly or rarely. A chi square statistic was used to determine the relationship between gender and frequency of alcohol consumption. From the chi-square it was found that there was a significant relationship between gender and frequency. X^2,(n= 227)= 56.9 , p=0.00). From the cross tabulation. 47.7% (n= 41) of females described the alcohol consumption as rarely, while 13.5% (n=10) males had abstained from alcohol in past 30 days. Also from the cross tabulation it was shown that 30.5% (n=43) of males stated that their alcohol consumption was daily with no women stating this. .The Cramer V statistic indicates a strong relationship between the two variables ; Cramer V = 0.501 (p=0.00).

5.5   Differences in mean distributions of data

This research is looking to determine if there are relationships, and differences between specific dependent and independent variables. There was a specific focus on identifying any significant differences in the mean scores of recorded units of alcohol consumption, increase in alcohol consumption and GHQ scores, according to gender, employment, marital status and income. Within this study the tool used to analyse statistical differences of means is the t-test and in particular independent sample t-tests. T-tests measure the distribution and locate the position of the arithmetic mean and then factor the potential variation of the mean. The second sample is measured the same way and compared to the first sample. The variations of the means are compared and if overlap occurs then they are deemed the same and if there is no overlap then they are deemed significantly different. The measured data used with t-tests is continuous.

Within this study there were a number of variables measured using continuous data and there are questions of difference attributable to certain independent variables.

The influence of gender on alcohol consumption and mental well being were analysed in conjunction with employment status, income, and marital status all of which have

been highlighted through research discussed in the literature review to have an impact upon alcohol consumption and mental health.

5.6 Results of T-Test and Anova's

The aims of the research was to identify the impact of migration upon individual's mental health. Increased alcohol consumption has been identified as a symptom of or a deterioration in mental health and can been seen as a copying mechanism for stress and anxiety.

The first group of t-tests focuses on gender as the independent variable and alcohol consumption and GHQ scores as the dependent variables.

The independent t- test is used to consider differences in the mean consumption of alcohol for men and women since migrating to Northern Ireland. The results indicate that there is a significant difference between men and women in alcohol consumption since coming to Northern Ireland   Males had a significantly higher level of increased alcohol consumption (M=5.48, SD = 2.3.) than females (M=4.69, SD =4.69)   (t(229) = 2.98, p=0.003)

5.6.1 Gender vs number of units of alcohol consumed in the last week.

There was a significant difference in the average number of units of alcohol consumed between males and females within the last week with males consuming more units (M=19.16, SD = 15.33) than females (M= 7.08, SD =7.8)   (t = (df 225) 7.8 p= 0.00.

5.6.2 Gender vs number of days alcohol consumed in the month.

Again there was a significant difference in the number of days that alcohol was consumed between men and women. Men consumed alcohol on more days (M=7.8, SD 8.7) than women (M=2.1, SD =2.3). T was calculated to be t=(223) 5.8, p=0.000. The table below details these results

Table 6 Sex v levels and frequency of alcohol consumption

	Sex	N	Mean	Std. Deviation	Sig.
During the last 30 days, on how many days have you drunk alcohol	Male	141	7.8652	8.77433	0.00
	Female	84	2.1429	2.03074	
units of alcohol consumed in the last week	Male	141	19.1645	15.33536	0.00
	Female	86	7.0826	7.82195	
Since coming to NI has your alcohol consumption increased or decreased	Male	145	5.4828	2.32171	0.03
	Female	86	4.6977	1.65969	.

5.6.3 Gender Vs GHQ Score

When analysed there was no significant difference in the GHQ scores for males (M 9.9 SD 4.5) and females (M=10.3 SD 4.0).

The GHQ subsets were then analysed. There was no significant difference between males (7.5 SD 1.8) and females (M=7.8; SD= 1.66) in the anxiety/depression subset. There was no significant different between males (M=11.4 SD=2.18) and females (M=11.18; SD=1.8) in the social dysfunction factor, however there was a significant difference between males (M=3.1 SD= 1.33) and females (M= 3.4 SD=1.12) in the 'loss of confidence' factor; $t(203)=1.79$ $p = 0.011$. The table below details these results.

Table 7: Sex versus GHQ score and GHQ factors

	Sex	N	Mean	Std. Deviation	Std. Error Mean	Significance
GHQ score	Male	145	9.9103	4.53829	.37688	.560
	Female	86	10.3372	4.08040	.44000	
Alcohol consumption	Male	143	.4476	.49899	.04173	.000
	Female	82	.0732	.26202	.02894	
anxiety/depression base on GHQ subscales	Male	145	7.5517	1.87798	.15596	.307
	Female	86	7.8140	1.66988	.18007	
Social dysfunction base on GHQ subscales	Male	145	11.4276	2.18500	.18145	.202
	Female	86	11.1279	1.87112	.20177	
Loss of confidence base on GHQ subscales	Male	145	3.1586	1.33685	.11102	.011
	Female	86	3.4535	1.12362	.12116	

Next a number of ANOVAS where run to identify differences due to other factors such as employment status, marital status and income level. The dependent variables again were those associated with alcohol use and mental health.

5.6.4 Income bracket and alcohol use

The ANOVAs indicated that those on the income level of £15,000 to £20,000 drank alcohol on more occasions (M=12.03; SD = 11.01) compare to income groups 'less than £10,000' (M= 3.4 SD=5.7), p=0.00; £10,000- £15,000' (M=6.33 SD=7.49), p= 0.02 ; £20,000-£25,000 (M=7.03, SD= .42), p=0.034 and £25,000 - £30,000 (M=2.0

SD = 1.4), p=0.00. There was no significant difference between the income brackets for units of alcohol consumed or the measure of alcohol increase since coming to Northern Ireland.

Income Level and Mental Wellbeing

Using the GHQ score as a measure of mental wellbeing it was found that those participants in the income level of £15,000 to £20,000 had a significantly higher score (11.66 SD 5.6) than respondents in the 'Less than £10,000 income bracket (M=8.95 SD 4.36) p=0.025. There was no significant difference between the other income groups.

Marital Status and alcohol measures

Marital status was analysed along with the alcohol measures. There was no significant difference between the different groups in this category and the number of days alcohol was consumed. However when the actual units of alcohol consumed was analysed within the categories there was a significant difference in the amount of alcohol consumed. The table below details the differences and the levels of significance

Table 8 Comparison of weekly units consumed to marital status.

	P value
Single(M=25.90 SD=17.90) Married (M=11.05 SD=9.66)	P=0.000
Single (M=25.90 SD=17.90) Divorced (M=10.4 SD = 13.83)	P=0.000
Single (M=25.90 SD=17.90) Separated (M=12.5 SD=13.17)	P=0.017
Single (M=25.90 SD=17.90) Co-habiting. (M=5.62 SD=6.74)	P=0.000

Marital Status and measures of mental wellbeing.

The GHQ score was measured along with marital status. The mean scores of the GHQ were compared. There was a significant difference between those who are separated (M=4.5 SD =3.13), and those who are married (M=10.87 SD=5.0) p=0.00. When analysed using the GHQ subset of depression/anxiety, married people scored significantly higher (M= 8.07 SD= 2.11) than singles (M=7.01 SD=1.28) p=0.001; and also those who are separated (M= 6.0 SD=2.10) p=003. The groups were also analysed using the GHQ subscale of social dysfunction. Those who were divorced scored significantly higher (M=12.8 SD=2.27), than those who were married (M=11.51 SD=2.31), p=0.00; those who are single (M=10.93 SD=0.31), p=0.00; separated respondents (M=8.0 SD=2.10) p=0.00 and those who co-habit (M= 11.00 SD0.00) p=0.001. These was no significant difference between the groups in the loss of confidence subscale.

Table 9 GHQ Score v Marital status

GHQ Score v Marital status	Significance
Married M= 8.07 SD= 2.11 v Separated M=7.01 SD=1.28	p-0.00
single (M=10.93 SD=0.31) v ; separated (M=8.0 SD=2.10)	p=0.00
single (M=10.93 SD=0.31) v (M= 11.00 SD0.00)	p-0.00

Employment Status and Alcohol Use

When employment status and the 'number of days alcohol was used' were analysed there was no significant difference between groups. There was no significant difference between the groups in terms of the units of alcohol consumed or the measure of alcohol usage since coming to Northern Ireland.

Employment status and measure of mental well being

There was no significant difference in GHQ scores between the different 'employment status' groups. However there was a significant difference for the anxiety/depression subset. Unemployed scored significantly higher (M=8.38 SD=1.75) against the employed (M=7.56 SD=1.81) p=0.39; and also compared to homemakers (M= 6.83 SD=1.02) p=0.027. There was a significant difference for the subsets of 'loss of confidence' between those who are unemployed (M=11.79 SD=1.79) and homemakers (M=10.08 SD=1.08) p=0.037.

5.7 Strength and direction of relationships between two variables.

Within this research the underpinning theory was that migration effects mental health and that an increase in alcohol use and/or substance abuse may be an indicator of the trauma of migration. Therefore in this section of the analysis the investigation in the relationships between indicators of mental health; i.e. GHQ scores and subsequent subsets, and measures of alcohol use will be presented. For example, increasing alcohol use since coming to Northern Ireland and number of days alcohol consumed. When analysed it was found that there was a small relationship between GHQ score and an increase in alcohol use since coming to Northern Ireland, correlation 0.282, p=0.00. When analysed further by GHQ 12 factors, there was no significant correlation between increase in alcohol use and the anxiety/depression factor, however there was a small positive correlation of 0.219 for the loss of confidence factor p=0.001 and a medium positive correlation of 0.344 for social dysfunction, p=0.00.

When mental wellbeing was analysed along with number of days alcohol consumed in the last month a number of correlations were identified. Firstly there was a significant positive medium correlation of 0.306, p=0.00 for number of days alcohol was consumed and GHQ score. There was a small significant positive correlation of 0.227, p=0.001, for alcohol consumption and the anxiety/depression subscale. There was also a small significant correlation of 0.269 p=0.00, between alcohol consumption and the social dysfunction subscale. Finally in this relationship analysis there was a significant positive medium correlation of 0.345 p=0.000, between alcohol consumption and loss of confidence.

These measures of mental wellbeing were also analysed alongside the number of units of alcohol consumed in one week. There was no relationship between the number of units consumed and GHQ score, anxiety/depression or social function. However there a small significant relationship of 0.159, p=0.023 between number units consumed and loss of confidence.

Since the measure of anxiety/depression, loss of confidence and social dysfunction are derived from the GHQ score it is of no value analysing them for relationship strengths. However the measure of alcohol use are independent of each other so it may be of analytic value to investigate any relationships.

5.8 Alcohol Use Analysis

Firstly there is a very strong significant positive correlation of 0.536, p=0.00, between number of days alcohol was consumed and the number of units of alcohol consumed in the last week. There was also a strong significant positive correlation of 0.635, p=0.00, between the number of units of alcohol consumed in the last week and an increase in alcohol consumption since coming to Northern Ireland. Furthermore there was a significant strong positive correlation of 0.503, p=0.00 between the number of days alcohol was consumed and an increase of alcohol use since coming to Northern Ireland.

5.9 Conclusion

In conclusion the data sets identified the demographic make-up of the population study. It highlighted the employment status and the income levels of the migrants who responded to the questionnaire. The data collected was then presented in terms of alcohol use and drug use. In turn, it attempted to identify links between different variables made including the links with the General Health Questionnaire (GHQ12). The data on its own does not give conclusions and needs to be taken into consideration within the wider context of the thesis. The data presented in relation to these variables may be associated with the move to a new country and the deterioration in mental health or a coping strategy to deal with mental distress. These issues will be discussed in the discussion chapter.

Chapter 6
Qualitative Findings; Migrants

6.1 Introduction

As highlighted in the literature review and the theory chapter, a number of issues exist in relation to access to mental health services for migrants in many parts of the world. Understanding different country's health service systems, language barriers and definitions of problems are all pertinent issues. Anecdotal reports from community workers here in Northern Ireland indicated that there was an increasing number of migrants, particularly Polish, who were using crisis services for people who have substance misuse problems. The issues facing these individuals was that due to their substance misuse, they had faced issues within their family, problems with their tenancy from their landlords, access to employment and maintaining their employment. Furthermore, it was indicated that many of the migrants were not registered with a GP and were unaware of how to access voluntary or statutory services to help support them with their substance misuse issues. With this in mind it was therefore necessary to discuss on an individual level the unique accounts of peoples experiences of their problems with substances here in Northern Ireland and their experiences of accessing support and assistance where applicable.

Within this chapter the findings of the semi-structured interviews with migrants will be detailed. The unique accounts are catalogued and the findings will be structured in themes, as it was evident when conducting this phase of the research that there were re-current themes. The unique experiences told in this phase of the research in conjunction with the findings of the other phases give depth and understanding to issues as a whole. In total 18 individuals gave up their time to recount and divulge their issues with alcohol and other substances, and also discuss their personal journey from their homeland in Poland to Northern Ireland.

6.2 Aim

The aim of the semi-structured interviews with service users was to explore the individuals' views of seeking help and support for their substance misuse and their experiences of service provision. The focus was mainly on their experiences since coming to Northern Ireland; however the interviewees were also encouraged to reflect upon their experiences in Poland.

6.3 Objectives

The objectives for this part of the study were to explore service users' experiences and views of both statutory and voluntary services they had accessed. The interviews also explored individual's personal experiences of taking substances and alcohol. The following objectives help to structure and explore the issues.

1. Individuals' personal information and background.

2. Migration history, particularly focusing in on who they travelled with, why they left Poland, why they came to Northern Ireland and their experiences of migration.

3. Alcohol and substance abuse/misuse.

   a. Drinking/substance misuse pattern in Poland

   b. Changes in drinking/substance misuse since coming to Northern Ireland, quantities, method of drinking and lengths of abstinence if any.

   c. Triggers to increase

   d. Impacts of alcohol/substance misuse on family, work, life.

4. Help seeking behaviour

   a. Reasons for seeking help

6.4 Methodology

A semi-structured interview was used to explore some of the key areas within the aims of the research. The interviews were structured in a way to explore each area individually. Participants were encouraged to speak in Polish because from literature reviews it has been found that individuals are able to discuss emotional problems and explain personal problems a lot more clearly in their native language thus a translator was used to aid the interviewing process. As highlighted in previous chapters there are issues in terms of ethics with using a third party however the depth, insight and quality of the interview are increased as long as ethical considerations are adhered to and acted upon.

6.5 Research Findings

In the following sections the research findings will be discussed according to themes derived from the thematic analysis. It is from these themes that conclusions may be drawn from the research questions presented. Firstly however characteristics of the sample will be discussed

6.5.1 Sample Characteristics

A total of 18 polish adults were interviewed throughout Northern Ireland. Just over three quarters of interviewees were male. The interviewees were aged between 25 and 58 years of age, and had accessed a variety of support services, including homeless hostels, drop-in centres, community addiction services, substitute prescribing programmes, in-patient addiction treatment programmes, and self-help groups in the form of Alcoholics Anonymous (AA). Of the eighteen, twelve were employed and six were unemployed. Sixteen of those interviewed live in rented accommodation while two lived in a squat.

Table 10 Sample characteristics of service users

	Male	Female
Employed	12	2
Unemployed	2	2

6.5.2 Migration

As stated, all those interviewed are Polish migrants. This next stage of the interview set out to explore the migration path and explore the reasons for coming to Northern Ireland. The main reason for coming to Northern Ireland cited by the interviewees was economic reasons. All but 1 of the 18 respondents came here to look for work or take up jobs that were offered to them. Whilst each individual migration path was uniquely different, there are some similarities among the migratory paths.

One young man described how he came over from Poland to set up a home;

> *'When I come over first I was here 7 months on my own, my wife said I needed to rent house first, and get stuff for the house, for her and the children'.*

Another man describes how Northern Ireland was his destination after travelling to different countries in the EU;

> *'I think in 2001, I went to different countries across Europe, and travelled. And when Poland became part of the EU I lived in Manchester, Liverpool and Sheffield. In Sheffield I was with the Salvation Army after I had started drinking again. I stopped then travelled to Northern Ireland...... Before I would have worked in different countries in Europe I would have only stayed a few months, but since coming to Northern Ireland I feel a lot more at home here I like it and that I can stay and be happy.'*

One female described how she came to work for a company after attending a recruitment fair in Poland;

> *'I came along with a group of people to work for a company who I had a contract with here. After some time many went back home but I stayed..... I had been in Northern Ireland in Dec 2003 to Jan 2004 and I liked it. When I had the opportunity to get a job here I thought I would like it. I also wanted to leave my past behind and seen this as a chance of starting a new life'.*

The theme of starting a new life and leaving the past behind was evident in 50% of the transcripts analysed. One interviewee stated that the reasons for coming to Northern Ireland were,

> *'for economic reasons, to find better paid work, and better quality of life'.*

Another male stated that his parents wanted him to travel here to stay with his aunt so that he could;

> *'start over and make a life for myself, as I had made a few mistakes in Poland.*

Another young man stated the reason for coming here was,

> *'Better money, better life, quiet life, so I thought I would try it . And now my wife is here the children are in school, we don't want to change our life'.*

It would be apparent there were family links to migration. One man stated that,

> *' I came over on my own but was coming to join my brother in law'*

Others had similar family support during migration.

> *'It was my wife who came first and then I came over 6 months later. She came over with her sister'.*

Another stated;

> *'I came here to join family as I knew I had somewhere to stay until I found my own place'.*

One lady explained that ;

> *'my sister and her husband came over here and I joined them a few months later; they helped me find an apartment and a job'.*

One women stated that there seemed to be more opportunities in Northern Ireland.

> *"I had family already here so I was able to stay with them until I had myself sorted out with job and somewhere to live"*

One man who came here to support a family member then stayed because of the economic prospects, he stated;

> *'I didn't come to Northern Ireland for employment or financial reasons. I came to be with my daughter. She had lost her baby during pregnancy 2 years ago. So I came here 2 years ago . ...The company I now work for is a good company and the manager and the other workers treat me well'.*

One man described how he came to Northern Ireland first to establish a home for himself and his wife and child.

> *"I came here with my brother to look for work and find a home for me and family. Once I had regular work my wife came over"*

It is therefore apparent that the family links do influence the creating of migratory paths. It is also the experiences of those family members that encourage others to travel, with their hopes of a better life. This hope of a better life was voiced by the majority of those interviewed, as all but one travelled here for economic reasons, and many have settled here. One lady stated that she did not miss Poland and stated that;

> *'I keep in touch with my family and I'm happy with that'.*

When asked about the positive aspects of Northern Ireland she replied;

> *'There are many reasons, the first is the life is more peaceful and quiet and people are very open, helpful and kind'.*

This was a similar experience by another interviewee when he stated

> *' life is very easy, a lot slower, in Poland everyone wants to go fast faster all the time, so to get more money everyone is working more all the time'.*

Although people are battling their addiction in a strange country they still feel happy to stay and work through their problem as they see many positives in the society in which they are now living.

6.5.3 Relationships

At the beginning of the interview the focus was on the interviewee's relationships to determine if they were in a relationship and how the relationship had been affected by their alcohol or substance use. Through analysis the relationship status was broken down into a number of categories. The following categories were devised.

Table 11. Relationship status of service user

Categories	Count
Married and living together	5
Married or in a relationship and living apart	6
Divorced	3
Not in a relationship	4

When discussed and asked about their relationships all interviewees indicated that their alcohol or substance use had affected the relationships they had been in, or their ability to form new relationships.

One interviewee who was still married and had young children stated that his alcohol use had caused severe strains on his family life including financial pressure.

> *"Well it was very difficult on my wife, I was spending too much money and there wasn't enough money for food, so that was a big problem. She gave me a choice, drink or her and children".*

Another interviewee described how he had been divorced twice and he would insist that alcohol was a huge contributor to his relationship breakdowns. He also described how his family relationships had been affected by alcohol. He stated that,

> *"I'm not in contact with my family, I just would contact my brother at Christmas time and send best wishes".*

Another interviewee who is married for the second time stated that his first marriage suffered because of alcohol use. He stated that his drinking got worse during relationship difficulties.

> *" …. when my first marriage broke up I was drinking for two-three days every two weeks, all day drinking and it was beer that I was drinking. After my marriage broke up I was drinking every time I had a problem with something. I would start by drinking beer then go to Vodka".*

The same interviewee was asked about the effects of alcohol on his current relationship and if it is being affected. He responded by stating that;

> *"Yes my wife has helped me to seek help here in Northern Ireland and when she had our child in the hospital I was not there as I was away drinking".*

Another interviewee when asked about his initial problems with alcohol stated that;

> *"Initially I used to drink on social occasions, but when I had marital problems my drinking got worse and became a problem".*

When expanding upon this the interviewee stated that;

> *"When I think back now the marital problems were probably because of my drinking and also the difficulties in moving to a new country".*

One female interviewee reported that she had relationship problems and alcohol did not help matters.

> *"When we (me and my partner) came to Northern Ireland we had hope and excitement, but my alcohol use damaged the dreams we had".*

She continued by stating that ;

> *"Our problems and experiences got worse, and so did my drinking, he was then working for the two of us, and I was drinking a lot of the money"*

In further discussions about family relationships, one individual disclosed how his relationship with his children had been affected by his use of alcohol. When asked has your drinking affected your relationship with your child in Poland, he replied,

> *"Yes, although me and his mother argued I then used alcohol which has had an impact on that relationship, I was not there for the child, and know my wife and my child has moved back to Poland".*

Half of those interviewed stated that they were in a relationship or married, however were living apart from their partners. When this was questioned further it was revealed that alcohol or substance abuse had played a part in their decision to live apart. One lady stated that,

> *'I know I have a problem, but I feel I can deal better with the problem when I live apart from my family.'*

One man commented that,

> *'if I was living at home I think my wife and I would have been divorced by now....because of drink'.*

One of the married interviewees explained that here in Northern Ireland it's difficult to deal with family and relationship issues because of the limited support mainly due to language barriers.

> *"When we have problems we can't talk to others, like counsellors, or family, instead I drink more".*

This section of the interview set out to explore the individuals' alcohol and or substance misuse. The issues that were discussed, the levels of use prior to migration, levels of use after migration and triggers to increased use or relapse. Each of the interviewees had a different story to tell about the use and development of their problem. From the analysis there were two distinct groups; those who had a problem before coming to Northern Ireland however the migration process seemed to amplify or trigger a relapse and those who developed a problem since coming to Northern Ireland.

Eight of the eighteen interviewees stated that they had an issue with alcohol or other substances before coming to Northern Ireland. One man interviewed said that in relation to his alcohol problem;

> *' it started when I was working in Poland about five years before I left to travel, whenever there was stressful situations to do with work I would drink'.*

Another man stated that when he migrated in the past his alcohol use increased;

> *'When I went to America I was drinking every day. When I was in Holland I was working a lot more but still I was drinking in the evenings and every weekend'*

Although he has not drank since coming to Northern Ireland he feels the need to attend Polish AA. He stated that;

> *'The group gives me support and people who understand. I have my mobile phone and at anytime I can phone people from the group. I know when I could drink, so I just phone and that helps me to stop'.*

He also described how migration was a trigger to his relapse and he stated in relation to migrating;

> *' I soon realised that the longer I stayed away, the more chance I would drink, that is why I would just go for maybe 3 months at a time'.*

Another lady who had been abstinent for a few years felt she needed to seek support to prevent relapse upon her arrival in Northern Ireland. She described drinking socially since she was 17 years of age however her use developed into a problem.

> *'Initially I used to drink on social occasions, but when I had marital problems my drinking got worse and became a problem'.*

This lady has been abstinent from alcohol for a few years but decided she needed the support to maintain her abstinence. She stated in relation to her group she attends

> *'Many times I have been tempted to drink and people who are addicted to alcohol understand the feelings and moods of each other so when I'm tempted to drink I can call my friends in the group'.*

In specific reference to migration and her alcohol re-use the lady states that

> *'I think that there are maybe new problems that occur that lead to temptation, the language differences can be stressful, and trying to understand how things work like health and benefits is also a stressful problem'.*

One young man had a substance problem in Poland came to Northern Ireland to stay with family in order to get a job, and leave his problem use behind him however he stated that;

> *"I was here (Northern Ireland) for 4 months and had a job as a forklift driver and hadn't used, but was finding it difficult to be away from Poland, I felt lonely. I soon met someone who I could get my gear (heroin) from. I was back using".*

This theme was strong in that 7 of those individuals who were abstinent upon arriving in Northern Ireland referred to migration as a stressful situation where relapse could have occurred. One man stated that,

> *'Coming to a new country, new challenges new problems. I had problems back home..., it was only when I came to Northern Ireland that the problems of homelessness started'.*

Another interviewee felt that the stress of migration had triggered a relapse but he also stated that,

> *'There is certain things about Northern Ireland that I feel makes it harder. Alcohol is in lots places around you, shops, in posters and on TV'.*

One other interviewee stated that he had been abstinent for six years with the help of therapy in Poland and since he has been in Northern Ireland he felt he needed the support from his counsellor for relapse prevention.

> *' I find it difficult to cope with normal day to day things because of language, and the different culture...this can be a temptation to use alcohol'.*

One interviewee who would describe himself as a binge drinker states that since migrating to Northern Ireland his binges have increased;

> 'Well I still would go away from 4-5 days to drink but I would go maybe 2 or 3 times a year instead of once a year'.

One female interviewee stated that loneliness was a big problem for her to deal with

> "In a country with a different language and different life you can be on your own a lot with your thoughts and feelings, this is difficult".

The responses from this group of individuals indicated that the migration experience seems to trigger relapse or the temptation to relapse. The second group identified through thematic analysis comprised those who had developed a problem since coming to Northern Ireland. Over half of those interviewed stated their drinking was not problematic in Poland. When discussing the amount and frequency of their use in Poland none of the individuals disclosed any traits that would be described as problematic. One young Polish man described that whilst his drinking initially remained at the same level in Northern Ireland as it was back in Poland , it gradually became more of a problem over a period of time.

> 'I was drinking one big bottle of vodka, 70cl bottles, at the start, every weekend and maybe some beer along with it for a better kick. And then I started to have a few glasses after work. I seen Irish people having a drink after work so I would have a drink as well, not getting full drunk just happy. So then I was drinking every day, and I think that is when my problems start you know'.

Another young father described how since coming to Northern Ireland his drinking had impacted upon his family life;

> 'Well it was very difficult on my wife, I was spending too much money (on alcohol) and there wasn't enough money for food, so that was a big problem'.

One man states that when he lived in Poland he wouldn't have been a 'drinker', however things changed when he came to Northern Ireland.

> "In Poland I just drank at family gatherings like weddings, and birthdays, but here I was drinking at weekends, then my days off and eventually everyday".

One Polish gentleman spoke of his cycle of drinking and then stopping.

> "I never had a problem with alcohol, but soon in Northern Ireland I found myself drinking for 3 or 4 days in a row then stopping and going to work for 4 days as I worked shifts then drinking when I was off".

The binge style drinking also was reported by a lady who prior to migration drank maybe once a year in Poland.

> *"My problem could be described as binges, where I drink for 3 or so days then I stop when I can't drink anymore because I feel sick. I take a few days to recover then I do the same again, I know it is madness".*

6.5.4 Boredom – Social Isolation

One lady who was referred to seek support by social services explained that her husband worked shifts in a local factory and she started to drink on her own in the evening through boredom and loneliness.

> *'I was fine in the beginning but as time went on I drank more often and drank a lot more'.*

She continued to explain that when she had children it was difficult for her to get out to see friends and she spent many evenings in on her own.

This theme of boredom and social isolation seemed to re-occur across both groups.
One gentleman stated that

> *' In Poland I would have went to the gym, but here when I come home in the evening I was too tired to go to the gym, so I would have just had a few drinks and went to sleep. Then it builds up and gets worse".*

Another man explained that the weather prevented him from interacting socially,

> *'I also feel that the weather makes it harder, as lots of times you can't go to the park or out places and you end up staying inside, then drinking'.*

This isolation extends to other aspects of life including work and welfare provision.
One lady stated that

> *'the language differences can be stressful, and trying to understand how things work like health and benefits'.*

One young man added to this by explaining,

> *'I felt cut-off from the rest of the world, everyone was doing their own things, I had nothing to do, no places to go, no people to see......I would drink for comfort'.*

This theme of isolation is encapsulated by a statement from one of the interviewees when he stated that;

'when I come here I was excited and soon I realised I was on my own,
different people, different language, different streets, so I would drink when I
came home from work to make it feel a bit better...that is when I think my
problem started'.

6.5.5 Honeymoon Phase

This idea of coming to a new society and having a honeymoon phase was a theme
identified in the interviews.

It was evident that there was a period when people felt resilient to the pressures of
migration however soon felt the need to use alcohol. A male stated that after one year
he realised his drinking was becoming a problem,

' I found myself drinking every day, but back in Poland I wouldn't even have
drank every weekend, just at birthdays, weddings and things like that'.

Another young man (aged 25) stated that he didn't realise he was drinking so much
until it was pointed out by a family member;

'They came over to join me after 8 months and they ask why are you drinking
so much,.... I was on my own and I didn't realise how bad it had got'.

Another young woman spoke of how she started to miss home, and although
she could telephone, it wasn't the same. She stated that,

"I was OK at the start I got on fine, but it became habit for me to ring home
every 2 days then I would drink maybe a bottle of wine after the phone call,
soon I was mixing vodka with the wine too, it made me feel better at the time".

Even with those who had been identified as having a problem before coming to
Northern Ireland there was an expression of a 'honeymoon phase' in that there was a
period of hope and optimism whereby for an determined period of time things seemed
to be going fine and there was an air of excitement and prosperity with the new
country of residence. One lady stated;

'I was off alcohol for two years before coming here and after 6 months I felt
the need to drink, I was very lonely and had very few people who could speak
Polish. At the start I was excited and happy, but soon I was anxious and sad."

There was a similar experience by a 39 year old man who stated,

"I came here in the second year of my sobriety, nearly two years sober, but
after 4 months things started to get on top of me and I relapsed".

One man who had travelled to a number of countries in his lifetime stated;

> *"When I came here things were good, I was working, I had accommodation and felt good, but after six months I felt pressures in work and started to drink".*

An older gentleman shared his experience of the 'honeymoon phase' by stating that;

> *"I was excited coming here to be with family, new country, new life, and it was good for a while, maybe 7 months, but soon I started to crave alcohol and again I was battling my addiction".*

This idea of migration being a stressor and leading to relapse or potential relapse was encapsulated by the fact that a number of those attending a Polish speaking AA group in Belfast were abstinent before travelling to Northern Ireland, however after their arrival they felt they needed to seek support to maintain abstinence or they relapsed and then needed the support to obtain abstinence again. In relation to help seeking this was one topic in particular that was explored.

6.5.6 Help Seeking.

Questioning around this area was directed to interviewees so that an understanding was developed of their experiences of trying to seek help and also of their knowledge of how to access services. Another aspect of this was to explore individuals' experiences of the help and support they did receive both from the statutory and voluntary sector. This aspect of the research was designed in line with the research question and in particular Aim 2, To investigate service users' experiences and perceptions of drug and alcohol services in the Province, and Aim 4, to identify gaps in service provision.

From the analysis a number of themes were evident including perception of the support and help available in Northern Ireland, confusion in relation to treatment and support and how it was offered. In Poland there is a very different system compared to Northern Ireland as outlined in Chapter 5. This was evident from the comments that some of the interviewees made. One young man stated he "locked himself down" at home for a week and didn't drink.

> *"In Poland people who are on the drink and they want to stop then they just get locked down so I decided that's what I do".*

He described that this is often the process back in Poland where people who have alcohol problems are 'locked down' in rehab for a number of months to complete the detox and then counselling. When asked about his pathway to care he described how

that it was his wife who suggested he contact his GP for support with the physical withdrawal. This lack of knowledge and awareness was apparent in many of the interviews conducted. One man in particular stated that;

> *'I have a GP here, but I have not spoken to him about my problem, I thought that I would need to see a psychotherapist about my problem'.*

An intravenous drug user stated that he realised he had a drug problem but didn't know how to get help or who to approach. He stated that,

> *'My dealer's mother told me how to get help through my GP, if she didn't I would not have got help'.*

This issue around lack of knowledge of GP access was further pointed out by another interviewee who stated that he attended his GP with a general health problem and it was the GP who made him aware of services that could support him with his alcohol problem,

> *"I went to my GP as I had stomach problems and pain in my side. He started to ask me how much I drink and when I told him he offered me support and help to cut down or stop my drinking. I didn't know my GP could refer me to get help".*

Ten of those interviewed were attending voluntary support services like AA. When this particular group were asked about their knowledge of care pathways, none were aware of service access via their GP. A recurrent theme was summarised by one lady who stated that

> *'In Poland I would not have used my GP for my alcohol problem so I thought it was the same here in Northern Ireland'.*

This point was shared by another male who stated that

> *'I didn't know I could go to my doctor about my alcohol'.*

Another man who had been abstinent for two weeks stated that

> *'I haven't heard of any places to get more help and wouldn't know where to go'.*

Of those accessing non-statutory support services their pathway to care has been similar in that many detail how word of mouth and recommendations of friends has helped them to access support. One man described how he had come into contact with a support organisation;

> *'About 3 years ago, I was drinking heavily, with some friends, drinking friends, not real friends. We stayed in a park for a week or so and were*

sleeping there. Once our drinking had slowed down one of the guys had heard of this centre close to the church. It was somewhere where we could get washed, shaved, brush our teeth and change our clothes' and get something to eat'.

Another man explained how in Poland he was able to stop drinking by himself but he had started again when he came to Northern Ireland. He was unaware of services available or how to access services and he explained that a friend recommended a Polish AA group.

"I have a friend who like me has a problem with alcohol. I was explaining to him that I wanted to stop drinking but needed help to do so. He told me about Krokus (Polish AA) and that is why I am here.

One other gentleman who had attended community addiction services was informed of the AA group by the community addiction worker as an additional support.

The Polish AA group in Belfast had a rolling membership of thirty five. Many of those who I interviewed stated that it was word of mouth and informal recommendations that led them to accessing the support.

6.4.6 Interpreting Services

One of this issues that is apparent for those who attend their GP or 'talking therapies' is the use of a translator or interpreter.   The Department of Health and Social Services co-ordinates and facilitates an interpreter or translator when requested for the use of patients whose first language is not English. The translator needs to be booked at least one week in advance.

Of those interviewed over half had used an interpreter when visiting their GP or community addiction worker. One interviewee declined the use of an interpreter during his sessions with the community addiction worker. He stated

 'I didn't ask for a translator because I know I can speak good English'.

One women also commented that at her initial appointment with her GP she was accompanied by her daughter who acted as a translator.

> *"My daughter came along with me to the Doctor as she can speak good English, and I don't like talking about my problems with a stranger".*

Of those who used translators a number of themes were highlighted. Firstly there was issue of having a three way conversation. One man explained that,

'It is ok telling a doctor that you have a sore leg or a cold through an interpreter but talking about alcohol and your personal problems is different, it is more difficult'.

Another man stated that,

'When using a translator you have interruptions in what you are saying and then you forget what you wanted to say'.

In another session one man spoke of his frustration due to his inability to speak openly because it was through an interpreter. He stated

'I find it hard to talk about how I have become an alcoholic especially to a stranger'.

This issue was felt to be exacerbated by the fact that a different translator would be present at the consecutive appointments. One man described how he felt that,

'Every week was like starting over again' ....,

When there was a different interpreter there. This point was reiterated by two others who stated

'It's difficult explaining over again each week with a new person', and it's hard to start to build up trust again with new interpreter'.

One interviewee highlighted the issue that she felt she was being judged by the interpreter because he didn't fully understand her problem with alcohol. She stated that;

'They look at you and make you feel that you have brought shame on the Polish people here'.

This issue around a lack of understanding and empathy towards the service user was highlighted again. An interviewee felt that not all the information was being translated correctly and also that some information was omitted from translation. One lady said that,

'When I explain my situation through the translator I think sometimes that they have not explained all because the Dr or counsellor doesn't react to what they have been told'.

One woman had informed me that she withheld information in a session because she didn't want to shock the translator with her story. She stated that

> *'I had been to social services and had been in a violent relationship, but I couldn't explain all the things because I felt I couldn't let the translator hear the bad things'.*

The issues faced by migrants using an interpreter seem apparent and could act as a barrier to achieving the full potential in a therapeutic relationship. This will be discussed in the discussion chapter when the issues are analysed along with the findings from the interviews with service providers.

6.5 Summary of research findings

The main reason for coming to Northern Ireland cited by the interviewees was economic reasons. All but 1 of the 18 respondents came here to look for work or take up jobs that were offered to them.

Different migration paths were taken but they included travelling with family, travelling to join family members, to take up a job that had been offered to them via a recruitment fair in Poland and to improve their life.

Northern Ireland was regarded as having a slower pace of life for most of those interviewed.

When asked about their relationships, all interviewees indicated that their alcohol or substance use had affected the relationships they had been in, or their ability to form new relationships.

When asked about the link with migration and alcohol use, there was a strong theme. Those who had an alcohol problem prior to coming to Northern Ireland indicated that the migration process was a trigger for relapse or a marker of when the alcohol use increased. Those migrants who were abstinent and remained abstinent since migrating felt they needed increased support since coming to Northern Ireland to maintain abstinence. Those who developed an alcohol problem stated that it developed after their migration to Northern Ireland.

Social isolation and boredom were quoted on occasions as triggering factors to increased alcohol use. This isolation includes language barriers.

A post migration honeymoon phase was experienced by many of the interviewees in relation to alcohol use.

In relation to seeking help and support for alcohol and drug misuse problems there was a lack of awareness of how to access support from statutory services. Some of the interviewees believed the system to be similar to that in Poland, which is not the case.

There was a clear lack of knowledge that the GP was the point of contact to access services.

Awareness of support services in the voluntary and community sector was via word of mouth.

Of those who had accessed services which involved 'talking therapies' there were a number of themes that emerged in relation to the use of interpreters. Firstly there was the idea that you were having a three way conversation which makes the session feel less personal. By using an interpreter there is a break in the natural flow of the conversation. The issue of interpreter inconsistency was raised and how in some cases a new interpreter was present every week which made the service user feel as if they were starting over again. There was also an issue that there was a lack of understanding and empathy towards the service user from the interpreter.

Chapter 7

Qualitative findings; Service Providers

7.1 Introduction

As discussed in previous chapters, research has indicated that there are issues facing migrants in terms of access to health services and support services if they have problems with alcohol or substances. This may be because of a lack of an understanding of different countries' health service systems, language issues or definition of what a problem is. There also maybe difficulties in providing services from a structural standpoint and at the point of delivery in terms of the availability of services and the understanding of the service providers of what is required. Within this chapter the findings of the qualitative phase of the research involving service providers will be presented. A total of 10 service providers gave their time to discuss the challenges in delivering services to the public in an ever changing society. This chapter details the findings looking first at the demographics of the sample and also the specifics of the services in which they work. There is a brief outline of the method used as a full account of the methodology is detailed in the methodology chapter

7.2 Aim and objectives

The aim of the semi-structured interviews, with service providers, was to explore the service provider's views and experiences of providing help and support to Polish migrants who had a problem or associated problems with alcohol or other substances. The interviews aimed to gain information in terms of quality and identify any specific themes that re-occurred among the service providers both from the voluntary and statutory sector.

The objectives for this part of the study were to explore service providers' experiences and views of providing services to migrants here in Northern Ireland. The objectives are in line with aims 3 and 4 of the study which sets out 'To Consider the views of service providers from voluntary and statutory services' and 'To identify gaps in service provision'.

7.3. Participants

Access to interviewees was facilitated through the statutory and voluntary organisations who care for and support individuals who have alcohol or substance misuse problems. These organisations include the community addiction teams in the Health and Social Care Trusts in Northern Ireland, the statutory based in patient

treatment units across the Health Trusts, voluntary drug and alcohol treatment units, voluntary run drop in centres across Northern Ireland, homeless hostels across Northern Ireland and self help groups aimed at supporting individuals with alcohol or drug problems.

Each organisation was contacted initially and details of the research were given. It was explained that the research project was looking to interview members of staff for the purpose of research. A service provider participant information sheet along with the interview schedule was forwarded to the organisations. Each month the services were contacted to see if any members of staff had provided support and care to Polish migrants. If they had then they were given the opportunity to share their experiences for the purposes of the research.

If the service provider was interested in participating an interview date and time was arranged at the convenience of the service provider. It was explained to the service provider the process of the interview and the reason behind the research. They were made aware of the topics to be covered. The service provider was made aware again that participation was voluntary and they could withdraw from the research process at any time. The service provider was also reassured that they did not need to answer any questions they didn't want to. All this information was also provided in the 'Service Providers Participants Information Sheet'.

7.3.1 Consent & Confidentiality

As with all research involving humans it is necessary to obtain consent from the participant. It is also necessary to obtain consent for the information they give to be used in the research report. The consent was provided at the beginning of the interview by the participant. The participant was also made aware that the information provide will be completely confidential and anonymity will be maintained. It was explained that the only circumstances where confidentiality would be breached was in the event of a disclosure of information which indicated that the individuals were at risk due to lack of action by the service.

7.4 Interview Structure

The service provider was introduced to the topics to be discussed and asked if they were happy to proceed. It was also explained to service providers that the interviews would last for no more than one hour. Section 1 was used to discuss personal

information; position within the organisation, role and function, professional background, and length of time in position.

Section 2 was designed to explore the service characteristics. This included questions in relation to type of service provision, level of service provision; tier 1 to 4, funding, ethos of service, referral route and client acceptance criteria.

Section 3 of the interview was designed to focus on demand for the service from migrants particularly Polish. Service users were asked to quantify demand over a period of three, six and twelve months. This was to enable the researcher to measure changes in demand over the previous year.

Section 4 of the interview was designed to explore the specific needs of migrants from the perspective of the service provider. This included perceived barriers to effective service provision, providing a therapeutic service to someone whose first language is not English and who has a perceived cultural difference. Other areas of questioning focused in on the service providers' perception of how well the service is equipped to deliver fully to those people from different migrant groups such as the Polish community.

The final part of the interview set out to capture the service provider's unique evaluation of the service based on their experiences. They were asked about their ability to provide a service to members of the Polish community and issues that arose, in delivering a full service to those clients. From their experiences they were asked what service gaps they may have identified in service provision to migrant communities?

7.5 Data Analysis

The interviewees were recorded live by dictaphone at the consent of the interviewee. The interviews were transcribed and compiled by the researcher.

The transcripts were analysed thematically. This process was designed to identify any emerging themes from qualitative data. Initially the transcripts were reviewed to highlight key points in the responses. With each question certain points or themes maybe discussed. These themes were then aligned to the questions. A matrix was developed where theme clusters were devised. The clusters were then analysed to elicit emerging themes,

This type of analysis was conducted for all the topics that were discussed within the interview.

7.6 Research Findings

In the following sections the research findings will be discussed in terms of emerging topics. The topics will then be grouped in themes as the analytic process indicates (Braun & Clarke 2006). There will be no ranking of importance as each service provider's experience was treated with equal importance. It is from these themes that conclusions may be drawn from the research questions presented. Firstly however sample characteristics will be presented.

7.6.1 Sample Characteristics

A total of 10 service providers were interviewed throughout Northern Ireland. From the voluntary sector three service providers were interviewed; one of which was a manger of an organisation and the two others were support workers. All of the voluntary organisations were based in the Belfast area. Seven service providers were interview from the statutory sector, and there was a variety roles ranging from community addiction workers, drug arrest referral worker, Consultant psychiatrist, and a Polish speaking GP. In terms of geographical location, two service providers were based in the Southern Trust, three within the Northern Trust, one in the Western Trust and one in the Belfast Trust. All service providers had experience in working with members of the Polish community who had an alcohol or substance misuse problem.

7.6.2 Professional Background and experience.

At the initial stage of the interview, respondents were asked about their position and role within the service and also their professional background. Nine of the respondents had a face to face role with service provision to service users. One person who was the manager of the service did on occasion have contact with service users. A matrix was devised of the professional background of the interviewees. In terms of experience measured in time there was a huge amount of experience in the provision of services, this has also been included in the matrix

Table 12 Professional Background and experience

Professional Background	Number	Years Experience
Social Worker	4	35
Community Psychiatric Nurse	2	32
Medical/GP/Psychiatrist	2	35
Housing	2	6
Total	10	116

From the matrix it is clear that between the various professions there is a vast amount of experience in providing service to people who have alcohol or substance misuse problems.

7.6.3 Service Characteristics

Through analysing thematically the service characteristics was broken down initially into two distinct categories, voluntary sector and statutory sector. However after further analysis it was realised that not all statutory services were similar in their role and provision, and that not all voluntary services were similar. It was also realised that some of the services overlapped, supported and complimented each other in their function. As discussed in chapter 2 the addiction services within Northern Ireland operate as a tier model of provision. Each particular service works within a particular tier.

7.6.3.1 Community Based Addiction Service.

The role of the community based addiction workers is defined by Government policy set out in the strategic direction for Drugs and Alcohol. Community based addiction treatment services would be described as a Tier 3 service under the National Treatment Agency for Substance Misuse (2006). From the ten service providers that I interviewed four were based within the community addiction services within statutory agencies. Two were social work trained and two were Community Psychiatric Nurses. Even though they were based in three different Health and Social care Trusts across Northern Ireland their roles were very similar in that they are tasked with providing therapeutic support to individuals who have problems with alcohol or substance misuse. The services which they provide, focuses on reducing, controlling or total

abstinence for the substances which the service users have a problem with. Education is provided and where necessary referral to additional services is often advised. One worker described how 'the service within which we work offers support in the community to those who are looking for support to abstain or reduce their alcohol or drug use. We also offer a follow-up service to clients who have been treated within the inpatient treatment programme'.

The community addiction service within the statutory sector is heavily influenced by a medical model of care. One worker informed the researcher during the interviews that community based alcohol detoxifications are becoming more and more prevalent. One worker was tasked specifically to work with individuals from A8 countries who may have specific mental health issues, housing issues, and family problems which may involve social services.

7.6.3.2 In-patient treatment

In-patient drug and alcohol treatment is provided by a number of service providers in Northern Ireland, including statutory health trusts, voluntary organisations, Church and religious organisations. There are no privately run in-patient facilities in Northern Ireland. In-patient addiction treatment services would be described as a Tier 4 service under the National Treatment Agency for Substance Misuse (2006).

The programme of care provided by the in-patient facilities varies across Northern Ireland. Some statutory facilities offer medically assisted alcohol withdrawal; however this is not available with the other facilities. The statutory services also provide substitute prescribing and medically monitoring in relation to this programme of care. All the facilities offer therapeutic counselling on a one to one basis or in a group environment. The length of treatment varies from two weeks to eight weeks. One interviewee who was based within an in-patient treatment facility described how, 'the in-patient treatment facility provides an intense level of therapy in an environment which is conducive to the care provided, there is the additional benefit of having staff available to address any medical issues associated with alcohol or substance withdrawal'.

7.6.3.3 Housing/homelessness day and night shelter

One of the problems and consequences of addiction are issues in relation to housing; family breakdown, breakdown of tenancy and homelessness are all realistic problems.

Because of this factor service providers in the housing/homelessness sector were invited to participate. During the research it was discovered that a number of organisations within the Belfast area were supporting Polish people with homeless issues because of their alcohol or substance misuse. Two service providers from two different organisations were interviewed. The first organisation was a day centre specifically working with individuals who have mental health and addiction issues. The service provides hot food and a place where the clients can get a shower and wash their clothes. The service also offers additional support in terms of offering to organise GP appointments and links with other statutory services. The service is run by a voluntary organisation and does not open at the weekends.

The second organisation was a homeless hostel which provided emergency overnight accommodation for individuals who are homeless. This organisation offers clients the use of wash facilitie's a place of safety and shelter and a place of contact to engage with services. There is additional statutory support through nursing and mental health services which liaise with the night shelter.

7.6.3.4 General Practitioner (GP)

The primary way in which to access statutory mental health services within Northern Ireland and the UK is via the GP. The GP would assess patients and refer onto additional services if there is a need. During this research it was deemed necessary to speak with a GP who has Polish patients registered with them in their practice. Through investigations a GP was located who had a large number of Polish patients because the GP was in fact Polish. This led to the additional opportunity to discuss the system here in Northern Ireland compared to Poland.

7.6.4 Migrant Demand

After the roles of the organisation and worker were discussed the questioning focused on migrant demand. This varied depending on the organisation and location. The voluntary support organisations had the highest contact rates with individuals seeking help and support. One day centre reported that in a one year period they had seen approximately 40 Polish migrants. The manager stated.

> *"Initially we would have supported 5 Polish migrants in the first few months of this year but as the year progressed we would have seen more".*

The worker continued to describe how service users would then bring their friends to access support.

> "As the clients benefited from the support offered, they would then ask could they bring friends who were in a similar position. In the past month we would have supported 15 new Polish migrants".

When asked about the specific needs of the Polish service users, the worker explained;

> "As a homelessness support organisation, we aim to provide services to those without a roof over their heads; this can be wash facilities, hot meals and advice on obtaining accommodation. But sometimes the clients have other issues impacting upon their lives such as mental health problems and/or addiction".

A support worker based in a night shelter also indicated in an increasing number of migrants availing of the service, particularly Polish. The worker reported;

> "A year ago we would have supported 3 or 4 Polish migrants on a regular basis, but this has increased. For example, one night last week 12 of the 15 emergency beds were in demand by Polish migrants".

When asked about the perceived increase in demand, it was explained that;

> "As A8 migrants they have no entitlement to 'Housing Benefit' or very limited homelessness assistance so we find them regularly trying to avail of the crisis shelter".

Another worker based within the voluntary sector had seen an increase in demand also from A8 migrants particularly Polish males.

> "We have been seeing more and more Polish people over the last year. It is mainly young men. We were supporting 2 Polish men one year ago but now we would be seeing about 8 or 9 regularly".

The statutory service providers had not seen the increase in demand from Polish migrants on the levels that voluntary sector had seen. Each of the community addiction workers stated that they were only aware of 3 or 4 Polish migrants who had accessed their service. One worker in Belfast stated;

> "They (Polish migrants) have been slow accessing the mainstream service here, I know of only 3 Polish men who use our service, however we know of many more who could be using our service".

When further asked about his knowledge of 'many more who could be using the service' the worker explained;

> *"Our colleagues in the voluntary sector are seeing many individuals who could use our help, and who have been offered our help, but for whatever reason they don't seem to coming through"*

One worker based in the Northern Trust explained that their level of involvement with Polish migrants was low.

> *"In the past year I have worked with 2 guys, one of which is still on my caseload and whom I see regular, the other only came to see me twice".*

Another worker based in the same trust had only one Polish migrant on her caseload. She explained;

> *"My client was the first migrant I had worked with and found it challenging. I have been working with this client for the past two months and I am not aware of anyone in my team with who has a client of Polish origin"*

In the Western Trust the community addiction teams had similar experiences one of the teams had no Polish referrals into its service, while the other team had two referrals during the research time frame. One worker explained

> *"We've had two referrals in the past year, one of which attended for assessment and never returned, while the other attended for 3 months and was discharged after completing the plan of work"*

In another Trust one worker who was specifically in post to work with migrants and support them it terms of issues such domestic violence, child protection and alcohol and substance misuse, has seen a significant increase in their case load.

> *"Since the beginning of the year the number of referrals has increased and now I would have approximately 12 Polish migrants on my caseload, and 12-15 other Eastern European families".*

In the same Trust, the inpatient addiction treatment unit had only 1 patient admitted for treatment in the past year. The consultant whom was interviewed stated;

> *"We have had very few referrals for inpatient treatment for Eastern European individuals, and in fact there has only been one Polish lady who has completed the programme here".*

When a GP was interviewed in relation to their role and the level of contact with individuals who were Polish, the GP explained that because of the location of the practice and their ability to speak Polish then this GP had seen a significant increase

in terms of 'Polish' referrals. The GP further explained that often when people attend the GP it is not necessarily in relation to their alcohol problems.

> *"When a patient arrives they may explain that they have low mood, anxiety or maybe stomach problems, and when I ask questions I find out that they are drinking everyday, or for four days at a time. I then make a referral to the community addiction service. In cases like this I have made maybe 15-20 referrals in a year."*

7.6.5 Specific Needs of Migrants:

Under the next series of questions during the interview schedule, the aim was to ascertain the perceived needs of the migrants. Interviewees were asked questions in relation to what they perceived to be the main barriers to effective service provision for members of the migrant population.

There were a number of themes that emerged from this line of questioning. The first being the ability to provide appropriate services based on financial constraints. One interviewee within the community voluntary sector stated that

> *"Access to public funds in relation to migrant eligibility would alleviate the homeless problem."*

Another interviewee stated that,

> *"In order to deliver a service appropriate to the needs of these men we would need to employ a worker who understand the problems they face and also be able to speak their language, we don't have the money for that specialist role".*

One worker within the voluntary sector explained that,

> *"Housing Benefit which covers the cost of our service is not available to these migrants, so therefore we have to turn them away and offer the service to those in receipt of housing benefit".*

This additional theme of legislative restrictions was experienced by other community based organisations who were confused in relation to eligibility of services. A worker explained that

> *"We were confused about the accessibility of these clients to our service, we are here to help and support, however that help has to be paid for, this then adds to the confusion of the migrant clients who themselves don't know what they are entitled to".*

This issue was explored more with the service provider who was asked to elaborate on how they deliver a service.

> *"We provide emergency/crisis beds for homeless individuals. We have a group of regular migrant homeless men and women who present nightly. We have agreed that if we have available beds after midnight we will then offer the beds to the migrants".*

It was then clarified that there was a priority system in operation.

> *"Yes locals, or those in receipt of Housing Benefit, will be offered the crisis beds first. If they don't avail of them by midnight then we will offer them to the migrants. There is usually a queue".*

This is demonstration of a barrier to a service, however it was clarified how it was also barrier to other services. The worker explained

> *"When we have people using our service we then try and link them with other services, such as the day centres, ethnic support centres, even a nurse and the mental health teams"*

The statutory services continued with the theme of eligibility as a barrier to services. One community addictions worker explained that they believed,

> *"These people don't understand how to access help because they believe they are not entitled to help and support. Others don't know how to access services".*

One community outreach worker added to this by detailing an incident where migrant men were sleeping in the bushes beside the community addiction team offices and they approached them to offer services.

> *"Some of the guys could speak some English and they understood the support we were offering but didn't realise they could get our help. When they came to see us the receptionist, who was Polish, was able to explain clearly about the service. Some of them engaged and we were able offer education and some harm reduction strategies and also refer them on to other agencies".*

The lack of understanding of how to access services was voiced by many other service providers. A GP stated that some of her patients attended with symptoms associated with alcohol problems and she explained to them how to access support.

> *"My patients attend here with problems associated with excess alcohol use, for example stomach problems, falls, low mood and when I ask how much they*

drink and they want help they are surprised that I can refer to the community addiction service".

One community support worker also detailed this theme of service users not being aware of referral processes.

"I work with migrant families and when I'm aware of issues around alcohol or substance misuse I ask if the client would like support. Many haven't been aware of how to access services or what services are available".

In another statutory service the worker believes that language was a huge barrier to service access and service delivery. They stated;

"Much of the work we do here is talking therapies. It is very difficult to avail of a service when you can't understand what is being said, or even the questions that are being asked."

The theme of language as a barrier was expressed by many other service providers. One arrest referral worker stated that usually they offer support to offenders at the point of arrest, but often they are unable to offer services to migrant people in custody, because they can't speak their language.

"we visit custody and offer a referral to anyone arrested or deliver brief interventions. Unless the clients can understand English we can't engage with them".

It was explained that in order to get a translator to custody or one on the telephone can take time, and the police have other tasks to complete within a specific time frame. A community worker also expressed the frustration of trying to engage with individuals who understand little or no English at all.

"We find ourselves trying to use 'sign-language' to show the people what we have to offer and how we can help them"

She added that,

"There are basic signs that people can understand, but often we can't explain what we need to, and at 12.30 at night you have limited options. At times we have used other migrants who have 'better' English to try and explain".

In a continuation with this theme, service providers were asked how they deal with service users who have limited English. Within the community, particularly in the voluntary sector where the service provision is sometimes unplanned workers find themselves improvising or using non verbal communication to communicate.

> *"We usually use actions or point to things to explain something, or we have found ourselves using other migrant service users to interpret".*

Another voluntary worker explained a similar scenario by explaining that,

> *"As a drop-in centre it's difficult to plan a time to work with clients so often we find ourselves using other clients to act as a translator".*

As identified earlier the use of ad hoc/informal translation services have also been used in drug outreach teams where it was reported that,

> *"When they (Polish clients) came to see us the receptionist, who was Polish, was able to explain clearly about the service".*

In another team one worker described how the client arrived with a family member to act as a translator.

> *"The lady arrived and had her teenage daughter with her, and she subsequently explained that she was there to act as a translator"*

One other worker from Northern Ireland, who could speak a little Polish, actually used their linguistic skills to speak with and engage with clients.

> *"I lived in the Czech Republic on the border with Poland and the area I lived spoke Polish so I learned Polish. Now I'm back here living I can use my knowledge of Polish to engage with these clients".*

Alongside the use of impromptu translation techniques there was also the use of experience qualified translators and interpreter's. Within the voluntary sector in the Belfast area the use of interpreters from an ethnic support centre are used for planned meetings with clients. One worker explained;

> *"If we have a planned meeting with the client to talk about things then we will book a translator for the session, if needed".*

Another worker with the voluntary sector explained how they used a telephone translation service.

> *"Sometimes we need to discuss things with the client that are unplanned and we need a translator so we would use the telephone translator".*

The telephone system of translation was also used in the custody suite when arrest referral workers were seeking to engage with clients. It was explained that,

> *"If a client is being 'booked in' and the PSNI are using the telephone translation service then I would use this opportunity to use the translator to offer my support".*

However, through the process of the interviews the most widely used method of translation was the use of an interpreter, whereby an interpreter was booked for a planned meeting and was present in person for the meeting. One community addiction worker explained,

> *"Before I meet the person I book the interpreter, because I don't assume what their level of English is."*

Another community based worker stated that her work is very much planned and she too would book an interpreter in advance. She explained,

> *"With my clients there are issues in terms of child protection, domestic violence and alcohol, therefore I plan sessions with the family and also book the interpreters for the sessions".*

Other statutory service workers stated this also explaining;

> *"I book the interpreter so that they are there for the appointment with the client, at least I can carry out the planned work."*

Some workers based in community realised the difficulties in working through an interpreter particularly for the client, whom may need to re-tell their story through an interpreter at every session. In order to reduce the impact that this has on the therapeutic relationship the same interpreter was 'block booked',

> *"With my clients I have maybe four or five sessions planned, therefore I try and book the same interpreter so that the client doesn't feel that in every session there is a new person in the room".*

Other workers explained similar actions:

> *"I try and get the same interpreter as it's less invasive for the client to have the same faces every week".*

Another worker stated,

> *"It's good to use the same interpreter if you can because they get to know what's going on and I think they feel more relaxed hearing some of the issues".*

However there were some negative comments in relation to interpreters. One worker believed that the interpreter was not sympathetic to the client and was judgemental.

> *"With the interpreter it was if they were 'giving off' to the client for their behaviour in relation to drink".*

A community worker also had a similar experience and she detailed that

> *"The interpreter seemed unsympathetic to the client's situation".*

However it is worth noting that some service providers didn't automatically book an interpreter. One worker explained;

> "if there is a referral to our service for a 'non-national', I would then contact the GP to see if it is necessary to book an interpreter".

Another worker also would use the same method of deciding to use an interpreter;

> "I would contact the person referring the client, whether it is the GP, or social worker, and ask them if it is necessary to use an interpreter"

One other professional had a completely different attitude by not using interpreters at all. The professional explained,

> "We offer therapeutic counselling and I believe that this cannot be conveyed via a translator. If people come here to live at least learn the language".

One other barrier in place due to language was the use of written information worksheets or forms that individuals are offered. One worker in a community addiction team explained,

> "We would use worksheets to help clients understand the impact of the drinking or drug use. We would also provide information in leaflets on things like relapse prevention but for many of the Eastern European clients this is not an option because they can't read English, and we don't have the leaflets in their language".

Another worker in a housing support organisation added to this by explaining that,

> "All the forms and information leaflets here are in English and many of the Polish clients can't read them, even the ones who can speak some English can't necessarily read English".

When asked about impacts on service user need and how culture would affect this, the answers were focused on the differences between our culture and the migrant's culture.

Within the community organisations the themes of not realising what help and support was available and how to access it were recurrent. It was explained during interview that;

> "These clients (Polish migrants) don't understand how to get help and support".

This was further reinforced by a community worker stating that,

> "The migrants don't realise these services are free".

 A Polish GP was able to give clarity to this by explaining;

> *"In Poland the system is different. If someone is unwell they visit their doctor. If they have an alcohol problem they will go and get help from another clinic or psychologist which has nothing to do with their GP".*

The lack of understanding of service and the treatment available was highlighted by a community addiction worker. She explained how her client perceived how the service would work.

> *"When he first came to see me he spoke of 'being locked down' which he explained was how he believed you were detoxed in Poland".*

She continued by discussing how the Polish patients she now sees here in Northern Ireland are unaware of the referral process.

> *"When Polish patients come to see me they don't realise I can refer them to get help and support for their alcohol problem".*

In addition to the differences of service accessibility another point highlighted was the fear of being deported.

> *"Some of the guys who use the service have a fear of authorities because they are frightened they are going to be sent back home".*

This fear was also highlighted by a Family Worker how works specifically with migrant families.

> *"Many of the families I work with have a fear of authority I think it is to do with a fear of deportation".*

Although language differences may be assumed to be a barrier to access, service providers were also asked to comment on how migrant culture of origin impact on the service users' need. A service manager within the voluntary sector felt that the,

> *"Lack of understanding of bureaucratic structures led to unrealistic expectations of what the service can deliver".*

This service manager further expanded that,

> *"Many of the service users have little or no understanding of registration (Worker Registration Scheme) requirements therefore cannot access the support they need".*

Another service provider within the voluntary sector stated that,

> *"The lack of insight into the way support is co-ordinated is very evident….the migrants don't realise the way in which services are structured and that there is a huge amount of bureaucracy".*

She further explained that,

"When crisis beds are available we allocate to those eligible for Housing Benefit as that is how the service is paid for, many of the migrants are not in receipt of housing benefit".

Another worker felt that there is a sense of avoiding authority.

"The migrants I have met like to stay below the radar, there is nearly a fear of being known to services".

When this was probed, the worker explained that,

"The migrants seem to fear authority and also have a fear of being deported".

When asked about specifics of the migrant culture there was a number of similar responses.

One community based worker stated that;

"The use of alcohol is a prominent part of their (Polish migrant) life".

Another worker stated that:

"The Polish way of drinking is very different to our way, in that they drink more at home and it seems more hidden".

He went onto to explain in his view that;

"They are big Vodka drinkers and therefore the levels they drink seems to be a lot more than we (Northern Irish) drink".

This perception of Polish migrants being 'heavy drinkers' was a belief held by many in relation to the Polish culture of drinking.

One member of staff within the statutory service stated that;

"Alcohol is a big part of the migrants lives so therefore there perception of what a problem with alcohol is very different to what our perception of a problem is".

It was further reported that 'help seeking' culture is not apparent because the migrants don't know what help is available or how to access it.

In terms of perceived cultural differences and expectations, interviewees were asked for their opinion in relation to the needs of migrants being meet under current mental health policy with specific reference to the Bamford Review of Mental Health.

A manager from one of the community voluntary organisation felt needs were not being met on a number of levels and for a number of reasons. She stated,

"Poor information both prior to coming to Northern Ireland coupled with poor guidance and support upon entering Northern Ireland are impacting factors".

This point was further elaborated on by another professional who stated that,

> *"When people arrive here they have no support in place, they then are not aware of how to access support from the likes of community organisations or health care."*

Coupled with this was what the expectations were in terms of care provided and the cultural differences.

7.7 Conclusion

In conclusion there were a diverse range of perceptions and problems highlighted across the voluntary and statutory services. Some of the problems were unique to particular services others issues like language were shared across the organisations. Another strong theme was the cultural perceptions booth from the service providers and the service users. A summary of these findings is detailed below. These will be discussed further in the next chapter in conjunction with the findings and results from other phases.

7.7.1 Summary

When reviewing the content of the interviews specific themes emerged. In summary the themes discussed are outlined below

- Increased migrant demand among the informal community based services

- No visible evidence of increased demand for services among statutory services

- Financial constraints do impede on the provision of specialist services

- Eligibility criteria seems to be barrier to accessing services

- Lack of understanding of how to access services is prevalent among migrants

- Language barriers do exist

- There are perceived difficulties in delivering services and specifically talking therapies via a translator/interpreter

Chapter 8

Discussion, Conclusion and Recommendations

8.1 Introduction

Within this chapter the findings and results of the thesis will be discussed. Firstly the objectives will be stated and details of how the objectives were met including the main findings of the research.

The aim of this study was to consider the nature or extent of substance use/misuse within the Polish community in Northern Ireland. The objectives of the study were

1. To conduct a substantial literature review and consider recent research within national and international contexts.

2. To conduct a study of the extent of substance use/misuse amongst a sample of the Polish community in Northern Ireland.

3. To investigate service users' experiences and perceptions of drug and alcohol services in the Province.

4. To consider the views of service providers from voluntary and statutory services.

5. Conclusion and recommendations for policy and research

Section 8.2 below outlines how the first four of these objectives have been met and the main findings of the study. Achievement of Objective 5 is outlined in sections 8.4 to 8.9 below.

This chapter will discuss the limitations of the methods of the study in section 8.3, considering in turn:

(1) The literature review

(2) the qualitative phases; and

(3) the quantitative phases.

Within this chapter, the discussion highlights how the findings link to:

- migration policy (section 8.4);
- theory development regarding acculturation (section 8.5);
- public awareness of services (section 8.6);
- access to services (section 8.7);
- service delivery in practice for migrants (section 8.8);
- skills for practice (section 8.9) including:

- o cultural competence;
- o working with interpreters; and
- use of and need for information systems (section 8.10).

Future directions in terms of future research are highlighted in section 8.11.

The Chapter concludes with a summary of key recommendations

8.2 Main Findings

The findings of three phases have been presented: a quantitative component investigating alcohol and substance use among a sample of the Polish population; a qualitative phase involving Polish adults who have used or who were using services during the research; and a qualitative phase involving service providers. The focus of this chapter is to bring together the findings from across the three phases and compare to findings from current literature. This section also summarises how the objectives set at the beginning of the PhD have been met. This is the first study to my knowledge which examines the alcohol and substance misuse among a migrant population in Northern Ireland and also that examines changes to alcohol and drug use since coming to Northern Ireland, access to services and also service providers' experiences and perceptions. As a result, this study provides a unique insight into these issues in Northern Ireland, and as will be discussed, the learning can be applied internationally.

8.2.1 Findings in relation to literature review.

The findings of the literature review will now be discussed. The first main finding was that migration can have an effect on an individual's mental health. It is acknowledged in research that migration, the process of, and the subsequent acculturating to a new hoist culture can be stress provoking and sometimes prolonged thus affecting emotional wellbeing. Some international studies examined gender differences in psychological distress within migrant groups. Mirsky (2008) reported on gender differences relating to coping. He found that women were more ready to admit to psychological distress and that men may use other means to cope with the mental strain. Alongside this are the cultural differences in which country of origin and culture do have a huge influence on how individuals express emotional and mental distress. Culture also influences greatly how individuals deal with or cope with emotional and mental distress. One of the literature review findings, discussed in chapter 3, is the link between migration, mental health and substance abuse. These findings from the literature, have a significant bearing of the first two findings from this research, as they complement each other. The literature review findings indicated that an increase in substance misuse, and in particular certain substances, which are culturally sanctioned is evident among various migrant groups throughout the world. Therefore the literature findings of, 3.3 Acculturation and Mental Health; 3.5 Gender,

migration and mental Health; 3.6 Culture and Mental Health and 3.7 Addiction, substance misuse and migration are all confirmed in the findings and reported in 8.2.2.1 and 8.2.2.2 related to this study in Northern Ireland, thus, suggesting the replication of a pattern that has been found across wider global studies of migration and mental health and addiction outcomes.

Within the literature review an additional finding relates to the utilisation of mental health services by migrants as discussed in 3.8 of chapter three. The findings indicate that migrants are underrepresented in mental health services, but present in crisis with acute mental health problems. Within the literature review it was identified from a number of studies that migrants find not only language a barrier but also cultural perception of mental disorders and the symptoms of, can prevent accessing help and support. Other issues such as cultural sensitivity and a belief in the service can impede people from accessing services. One of the final issues in this finding was that there is often a lack of understanding of how to access services in the host country. Care pathways differ from country to country and how services are funded and accessed is different. These findings link very much to the findings presented in this thesis, whereby access to services and in particular access to specialist services can be somewhat confusing. Therefore, the literature review findings in 3.8 of chapter three are confirmed by findings of the present study.

8.2.2.1 Male Polish respondents' alcohol use.

A proportion of first generation Polish Males report that their alcohol use has significantly increased since coming to Northern Ireland.

One of the aims of the research was to determine if migrating to Northern Ireland had contributed to an increase in alcohol consumption as reported by the respondents. The reason why the focus was on alcohol was based on Berry's (1997) acculturation theory and in particular as a stress coping mechanism. Over two thirds of respondents indicated that their levels of alcohol use had stayed the same or decreased since coming to Northern Ireland, but nearly one third of respondents stated that their alcohol use had increased. An increase in alcohol use was a significant finding in that many previous studies investigating mental health migration and alcohol or substance misuse reported this. This was discussed in-depth in 3.7 of chapter three but to date no such research had been conducted in Northern Ireland.

Van Geest (1997) found that migration is seen as a chronic strain as opposed to an acute strain and therefore leads to on-going stress. To clarify this briefly, it is helpful to understand that the terms 'acute' and 'chronic' sit at opposite ends of a spectrum (Dorland, 2003). In relation to mental health, acute relates to rapid deterioration of mental health with rapid onset however with relatively brief duration, while chronic relates to a long duration with slow changes in condition (Dorland, 2003). So therefore Van Geest (1997) highlights that the impact of migration on mental health is not something that can happen in a short period of time, but it may be long term and is a burden on migrants' mental health over a long period of time.

The stress can then trigger the misuse of substances which is a maladaptive coping response to the stress of migration. As discussed in the review of literature some migrant groups do sanction the use of alcohol as an acceptable response to migratory stress. In Selkirks' (2012) research in Scotland it was reported that particularly Polish males used alcohol in Poland to cope with stress and this was seen as acceptable. Polish peoples' use of alcohol may be similar to that of Irish people (EMCDDA) but where they drink is somewhat different with an increased majority of Poles drinking at home. From the quantitative research conducted the results indicated that most of the respondents drinking at home with fellow Poles. The frequency of alcohol use would also indicate that a number of respondents, in particular males, with nearly one in three reporting daily drinking. This was also analysed by focusing in on daily alcohol use. There were also significant differences in gender when looking at increases in alcohol consumption since coming to Northern Ireland. Males had a significantly higher level of increased alcohol consumption than females. However, this could be construed as consuming 1 glass of wine a week in Poland and when you come to Northern Ireland it increases to 2 glasses. However when the volume of alcohol consumed in the past week was analysed men were consuming on average 19 units of alcohol, with a standard deviation of 15, which would indicate some people drinking in excess of 60-70 units per week. Correlations were also investigated as detailed in chapter 5. Furthermore there was a significant strong positive correlation between the number of days alcohol was consumed and an increase of alcohol use since coming to Northern Ireland. This is a significant finding. Therefore it is evident that those who report consuming more alcohol are also increasing the frequency of consumption. So from the research it was evident that males in particular had

increased their alcohol use since coming to Northern Ireland and some respondents' drinking levels can be described as hazardous.

In terms of mental health and alcohol use it was found that there was a small relationship between GHQ score and an increase in alcohol use since coming to Northern Ireland. This would indicate that there is link between increased use and an impact upon mental health and in particular around the element of social dysfunction within the GHQ. Albrecht (2005) found that migrants who had a drug-dependency showed significantly higher levels of anxiety, depression and negative stress-coping strategies. Within Albrechts' (2005) research and this research it is difficult to differentiate between mental health issues associated with increased alcohol and drug use or migration. However what adds gravity to the quantitative data presented, is the experience of the services users in the qualitative element of the study and their narrative. From the quantitative study it has been identified that a cohort of respondents have increased their alcohol use since coming to Northern Ireland and related this as being due to mental health issues, as an implication of migration. From the interviews with service users it has been reported that they felt increasingly stressed since coming to Northern Ireland. Although some people reported Northern Ireland as a slower pace of life the stress can be in the form of a new culture, new language, not being aware of how to access services, not having close family support, all of which have been identified and discussed in chapter 3 in the literature review, but also these themes were recurring in the analysis of interviews with Polish migrants.

Increased alcohol use was also reported by individuals who had an alcohol problem prior to coming to Northern Ireland .They also stated that their alcohol use intensified, reduced time between binges and an increase in the length of binges. A small number of those interviewed, that were abstinent when they came to Northern Ireland, felt at increased risk of relapse. These individuals knew from their own experiences the triggers to relapse, which were stressful situations and feelings of isolation and loneliness and they subsequently acted to prevent relapse which involved seeking help and support. Some did relapse after migration and their problems intensified with issues such as homelessness, physical health problems and relationship problems. Although it is indicated in the literature review that women tend to report higher incidence of psychological distress associated with migration, this does not

necessarily mean that men acculturate or cope with migration more effectively. How they deal with migratory stress may be in the form of maladaptive coping mechanisms such as increased alcohol use. In Selkirks' (2012) study it has been reported that Polish men use alcohol to cope with everyday stressors. This is a very similar phenomenon to the Irish migrant in England as discussed by Tilki (2006). Leavey (1999) suggests that perhaps more so than other groups, alcohol use is culturally sanctioned as an acceptable response to stress by certain cultures including the Irish. This links this behaviour to the social learning theory of alcohol use and misuse discussed in chapter 2. This could also apply to the Polish group within this research. Tilki (2006) states that there is a relationship between the use of alcohol as a means to coping with psychological distress among the Irish. There are certainly similar parallels to the chosen research group. Berrys' (1997) Acculturation Theory provides additional clarification by identification of the difficulties associated with acculturation. At an individual level there are factors that influence the acculturation process; however how individuals then deal with the acculturation process, is what is evident in this research. Specifically, looking at moderating factors during acculturation, and specific 'coping strategies', it can be argued that the likelihood of Polish migrants in Northern Ireland using alcohol to cope with acculturation stress, is quite high. Specifically, this is because the Polish culture sanctions the use of alcohol in stressful situations, particularly among men. This also may in fact seem to be the ideal strategy to deal with moving to a new country particularly more so in a country where alcohol use is culturally sanctioned as an acceptable response to stress. A support worker in a voluntary organisation in Northern Ireland commented that they were seeing more young Polish men with alcohol issues, or issues associated with alcohol dependence, including mental health problems and homelessness.

O'Brien (2012), in his study of Traveller men in Northern Ireland found that there are clear inequalities in terms of health between men and women and also between men in ethnic minorities and host populations. In addition there have been other studies which have indicated that mortality and morbidity disparities exist between men and women. The European Commission in their 2011 report identified that across Europe male life expectancy is 6.1 years lower than females. The Commission also found that lifestyle is a huge influential variable in predicting men's health outcomes. This lifestyle element is also affected greatly by economic, social, cultural and environmental elements (Commission on Social Determinants 2008).

Within the sphere of lifestyle, alcohol consumption is an intrinsic factor. The European Commission (2011) reported that 'men are more likely to drink and drink in harmful ways' than their female counterparts. The Commission also reported higher mortality and morbidity rates and accidents due to alcohol consumption. Polish men have the 10th highest death rate from liver disease in Europe out of the 32 countries, UK is 19th and Ireland 26th.

Coupled with the research findings that people may increase their alcohol or drug use to cope with the chronic stressors of migration, it is apparent that young Polish males may be at risk. This problem is compounded by help seeking behaviour, or lack of, when in a new country. This particular issue will be discussed in section 8.6 of this chapter.

8.2.2.2 Prevalence of drug use

Within the study, another of the aims was to determine prevalence of substance misuse and also investigate if respondents' substance misuse had increased since coming to Northern Ireland. Within the quantitative phase of the study it was reported that in terms of lifetime prevalence cannabis was the highest with nearly 1 in 5 using cannabis in their lifetime. This is higher than the Polish prevalence figures detailed in chapter 1 however much lower than UK prevalence. 2011 prevalence for cannabis use in Poland was 3.8% (EMCDDA 2011) and a last month prevalence was 1.8%. This study reported a last year prevalence of 12% amongst Polish immigrants to Northern Ireland a 'last month' prevalence of 6 %.

Therefore, it is evident that the cohort included in this study, are using cannabis more than the general Polish population. Among those who are currently using over 40% indicated that there was a slight increase in their use. Other drug use is not comparable to the general Northern Ireland population. So, although those sampled have low levels of drug use, some of those that do use, have indicated an increase in drug use since coming to Northern Ireland. Again this highlights the potential link to migrating and using or increasing substances to help with the transition, social isolation and often traumatic process of acculturation.

8.2.3.1 Care Pathways to Seeking Help

One of the aims also explored was the idea of help seeking and how this would manifest itself. In 8.1.1 of this chapter there has been reference to help seeking among

males for general health problems and mental health problems. From the research it is evident that where to seek help proves a huge quandary for Polish migrants and not just males. This can be further described as a lack of understanding of how to access services both from the service providers stand point and also the service users, however this will be discussed in the next section specifically.

Within Northern Ireland the process of seeking help and support for statutory services is via the General Practitioner (GP). GP's can also refer to voluntary and community organisations.   The GP is the main referral agent for specific Tier 3 and Tier 4 treatment services for alcohol and substance abuse and is often the main provider of brief interventions and education in relation to drugs and alcohol. From the findings of the quantitative phase conducted, three quarters of those sampled stated that they would seek help and support from a family member or a friend, with less than 1 in 5 stating they would seek help from a GP. However it is also worth pointing out that recognition of a problem, or the development of a problem is often a precursor to seeking help. This is discussed in chapter 2 in relation to theories of change.

8.2.3.2 Access to drug and alcohol services.

One of the aims of the study was to investigate service users' experiences and perceptions of drug and alcohol services in the Northern Ireland and another aim was to identify gaps in service provision. This was a point highlighted during both phases of the qualitative research. Service users were consistently unaware of the support available from a GP or the opportunity to access additional services via a GP. In the analysis in chapter 6 and 7 there are specific transcripts detailing this, including incidents where individuals attended their GP for other health complaints associated with alcohol or substance misuse, and who were then referred to specific treatment services. This was similar to Moller-Leimkuhler (2002) findings in that men often attend GP's with other health complaints that are associated with psychological distress or mental health. On occasions, it was during the research interview that participants were made aware of the ability to access service via a GP. This issue was also highlighted by the fact that over the prescribed period of data collection in 2009-2010, there was only approximately 8-10 Polish service users accessing statutory addiction services across all health and social care trusts in Northern Ireland. This indicates that this population are underrepresented in services. These findings are similar to findings by Selkirk et.al. (2012), in their research amongst Polish nationals

living in Scotland. In their review of literature, they found that migrants are less likely to avail of mental health services than the local population. In this Northern Ireland study it was evident that individuals were unaware of how services are accessed via their GP. Prins et al. (2008), state that factors such as gender and education levels influence the rates of accessibility. Additional factors affecting service utilisation from these reviews included, stigma, fears about treatment, social norms and self-concealment (Prins et al. 2008), all of which were apparent themes, in particular when discussing the use of interpreters in health services.

It is pertinent to note that there is no assumption that respondents from both phases of the study were in fact registered with a GP. In a recent study by the Public Health Agency (PHA 2012) for England and Wales, the study found that 32.5 % of migrants coming to UK failed to register with a GP by the first 9 months of residency (Stagg, et al., 2012). There may be a number of explanations for this which will now be discussed . Aung & Rechel, (2010) in their UK study found that there was confusion of entitlement to health care services, and Stagg et al (2012), found that cultural and linguistic barriers can influence registration. In addition to this there may be additional confusion over access due to the Worker Registration Scheme. Although the scheme has stopped in 2011 at the time of research A8 migrants (A8 refers to eight countries that ascended to the European Union on 1st May 2004) needed to register under the scheme as detailed in chapter 1. This process may have acted as an additional barrier migrant workers. However in a recent study in 2015 Sime and Fox found that the barriers still exist in the forms of

- lack of accessible information on services available and entitlements
- Cultural barriers and issues of trust in services.

(Sime and Fox 2015

p531)

Sime and Fox (2015) further argue that services are designed to suit the native population. As discussed in chapter 1 the new legislation has been introduced in relation to GP registration for migrants.

In addition to the complexities of registering with a GP and knowing whether you are entitled to health care, there was also apparent confusion around treatment available. As stated above the health care system in Poland is different to that in the UK and the

treatment services are different. The narrative of the interviewees confirmed this. One respondent stated that he decided to 'detox' himself from alcohol because he wasn't aware of the support that he could get from his GP, as this was the process in Poland. In Poland psychologists were used to help with the motivational aspect of change in terms of alcohol and drug use, but these services were accessed privately. The confusion over access to additional support services was very much evident, with often by-chance signposting to services through friends and families or established alternative referral routes such as arrest referral workers, drug outreach workers or via A&E departments. Kirmayer et.al., (2007) argue that being an immigrant is related to lower use and access of mental health services even with universal access like that in the UK. Kirmayer et. al. (2007) further states that barriers such as language and poor cultural competence affect take up rates. Lindert (2008) states that accessing health care services for migrants is difficult because of the unfamiliarity of the system. In conclusion from the quantitative study it was found that not one person had looked for help for either drug or alcohol problems.

8.2.3.3 Oppressive Experiences & Barriers to healthcare

Services offered to migrants based on the concept of 'universal access' may seem as one system fits all. As discussed earlier there are blocks and barriers to the welfare offered from a legislative and policy stand point. In addition, what was evident from the interviews with service providers, was a less than sympathetic or empathetic attitude to the plight of some of the migrants they had worked with. This can be argued has led to oppressive practice. This was evident in some of the comments and practices that were employed. There was a concern around eligibility of services and understanding eligibility. From the ten service providers interviewed five perceived that migrants were less eligible than local people to health care services including emergency housing, addiction and mental health services. A community based worker highlighted how they were confused in relation to eligibility of services.

> *"We were confused about the accessibility of these clients to our service, we are here to help and support, however that help has to be paid for, this then adds to the confusion of the migrant clients who themselves don't know what they are entitled to"*

Another worker discussed difficulties in terms of signposting and what migrants were entitled to. Through the interviews it was felt that some service providers were frustrated by the lack of cohesion and also the way in which there were perceived limited options. These frustrations could then be seen being directed towards the service users and also by labelling and to certain extent blaming them for their situation. There was a theme of 'learn the language' if you want to come here. When it was discussed about barriers to effective service provision some providers felt that service users should learn the language. One service provider felt very strongly about this and stated they were reluctant to work through a translator or interpreter.

> *"When they (migrants) are deciding to migrate to a country, one of the deciding factors should be can they speak the language, and if they can't they should learn".*

This practitioner went on to describe how difficult it is to offer talking therapies to someone who doesn't fully understand what you are saying, and how the benefits from pauses and tone of the spoken word are lost. This practitioner went as far as stating he would not use the translation service as he felt there was little benefit in offering talking therapies via a translator. Other service providers did not use translation services as they felt that it was difficult to treat via a translator and others felt that they could offer treatment with the level of English that some of their clients possess.

Practitioners assuming a level of understanding can be seen as failing to provide an adequate service. Improving minority ethnic access to health and social care services requires increased use of interpreters (Raval 1996). Further research by Raval (2003) highlighted that using interpreting services create "a greater sense of professional attention". However these comments are usually rooted in the experience of providing pharmacological or surgical treatments. The situation is clearly more complex in relation to psycho-social interventions. Some service providers did describe how difficult it is to deliver this type of treatment via a translator/interpreter, and some may assume that the service users can articulate their emotions and feelings effectively in the foreign language of English although Tribe (2009) argues that "having the option of speaking in a mother tongue in mental health is becoming increasingly recognised for its potential in allowing clients to access certain emotions and experiences" (Tribe 2009 p96). Resara et.al. (2015) discuss these issues of the

delivery psycho-social interventions in depth in a recently published paper. The research focused on the how interpreters found there role in psycho-social interventions in mental health particularly different than in other contexts like law or medicine. Resara et.al. (2015) found that there are a number of overarching themes, including the interpreter role, the dynamics of the triad, the relationship that develops between the interpreter and the client and the power dynamics. Under these themes the specific themes that were apparent were issues such as interpreters as cultural informants and interpreters as a therapist. These issues explored found the emergence of issues around trust, boundaries, gender, religion, political views and cultural background and issues around meeting the client meeting the interpreter outside of the care setting in their cultural group or social setting. These issues are prevalent within psycho-social interventions that are clearly used in many facets of social work and by other Allied health professional across a range of health and social care settings. In conjunction with the interpreter issues, mental health practitioners at times feel excluded from the dialogue and find it difficult to focus due to the constant stop-start nature of the translation process (Cecchin, 1987; Raval 1996; Roy, 1992). Also, because of the three-way process, non-verbal communication can be difficult to direct and comprehend (Cushing, 2003; Raval, 2000). These themes were all apparent in the analysis of the transcribed interviews both with the service users but all the service providers. Themes of distrust and shame were openly discussed. In addition to this, this research has indicated that within addiction services there is a high DNA (did not attend) rate therefore therapists have stated that there are reluctant to book interpreters in the likelihood of the individual failing to attend. One service provider stated that he could speak some Polish and was able to use his limited knowledge of the Polish language to provide support to an intravenous drug user. It was also found that some service providers thought that the service users' level of English was satisfactory in order to comprehend the talking therapies delivered. Tribe (2009) argues that this ambivalence to working with interpreters is apparent in the UK and has been reported in other literature including Spectre.et.al. (2009).

Alongside these practices some service providers used ill-informed myths and stigmas to describe Polish clients. Three service providers made comments that inferred that Polish people abused alcohol. They referred to them as 'big vodka drinkers', and stated 'they like their vodka', with another service provider stating that 'there's a huge drinking culture among the Polish'. These generalised statements start to inform bias

and impact upon decision making. At this point, it is worth clarifying that when comparing Poland to Northern Ireland, Poland has 27.3 of its adult population as lifetime abstainers from alcohol, while Northern Ireland has 15.1% abstainers and the Republic of Ireland has 6.7% lifetime abstainers. A comparison of 'heavy episodic drinking' (consumed at least 60grams or more of pure alcohol on at least one occasions in the past 30 days) showed that 33.4% of drinkers in the UK and Northern Ireland had consumed to these levels, 48.2% of Irish had consumed to these levels while only 10.2% of Poles consumed to these levels (WHO, 2010).

In conclusion the results from the mixed methods methodology did indicate that there are barriers to service provision across a number of levels. The evidence of these barriers were supported by results in the quantitative questionnaire results and from the narrative of the semi-structured interviews with service users and providers. In addition there was a particular group who were identified in the quantitative study who had increased their alcohol use since coming to Northern Ireland. Finally there was evidence of a lack of insight, oppressive practice and a lack of cultural competence when service delivery was examined.

8.3 Limitations of the Study

After discussing the findings of the study it is useful to discuss the limitations of the study including the literature review. As highlighted, this study was a mixed methods study encompassing both quantitative and qualitative studies. Each one had its limitations and will now be discussed.

8.3.1 Literature Review Limitations.

The literature review presented in the first part of the thesis did have its limitations. Firstly the literature searched did have a lot of results which was specific to refugees, which in itself is different from a process of migration which involves a lot of choice, therefore it was pertinent to sift through and extract the literature that only looked at migration as a choice. The next difficulty was trying to compare research that looked at acculturation measures. Acculturation, the process of, can be described as a human process of development. There are many aspects of measuring the transition from one culture to another, therefore the research is varied and often a true comparison is not possible between research. In addition to this there was the difficulty in finding research that looked at migration to Northern Ireland or even Ireland primarily because Ireland and Northern Ireland historically produced migrants as opposed to attracting them. Though there were some excellent pieces discovered including the work of Kouvonen et.al. 2014. There was many pieces of research conducted in the US among many migrant groups, and that is expected as the US is a country with a huge migrant population, however small European countries which tend to be countries of source as opposed to the receiver of migration have little research carried out, therefore replicating or comparison is difficult.

In addition to these limitations sourcing literature on the impact of migration on mental health was challenging in that to truly understand the impact on mental health a measure of mental health prior to migration would have been needed and few studies looked at this element.

With these limitations however a substantial review of literature was conducted within the time frame parameters, a library of research was compiled examining the many facets of migration, mental health addiction, help seeking and access to services. The review helped guide the research within and the findings were comparable with international peer reviewed findings. The lack of local research within this area also identifies the uniqueness of this research.

8.3.2 Quantitative phase limitations

From the onset of the study there were challenges in terms of using the appropriate tool to ascertain the data required for the study. The actual tool used was an adaptation of a prevalence questionnaire used in Northern Ireland and the Republic of Ireland (DAIRU 2006). The questionnaire is based on the EMCDDA model questionnaire (EMCDDA 2004) and part of the difficulty was whether or not the tool could be directly translated into Polish and still maintain its meaning after translation. There was a fear of that some of the content would be 'lost in translation'. There was no Polish equivalent, therefore a process involving two separate Polish translators was used to firstly translate from English to Polish then from Polish to English. Figure 20 below details the flow.

Figure 20 Translation process

English questionnaire	→	Translator 1 translates tool to Polish	→	Translator 2 translates Polish tool to English	→	Original is compared to product of the translation process
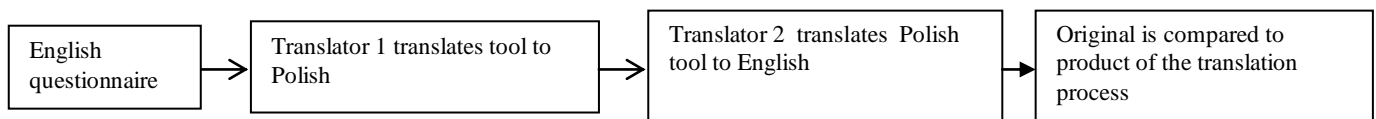
Form the output there were some meaning discrepancies that had occurred and they were rectified.

The same process was used for the General Health Questionnaire (GHQ12) which was also distributed.

Another limitation of the tool was that there were no opportunities for the respondent to add additional comments, But after consideration it was decided that the option for additional comments was not viable as additional translation work would need to have been undertaken and due to budget constraints this was not viable. All information collected was recorded using coded options therefore insuring data input was accurate and could be done by the researcher and not a translator

In terms of population size and access to the population this proved difficult and limited the study somewhat. Firstly, determining how to access this hidden population proved difficult. There were a number of sample points identified including places of work. Many Polish migrants are economic migrants and from anecdotal research, and

as a native of Northern Ireland it was discovered that many local companies went to Poland to recruit directly for their labour intensive manufacturing processes. Distributing questionnaires at work places was considered, however because the questions requested information of a sensitive nature and illegal activity it was considered unethical to use these sampling points. Another consideration was to use places of worship as sampling points. Poland has a predominately Catholic population and the migrant population were indeed offered the services of the Catholic Church here in Northern Ireland with weekly mass in Polish in some parishes. It was considered a viable sampling point however due to ethical reasons and a proposed 'public' distribution of the questionnaire it was disregarded. The next viable consideration was to identify signposting and support organisations that migrants may visit on a regular basis. The sampling points therefore were those community development organisation that give support and advice to members of the Polish community. There were seven in total identified. However once these limited sample points were identified the sample population was limited.

8.3.3 Qualitative phase limitations

The qualitative component of the study had particular limitations when conducting interviews with service users. Initially it was anticipated that most of the interviewees would have some involvement with statutory services however across Northern Ireland there was limited a number of Polish individuals who were accessing statutory substance misuse services.

Based on the large number of referrals to statutory services it was anticipated that our recruiting of Polish individuals would be achieved via the statutory service referrals, however the majority of individuals recruited for the qualitative phase were recruited from voluntary services who engage with services users with substance misuse problems. These services included crisis housing services, day hostels, self-help groups and homeless services. This meant that in terms of service evaluation, from a client point of view, there was a limited amount of persons who had experienced statutory services in terms of substance misuse. Therefore the sample may have been somewhat selective.

Another potential limit to the research was the use of translators in qualitative research, particularly research that covers potentially sensitive issues such as drug and alcohol use/misuse. Elam (2003) describes sensitive issues as the issues that people

regard as private and also involve stigmatised behaviours' or evoke strong emotional feelings (cited in Lee et.al 2014). Temple &Young (2004) state that within qualitative research individuals use language to communicate to discuss their differences and similarities. It is through language that individuals are able to recall their individual experiences, how they felt and the impact that experiences have had on their lives. By speaking and communicating, individuals are able to articulate issues related to their ethnicity heritage, gender and other aspects of their identity (Hole 2007; Temple 2002). One important factor is that remained constant in the research was that participants were able to discuss the issues in their own language. Twinn (1997) argues that, 'it is more appropriate for researchers to use the language of the informant to obtain an understanding of health experiences and perceptions of health care' (Twinn 1997 p.419).

From previous research and from the review of literature it was significantly important that translators were used. To ensure the impact of the translator was minimised, and to a certain extent, added to the quality of the data recorded, a number of issues had to be taken into consideration. The first consideration was the ability of the translator, in terms of linguistic competence. Squires (2008), adapted from Danesi (1996), details four levels of competence in terms of translators used in research; grammatical, discourse, sociolinguistic and strategic. Squires (2008), concludes from her reviews that in terms of research, translators must poses a minimum of sociolinguistic competence. The translator used in this research was of this level. The translator was a native of Poland and did have an insight and understanding to verbal and non-verbal communication and cultural norms and expressions. However having an understanding of both languages does not merit an effective translator in qualitative research. Within the preparation of the field work four candidate translators were identified to work with, and it was soon realised that to ensure the consistence of the data collected, and to reduce variation that this number would have to be reduced to two or even one. The criteria for selection was linked to the research theme, in that translators were needed who had an insight into mental health, alcohol and substance misuse and understanding of the process here in Northern Ireland. Squires (2008), states that in qualitative research using translators, that having an understanding of the concepts discussed will add to the quality of the research data. Larkin et.al. (2007) adds to this by arguing that the translator with knowledge and experience conceptualises and puts into context the participants words. Therefore

within this research a translator with specific these qualities was chosen. The translator chosen had been working within a specific project of a mental health charity offering 1:1 support for Polish nationals and her qualifications, to degree level, were in relation to mental health and psychology. This helped in that she understood the language terms and was able to articulate the issues faced by the individuals. In addition to her understanding of mental health and in particular substance misuse additional 1:1 training was given to the translator on the overall research and specifically to the qualitative element with service users. The training focused in on alcohol and substance dependence and the consequence, the research question and in particular the questions of the semi-structured interview. In addition a separate training session took place exploring the concept of confidentiality and disclosure, and more importantly how to deal with disclosure of feelings of life not worth living or plans or intent to self-harm or commit suicide. The training was based on a suicide awareness training package and was adapted with the research in mind.

The actual interview process did have its limitation in that a three way semi-structured interview can limit the data collected and the flow of the interview can be interrupted. In order to reduce the interruptions and flow, the service users were made aware of the content of the interview prior to arriving and again at the beginning of the interview. The translator fully understood the reason for the research and research questions. The interviews were recorded with the consent of the participants so that further translation could place via transcription. However the difficulty with this process is that if additional points are picked up on during the transcription process then it is too late to probe and clarify.

During the qualitative element of the research women were under represented. Of the 18 service users interviewed only 4 were female. This highlights some of the issues in terms of women being under represented in addiction treatment settings

8.3.4 Limitations of the thesis

As a whole the biggest significant limitation of the thesis has been the time scale that it has taken to compile as some of the literature reviewed is dated, however much of which is still relevant as research on migration follows the waves of migration. This limitation is off-set with a more recent search of the literature, using key concepts to update the literature presented. Due to time taken be granted ethical approval and then

to source a hidden population which was shrinking and align interviewees with a translator was a task that was underestimated in terms of resource and time. Another limitation is the limited application of some of the findings as with the UK leaving the EU may have an impact on the application of policy and legislation findings. Although the limitations are there, the thesis still presents 'new knowledge' and opportunities for future research which includes the impact of service provision for refugees which the UK government has committed to supporting under the Vulnerable Person Resettlement Scheme and also why some migrants and refuges suffer less in terms of mental health, so a study in terms of resilience and give a better understanding of the population. In addition to this the methodology of conduction social science research via interpreters is unique learning process

8.4. Link to Policy

Within Chapter 1 there is a specific section that sets out the EU migration policy in a UK context, that will no doubt change in the next 2years with the onset of UK subsequently leaving the EU. The policy analysis looks back and examines how the UK policy has been an mechanism for both triggering migration and stemming depending on the economic demands of the UK. It has also examined how EU policy can influence and shape Member State legislation. Within this section of the chapter the policy on migration at the time of A8 Ascension is also discussed alongside the concept of the 'Freedom of Movement' and implications for non-UK nationals. The section also highlights that there may be confusion in relation to a 'Freedom of Movement and a freedom of services, and a freedom of welfare'. This point was discussed in the in Chapter 1 in relation to accessibility of Health and Social Care Services. With the different legislation pertaining to different migrant groups there is a reticence of the Old Poor Law, with deserving and undeserving migrants. In terms of policy there is evidence of confusion over policy and legislation and how this translates into practice. Firstly, as discussed within the Policy section and evidenced in the results chapter there was confusion over the Worker Registration Scheme and entitlement to health care provision. However the WRS is now been withdrawn as it was it was only a seven year programme after A8 accession. This highlights even further concerns about remaining migrants .But the confusion still exists as financial welfare support is very different from health care as welfare with prerequisites. As demonstrated in the research and findings homelessness is a very often a consequence

of mental health and addition. This is compounded even more by the fact that A8 nationals are not entitled to housing benefit unless they fulfil certain prerequisites. These include not being able to claim benefits for at least 3 months after being in the UK and then they have to pass a 'habitual residence test'. This is difficult to prove if you are homeless. In relation to service provision, organisations like homeless hostels receive their income from housing benefit and by excluding migrants from this benefit it therefore excludes them from accessing this service. In a recent policy change the UK Government has revealed that EU migrant worker who find themselves unemployed will not be eligible to claim Housing Benefit. This is an added exclusion that exacerbates the problems associated with mental health and addiction. In addition, the Bamford Review of Mental Health (2007) identifies poor housing, housing security and homelessness as having a profound impact upon mental health, and from discussion in chapter 1 it is evident that migrants in Northern Ireland often find themselves renting the poorest housing in the least desirable areas.

In terms of Policy, in relation to access to health care and care pathways, it has been identified in the Bamford review of mental health that migrants are a vulnerable group, not only because of precipitating factors such as housing but also because of the impact of migration. Language barrier was also identified as a potential issue with service access Kuovonen et.al. (2014). Also within the Northern Ireland Strategic review of Alcohol Drugs 2006-2011& 2011-2016, particular groups were identified as vulnerable in respect of alcohol and drug misuse. These groups included homeless individuals, ethnic minorities, refugees and asylum seekers, and people with mental health problems. In addition to the impact of a legislative minefield, this then somewhat transfers to practice issues and confusion as to entitlement of what services individuals can avail of.

8.5 Theory Integration and Development

When reflecting upon the implication of theory in terms of the findings from this research it is worth firstly identifying how many stories of migration, shared via the qualitative phase and also from the questionnaire, are very much attributable to the multiple facets of the theory of migration. Many of those who completed questionnaires were in employment and had arrived in Northern Ireland as economic migrants. However, with the qualitative part of the research people were able to detail

how they had travelled here to set up home then invite other family members, or that they had followed their children here to be close to them and their grandchildren. Others described how they travelled alone, but with the view of meeting up with friends, while others travelled in groups. The micro structures as discussed in chapter 2 and what Bourdieu (1992) refers to this as social capital are very apparent in the narrative. In these stories there is also evidence of the macro factors, including government policy as discussed in chapter 1, in this case freedom of movement of EU nationals and the need for economic migrants could be argued as pull factors.

In addition to theories of migration, there is theory of acculturation and assimilation. Many of the components of theories are discussed by individuals and reported upon, whereby there is that process of acculturation, however where some individual's struggle to acculturate to their new host culture they seek solace in a known, culturally sanctioned method; substance use. This in itself has a myriad of theories as to why people use, abuse and become dependent on substances including alcohol and what is central to these individual theories is Berry's Acculturation theory (1997). It takes into consideration the process of migration and the individual impact. It also highlights stress coping and sets out to explain how some individuals can acculturate with better outcomes. It does hint at the idea of help-seeking but in the form of social support but falls short in discussing seeking formal support from health care services, or gender differences in help seeking. In addition there are also the separate theories that are considered in relation to help seeking and in particular around help-seeking for psychological distress and the cultural links to this. Through this research the theories discussed have been used when considering the research questions and helped to make sense and try to understand the findings. These finding can be linked to specific theory outlined within the theory chapter. In particular this research has focused on the migration and mental health with particular reference to the maladaptive coping mechanism of substance abuse to cope with the migratory process. Berry (1997), in his acculturation theory model, explains individual level variables that impact upon an individual's acculturation process, and how these variables can have an impact on the positivity of the acculturation process. These variables will now be examined in relation to the research outcomes focused upon. When looking at moderating factors prior to acculturation, age and gender, these moderating factors that could be deemed as predictive factors to increased alcohol use. Cultural distance and language affect all those who migrate however those with

less linguistic skills may be have a higher predisposition to acculturate less positively and those who use alcohol as a method of coping.

Moderating factors prior to Acculturation
- Age, Gender, Education (pre-acculturation)
- Status, Migration Motivation, Expectations
- Cultural Distance (language, religion)
- Personality

Moderating factors during Acculturation
- Phase (length of time)
- Acculturation Strategies
- Coping : Strategies & Resources
- Social Support
- Societal Attitudes: Prejudice & Discrimination

If factors during acculturation are examined then coping strategies are a significant factor, and within this research substance misuse was identified as a possible coping strategy. With the factors identified in Berry's (1997) model and the research outcomes within this thesis it may be of benefit to develop a model of risk using Brearleys 1982 model. Brearleys model and the theory associated with has been discussed in chapter 2. Risk assessment and management in social work and the wider health and social care settings involves attempting to predict harm or injury or deterioration in health or relapse or in some instances re-offending or death. How risk is assessed and the harm or relapse is predicted can be complex. Taylor (2012)discussed models of professional decision making in social work whereby judgement and decision making are interlinked in relation to risk and assessment. Taylor (2010) states that judgement means 'the considered evaluation of evidence by an individual using their cognitive faculties so as to reach an opinion on a preferred course of action based on available information, knowledge and values (Taylor, 2010, p. 165).

Within the context of migrants judgement can be limited as information is limited, a social context is limited and often cultural naivety can affect the ability of social

workers to make informed judgements. Based on these factors, to improve judgement and decision making with migrants, a specific tool for use in assessing migrants mental health may enhance the process thus leading to better outcomes for the client. There are certain factors that are prevalent among migrants that the literature review has identified along with this research, factors that contribute significantly to poorer mental health among migrants.

The factors are identified below

Table 13 Brearleys Risk model with migration and mental health

Background hazards	Situational Hazards	Strengths	Danger
Age	Availability of alcohol/substances	High employment	That migrants will develop maladaptive coping strategies to deal with acculturative stress
Gender	Host country sanctions excessive alcohol use	Low levels of drug misuse	That individuals will develop alcohol problems including dependence
Language	Failed expectations	Ethnic support networks both formally and informally	Individuals are unaware of how to seek statutory and voluntary services for help
Cultural Distance	Limited support	Formal care pathways	Services difficult to provide via translators
Previous substance misuse	Unaware of how to access support from statutory or voluntary services		
Single	Service providers unaware of entitlement		

This table demonstrates how a model of risk has been developed using the findings from the research coupled with moderating factors outlined by Berry (1997).

8.6 Public Awareness of Services

This issue of care pathways is one area that has been highlighted whereby potential service users are unaware of how to access support. All statutory health service treatments are accessed via the GP, so therefore GP registration is imperative. This is a difficulty with researching migrant groups. Although no Northern Ireland figures are available, research conducted by Stagg et.al. (2012) found that out of a sample of 252,368 migrants entering the UK over an 18month period, after a minimal follow-up time of 9months, only 32.5% had registered with a GP, with women being more likely to register than men. So in terms of care pathways, accessing services is the first obstacle. This was reflected in the quantitative phase of this research, in that a small proportion of respondents felt they would go to their GP for help. Alongside this as reported in the qualitative findings, many respondents were not aware that GP registration was a necessity to access services. This can be partly explained by the fact in their home country Polish people may seek psychological services privately and not through their GP. Selkirk (2012) stated that studies have found that cultural mismatch and a preference for help seeking from alternative sources were barriers to help-seeking from professionals such as GP's. The reasons for this may be found in previous research. Czabala et.al. (2000) in their research on Polish mental health, found that mental health issues were stigmatised by the general Polish population. In addition, Knab (1986) states that good family support is an important aspect of Polish culture and acts as a protective factor and therefore prevents shame coming onto the family. Selkirk (2012) suggests that these factors may influence Polish individuals from accessing help particularly in a foreign country, away from family and extended family. In his study in 2012, Selkirk found that Polish people in Scotland used family and friends as 'the first port of call' for financial, practical and emotional support. Therefore seeking outside help may be viewed in a negative light by the community (Selkirk 2012). In addition to this, keeping problems in a close family network played an important role during communist rule. It allowed individuals to buy goods on the black market, helped people advance in jobs and protected them from authorities (Kawalek 1992). In addition to this the NHS is highly developed compared to the health care systems in Poland. The Polish system during the communist era, was underfunded and inadequate, and many GP's and specialists operated privately, therefore people were unable to access the care they felt they needed because they

could not afford it. This continued post communism, so the idea of seeking help via your GP in Northern Ireland maybe alien. So this in turn leaves the problem of Polish people with mental health and substance misuse problems unaware of the care pathways. As highlighted already in this chapter there are the barriers associated with male masculinity, that add to the barriers already discussed.

8.7 Access to Services

A theoretical relationship between help seeking and life stage, has been discussed in the theory chapter. There is an understanding that people seek help at different times for various heath related issues. Juel & Christensen (2007), found that men delay help seeking, both for physical health mental health and anxiety related issues. The European Commission (2011) states that depression in men alongside other mental health conditions are under detected and under reported across all European countries. It has also been reported that although men report better mental well-being they are more likely to commit suicide and have higher rates of substance abuse, and use maladaptive coping mechanisms to stress, anxiety and depression. Moller-Leimkuhler(2002) in her research looking at barriers to help seeking found that when men do engage with health services, they are less likely to discuss mental health problems. There is also components of masculinity, and cultural differences in masculinity that may also pose as a barrier to seeking help. Compounded by this is the eligibility of services. There is limited research in Northern Ireland in relation to migration and mental health, and any research that has been conducted has been in the broader context of homelessness, welfare and looking at cultural diversity rather than access to health services, however a recently published study by Close et.al (2018) migration and mental health was examined but again it focused in on the registration of migrants in administrative registers which does have some implications for this research. In 2014 there was a policy paper presented to the Northern Ireland Assembly at Stormount complied by Kouvonen et.al. looking at Polish migrant mental health and well being and the themes that were discussed in this policy paper were consistent with the findings of this research including limited access to services and also being unaware of how to access services. Dunne and Irwin (1997) studied ethnic minority populations in Northern Ireland and examined access to services, however their measure of accessibility was based on language or access to bilingual services. Other research by McAreavey (2010) on ethnic minorities in Northern

Ireland focused however on involvement in social science research and barriers including ethical considerations. The main publication of relevance has been published by Northern Ireland Human Rights Commission (NIHRC) entitled 'No Home from Home'. This was primarily published as a response to the growing number of immigrants and asylum seekers coming to Northern Ireland and specific incidents whereby people were left 'going round in circles' seeking help from various statutory and voluntary agencies, however, there was confusion over entitlement and rights. In specific terms the NIHRC found that in terms of health care provision, the investigators found 'an absence of formal guidance and training within each Health and Social Care Trust in Northern Ireland in relation to non-UK nationals' (NIHRC 2009 p50). This can be viewed as a lack of adequate training and support for staff, and ultimately individuals are making decisions on their own initiative. This links to findings of this research where professional staff are confused over entitlement which may lead to the delivery of inadequate services or none at all.

On a broader UK scale there are a number of pieces of research that have links with this research however there are opportunities for more. Tilki (2006) in her research specifically focused on Irish migrants in England and their increased use of alcohol. She reports that there is a relationship between the use of alcohol as a means to coping with psychological distress among the Irish. This mirrors the findings of this research particularly among young Polish males. This is also similar to Selkirks' (2012) research in Scotland where the findings mirrored the findings of this research in that informal support is seen as the way to deal with psychological distress, and whether this was because of a lack of awareness about services or the need to not disclose feelings of inadequacy because of mental ill-health. This again is linked to previous discussions around males seeking help and masculinity. In addition to this, specific UK research on help seeking in relation to substance misuse and access to services was published by Mils (2010). In this research Mils stated that 'little is known about substance misuse among A8 nationals in the UK'(p854). Mils (2010) also states that there are many unclear areas including, the prevalence and nature of substance misuse, the impact of migration on substance misuse and access to services for A8 nationals. The findings from this research are congruent with the finding from this piece of Northern Irish research in that, there are services available, but the point of delivery is usually communicated through a translator. Entitlement to services varies

across Boroughs in London, again depending on the practitioner within the services, which is a finding that was highlighted in this study . One additional point highlighted by Mils (2010) was 'not knowing' how many were in treatment, and again 'not knowing' how many people are in need of treatment. This is a point that will be discussed in section 10.10 of this chapter. In an more up to date review by Maciagowska & Terry (2017), their review of eight pieces of UK based research with post accession Polish migrants found that language difficulties, financial hardship, discrimination and isolation, cultural shame and unfamiliarity are all factors which contribute to negative mental health.

8.8 Service Delivery in Practice

As highlighted in section 8.7, the way in which services are delivered in practice is somewhat problematic. This is evidenced in the transcripts of the qualitative research whereby service users and service providers discuss practices and how therapeutic practices are delivered via family members, or in language which is not the service user's primary language. Mind, a UK mental health charity, in 2013 reported that Black and minority ethnic (BME) are underserved in primary mental health services. The report further highlighted that people from BME communities are less likely to be referred to talking therapies for mental health issues. When individuals from BME communities do access mental health services it is usually at an acute stage of their mental health problem (Mind, 2013). In addition to this is the complication of service delivery in broken English or the use of interpreters within a service which may not be culturally competent. The use of translators and interpreters in a therapeutic context has advantages and disadvantages. Firstly there is the logistics of organising a translator. Within addiction services there is a high rate of clients failing to attend, and as reported in the transcripts in this research an additional cost of a translator to incur for a DNA (did not attend) appointment is often a quandary for the service. In addition to this, is the clients' perspective, whereby there is a fear they may know the interpreter and subsequently feel judged. Mind (2013) in their review of talking therapies in the UK found this was very much a realistic fear among people from BME communities. Once the decision has been made to use an interpreter there is the question of whether it is going to be effective and the level of effectiveness delivering talking therapies through a third person. Tribe and Patel (2007), found that although migrants and refugees may feel isolated socially, in their host country the presence of

an interpreter conveys of the idea of 'wanting to be heard'. This evokes other questions of whether 'being heard' is enough. Tribe & Woods (2009) reported that interpreters are frequently seen as a 'necessary nuisance', however for many clients it is their only path into mental health services (Tribe & Raval 2003). The idea of developing a therapeutic alliance via a third party may be alien, and more so using therapeutic techniques such as motivational interviewing via a translator maybe somewhat difficult to achieve, as timing of response, pause and active listening, are all difficult in the context of a three dimensional dialogue. Foster (1998) argues that using translators in therapeutic approaches 'would be almost untenable', because of the complexities of the client counsellor interactions including transference. However Thompson and Woods (2009) argue that the use of an interpreter can enhance the therapists work.

8.9 Skills for Practice

In order to enhance the working practices of social workers to ensure, that they not only meets the perceived needs of their clients, but also in order to fulfil their statutory duty as detailed under the Northern Ireland Social Care Council (NISCC) standards, it is now worth discussing the implications of this research in terms of skills for practice. As with many professions, social work needs to adapt and change to meet the needs of their client groups and this sometimes includes working with people of different cultures, nationality and those whose first language is not English. By adapting, the profession needs to ensure that the service delivered is the standard expected and legislated for.

8.9.1   Cultural Competence

The concept of cultural competence is not new, and is highlighted in many aspects of social work training and education, and continually in practice. The concept is enshrined in the Northern Ireland Social Care Councils' (NISCC 2015) standards of conduct with 1.3 of the code stating social workers must empower 'service users and carers to communicate their views, needs and preferences, taking account of their preferred language and form of communication'. Within 1.10 of the standards it states that social workers must 'Respect diversity, beliefs, preferences, and cultural differences'. However one of the difficulties is knowing and understanding cultural differences. Harrison & Turner (2011) state that cultural competence is a 'somewhat

murky concept' because culture has many facets and many meanings, while the meaning of competence needs to be taken in the context it is based. The move to 'teach' social workers to be cultural competent has promoted a review of such an ability in the past 20years. O'Hagan (2001) and Laird (2008) argue that there is lack of cultural competence in social work and more evidence of cultural insensitivity. However, even when practitioners do gain cultural knowledge there is no guarantee of cultural competence (Ben-Ari and Strier, 2010). In order to be culturally competent, it is first beneficial to define culture. Harrison & Turner (2011) in their study among social workers reported a near endless list of components for what culture was. However one key intrinsic component was language. Language was described an 'embedded in culture' and 'a tool to maintain culture' . (Harrison & Turner 2011, p340)

8.9.2 Social Work and Working with Interpreters

Within each of the Trusts in Northern Ireland there is specific 'policy' and guidance for working with interpreters devised from a regional policy. The use of Interpreters is detailed in guidelines produced by the Northern Ireland Health and Social Care Interpreting Service (NIHSCIS). It explains the process of deciding how to decide when to use an interpreter or translator and offers guidance on how to book and the associated cost. The guidance also gives 'good practice pointers' however the pointers are very limited and fail to acknowledge the complexities of developing a therapeutic relationship and providing talking therapies using an interpreter. The Australian Psychological Society (2013) published a practice guide to working with interpreters and it does acknowledge the complexities in working with adults and children using an interpreter. The guide gives excellent guidance, specific reference to interpersonal dynamics, the use of paraphrasing and active listening. Also in Australia, the Victorian Trans-cultural Psychiatry Unit produced guidance for effectively working with interpreters in mental health settings. Such guides are an effective tool helping practitioners deliver talking therapies more effectively. Within the Northern Ireland Health and Social Care Services the availability of such a detailed guide may be of benefit to practitioners working with clients whose first language is not English. The guidance can enhance practitioners delivery of a highly skilled task.

In both guides, the use of visual communication tools was advocated to explain concepts to the interpreter and therefore for the interpreter to explain to the client. In

fact Garcia-Retamero and Dhami (2011) in their study of Polish migrants understanding of medical risk in relation to surgery, found that migrants who were explained concepts by an interpreter and using visual aids, had a greater understanding of risk as opposed to those whom were only explained the concepts through an interpreter. In terms of implementation of similar practices to Social Work in Northern Ireland, it may be of benefit to the practitioner and the client. Using visual aids to explain support being offered, explaining concepts such as the models of change (Prochaki & DiClemente 1982) and care pathways may enhance clients understanding of the care being delivered. In addition to the use of visual aids the use of validated translations of standard tools is also an effective option. Asking questions around mood and sleep patterns maybe lost in translation, however using the GHQ12 authentically translated into the clients native language will give more insight and use less time in trying to understand the current situation. The use of such tools can be used as a baseline in order to measure progress in treatment.

8.10 Information Systems

With the development of complex health care systems, and as Bengoa (2016) identified in his review of health care in Northern Ireland, we need 'systems not structures'. Therefore the need for information to meet the needs of our changing population has never been so necessary. Within the context of Northern Ireland, the information systems that are used to record information about people entering treatment for mental health issues, do not record ethnic minority groups and their outcomes. to the extent that would be beneficial to help and shape services. This is a point reported by Close et.al (2018) in their research in Northern Ireland .The systems used in health care setting record religion to ensure discrimination doesn't occur, however cultural background in terms of country of origin and length of time in the country is not systematically collected. Research in Israel demonstrated that such information is valuable when planning for services (Mirsky 2008). Mirsky (2008) highlighted that the system in Israel, records new migrants country of origin and a subsequent follow-up is carried out. Similarly the LSIC study in Canada as discussed by Trew (2013) also highlights the benefits of understanding the physical and emotional wellbeing of migrants. By doing so the specific needs of sub groups can be categorised and need identified.

Within the adult mental health system in Northern Ireland and specifically drugs and alcohol treatment, there is currently no recording of ethnicity in data systems only with the clients personal notes. The EPEX electronic system is a system for also recording notes and risk assessments with the statutory mental health services and it does not contain information on ethnicity or country of origin. During the annual census of patients currently engaged in treatment, whether community or inpatient, for drug and alcohol problems there is no request for country of origin or specific ethnic group. This data is used to plan policy and services for the population of Northern Ireland. Additionally, the current Drug Misuse Database, which requires the substance misuse worker to log client details in relation to demographics, treatment given and substance used does not record country of origin, only ethnic group which is not enough information to identify specific needs.

8.11 Future research

Within any research there are specific limitations and learning points. Within this research from the limitations and learning points further research directions have been highlighted.

Firstly, as a proportion of our population, migrants have specific needs, assessing this need is vital to providing services. Within the UK as whole migrant workers contribute significantly to the economy therefore the development of services to support an intrinsic part of our economic growth is essential. The literature review highlighted the impact that migration has on mental health, how it is culturally defined and that there are gender differences. It was also evident from reviewing the literature, that much research has been completed in other parts of the world, however Northern Ireland has limited research on this topic. It is therefore pertinent to recommend that further research is conducted among migrant groups in Northern Ireland to look at the process of acculturation and assimilation using international validated tools such as Abbreviated Multidimensional Acculturation Scale (Zea et.al. 2003) Acculturation Attitudes Scale (Berry 2010) and Acculturation Attitudes Scale (Ward & Rana-Deuba 1999), and compare the process of acculturation in Northern Ireland to other parts of the UK or internationally. The political and social context of Northern Ireland may add complexity to an already complicated process, regarding acculturation, for immigrants. Given that the political landscape remains unclear, as well as the unknown implications of 'Brexit' on inward migration, Northern Ireland

complexities will require ongoing research on this topic. There is also the opportunity to compare different migrant groups in Northern Ireland, for example Polish and Portuguese. By doing so would give insight into how the two groups differ in their acculturation strategies, as discussed by Berry (1997).

8.11.1 Audit of Mental Health Access

Within the UK, access to mental health services by non-UK nationals is not formally recorded. If it was, further insight into the impact of travelling to, and living in the UK could be assessed. Services then could be tailored to meet the needs of this specific group. Because of the lack of recording the only viable way to gather information would be to conduct a file audit of a sample of services within some of the HSC Trusts. In doing so, an understanding of the type of service accessed, length of involvement, and how the service was delivered, are just a few of the outcomes that could be assessed.

8.11.2 Refugee Mental Health

In 2014 the UK Government agreed to offer asylum to Syrian nationals fleeing the war in their homeland under the Syrian Vulnerable Person Resettlement Programme (VPRP). Initially it was anticipated that a few hundred refugees would come to UK, however from September 2015 it was agreed to resettle 20,000 people. The refugees were given initially 'humanitarian protection' status for a period of 5 years, which meant permission to work and access public funds for 5 years in the UK. As research has indicated, and discussed in Chapter 3, the moving of one country to another can be traumatic, the additional complexity of forced migration, with the trauma of war can in itself cause emotional and mental health problems. In addition, the uncertainty of migrant status can have compound an already difficult situation. There has been no research into the effectiveness of the UK Government response within this crisis. Also, as each UK region responds differently in its host role it may be worthwhile reviewing the role of the host and identifying good practice. The review of care pathways and accessing services, delivery of services and their effectiveness maybe necessary for future learning and better response to the next tranche of refugees. In total to date (Dec 2017) 860 Syrian refugees have been relocated to Northern Ireland under the UK Government's Vulnerable Persons Relocation (VPR) scheme (Department for Communities Northern Ireland 2018). With this in mind the impact

of forced migration and the trauma of coming from a war torn country exacerbates mental health difficulties, thus the need for access to services maybe greater and an understanding of how to support forced migrants in our communities more complex.

8.11.3 Effectiveness of SKPE-Style therapeutic intervention

As discussed earlier, when delivering talking therapies via a translator/interpreter the effectiveness of the intervention can be impacted due to the inability to respond and engage at a level that is often required, as well as the dynamic changes with a third party and the loss of privacy. One of the emerging methods to delivering talk therapies in the service users language is via video link or SKYPE. Such methods allow the service user to receive therapies through a video link from a professional trained therapist, in their native language thus eliminating the need for a translator/interpreter. By doing this, it eliminates the need for travel. A study examining the effectiveness of such interventions in the field of addictions may help us to understand the benefits and the effectiveness of such methods. Such methods have been used in other parts of the world and their effectiveness has been researched and published. Hilty et.al. (2013) in a review of studies found that such methods as described as 'telemental health' are effective in working with ethic groups when using trained translators within the mental health discipline or psychiatry.

8.12 Conclusion

This study set out to examine a particular aspect of mental health among migrants. The literature review gave increased insight and helped shape the structure of the research framework. The research was contextualised within the strands of policy which impacted upon migration, health service delivery and accessibility. Throughout the research the underpinning theoretical perspectives gave thought and explanation to the facets of behaviour, emotion and action that was presented in the various phases of the research.

Within this study, an interesting data set was constructed which set out to give an insight into the substance use patterns of a relative new and somewhat hidden population within Northern Ireland. The quantitative data also captured a certain aspect of help seeking. In conjunction with the data there was also the added benefit of the General Health Questionnaire 12. The qualitative phase which explored the

human stories both of the service users and providers added depth and gravity to experiences and the narrative contextualised the numbers from the data set.

Northern Ireland has a population of people who have migrated here, for whom English is not their first language and the Northern Irish culture is alien to them. These people do try and assimilate to the host culture whilst still trying to hold onto some parts of the own. This process can be very stressful, anxiety provoking and often an enduring period of sadness and isolation. How people adapt and cope and how maladaptive measures are used can exacerbate and cause additional problems.

The help seeking for these problems can in itself be stressful, whereby people negotiate the care pathways of a new health service, very much different from the one they left in their home country. After they have found the correct service to support them they can be faced with reluctance from service providers or a limited intervention due to the delivery of talking therapies via an interpreter.

The needs of our migrant populations are unique because of their experience of migration. Their needs are gender specific, and care pathways have barriers, alongside the service delivery. Within the increasing globalisation of humans and the commitment to provide refugee status to more and more Syrian nationals displaced due to war, there is an increasing demand to respond to the health care needs of immigrants and refugees.

Conclusion 1. This is the first research of its kind in Northern Ireland investigating the mental health of migrants including service delivery.

The literature review did identify that when people migrate they can in fact suffer mental health problems and that as a means of coping can use substances and subsequently develop problems due to their substance use/misuse. Limited research to date has been conducted in Northern Ireland looking at the mental health and access to services of migrant populations.

Conclusion 2. A cohort of young Polish males reported that their alcohol use had significantly increased since coming to Northern Ireland. Using the GHQ score as an indicator of mental well-being, there was an evident relationship between lower mental well-being and an increase in alcohol use since coming to Northern Ireland.

Conclusion 3: Service users reported that they felt increasingly stressed since coming to Northern Ireland. Although some people reported Northern Ireland as having a slower pace of life the stress can be in the form of a new culture, new language, not

being aware of how to access services, not having close family support. A cohort of these respondents have increased their alcohol use since coming to Northern Ireland and related this as being due to mental health issues, as an implication of migration.

Conclusion 4: Although those sampled have low levels of drug use, some of those that do use, have indicated an increase in drug use since coming to Northern Ireland. Again, this highlights the potential link to migrating and using or increasing substance use to help with the transition, social isolation and often traumatic process of acculturation.

Conclusion 5: The use of translators to support the delivery of services has limited effect and can add to the complexity of the therapeutic relationship.

Conclusion 6: Migrant service users find it difficult to navigate through the care pathways and there is confusion around eligibility to services both from the service users point of view and that also of the service providers.

8.13 Recommendations

8.13.1 Recommendations from literature findings

Aim - To conduct a substantial literature review and consider recent research within national and international contexts.

Findings -Migration can have an effect on an individual's mental health. It is acknowledged in research that migration, the process of, and the subsequent acculturating to a new host culture can be stress provoking and sometimes prolonged thus affecting emotional wellbeing.

Gender differences in psychological distress within migrant groups exist and Mirsky (2008) reported that women were more readily to admit to psychological distress and that men may use other means to cope with the mental strain. There are cultural differences in the presentation of mental health. Country of origin and culture can have an influence on how individuals express emotional and mental distress. Culture may also influence how individuals deal with or cope with emotional and mental distress. One of the literature review findings in particular noted the link between migration, mental health and substance abuse. The literature review findings indicated that an increase in substance misuse, and in particular certain substances which are culturally sanctioned, is evident among various migrant groups throughout the world.

Recommendation 1: As highlighted within the findings, there are differences in gender in the presentation of mental health, and help seeking. Therefore, it may be of benefit for mental health services to tailor not only to the needs of particular migrant groups but also to be gender specific. It may be argued that the first step to any treatment is awareness and that prevention is a prerequisite to these. Health & Social Care Services within Northern Ireland therefore, need to work in partnership with migrant and ethnic support groups, highlighting the potential for mental distress and how it can be reduced, thus potentially increasing the likely hood of positive outcomes for migrants. Education on the culturally defined symptoms of mental distress and ways to deal with them is essential. In addition, education around the impact that alcohol and other substances have on mood, and ability to regulate emotions needs to be highlighted, particularly in what is potentially a significantly stressful time.

8.13.2 Recommendation from quantitative findings; immigrants

Aim –To conduct a study of the extent of substance use/misuse amongst a sample of the Polish community in Northern Ireland.

Finding: First generation Polish Males report that their alcohol use has significantly increased since coming to Northern Ireland.

Recommendation 2: As reported, the specific needs of male Polish migrants need to be addressed. In conjunction with the previous recommendation, it may take the form of targeting specific locations or groups with relevant information. This health promotion information from Health & Social Care Services should be provided in a format that is accessible by the recipient and will be designed to inform migrants of the risks of alcohol and other substances and, the effect on the mood, the physical impact and links with crime and accidents.

8.13.3 Recommendation from quantitative findings with service users

Aim - To investigate service users' experiences and perceptions of drug and alcohol services in the Province.

Finding - Migrants are unaware of care pathways to seeking help which consequently acts as a barrier to accessing drug and alcohol services.

Recommendation 3: As discussed in the theory chapter and as reported in the findings, help seeking behaviour and lack of knowledge of care pathways can act as

barriers to getting the right support or any support. It is therefore recommended that migrants register with a GP when they come to Northern Ireland. By doing so, they can access services when required. The registration can involve the delivery of a language specific information pack with an overview of the architecture of the GP services and in addition details of hospital and community-based services that are accessed via the GP. This recommendation could be coupled with recommendation number 2.

8.13.4 Recommendations from quantitative findings with service providers

Aim : To consider the views of service providers from voluntary and statutory services.

Finding – Barriers to delivering effective services via a translator.

Recommendation 4: The delivery of talking therapies in English to a client whose first language is not English may have limited effect. Delivery via a translator/interpreter also generates issues which have been discussed. It is therefore a recommendation from this research that a pilot study be undertaken of the use of SKYPE/ E-Health to deliver talking therapies within Health & Social Care Services by specialist clinicians/therapists who speak the native tongue of the client. With the advancement of technology and globalisation in the delivery of health care there may be increasing possibilities for a Polish clinician based in a different location in the UK delivering Motivational Interviewing or other talking therapies to clients in Northern Ireland.

Recommendation 5: The Trusts do offer training in 'working with interpreters', however it is limited in that it instructs staff on how to book an interpreter and the circumstances of when to use one. The training does not increase awareness of cultural competence which as discussed earlier may be of benefit. The training does not make staff aware of the entitlement of migrants to health care services and, as highlighted, is a misconception for some staff. It is therefore recommended that staff are trained on engaging with migrant groups, focusing on the specific cultural elements of the particular ethnic group.

Recommendation 6: As discussed in 8.10, the use of information systems with specific information may be of benefit. Therefore, there is a need to identify, at a single point of entry or contact, the needs of Northern Ireland residents with

consideration of their cultural background and country of origin. This may require the efficient use of the new healthcare data systems including PARIS which is currently being implemented across 4 of the 5 Trusts mental health services, and ECR which is used in all medical sectors with the Trusts. In addition, the current substance misuse database does not record country of origin, however if added would give a clearer indication of whether migrants are accessing drug and alcohol services.

Appendices

Appendix 1

HSC REC 3

31 March 2009

Dr Anne Campbell
Senior Lecturer, University of Ulster
University of Ulster Magee
Northland Road
Derry
Northern Ireland
BT48 7JL

Dear Dr Campbell

Full title of study:	**An investigation into the extent and nature of substance use/misuse among a sample of the Polish community in Northern Ireland, considering also implications for access to and use of treatment services.**
REC reference number:	**09/NIR03/1**

Thank you for your letter of 16 February 2009, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been received on behalf of the Committee by the Administrator as delegated by the Alternate Vice-Chair.

The updated documents were received by the Administrator on the sponsor's letterhead as requested by Sub-committee at the meeting on 26 February 2009.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Local Research Ethics Committees to be informed or SSA to be carried out at each site.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Participant Consent Form: Service Providers	1	01 November 2008
Participant Consent Form: Interview	1	01 November 2008
Participant Consent Form: Questionnaire	1	01 November 2008
Participant Information Sheet: Service Providers	1	01 November 2008
Participant Information Sheet: Interview	1	01 November 2008
Participant Information Sheet: Questionnaire	1	01 November 2008
Letter of invitation to participant Interview	1	01 November 2008
Questionnaire: Investigation of alcohol use/misuse amongst the Polish Community in NI, Nov 2008		
Interview Schedules/Topic Guides Polish Service Users of Voluntary and Statutory Addiction Support Services		
Covering Letter Mr S Roddy		
Protocol		
Application		17 December 2008
Interview Schedules/Topic Guides Service Providers	1	
Compensation Arrangements Mr N Curry		16 December 2008
Letter from Sponsor Mr N Curry		16 December 2008
Belfast HSC Trust agreement to project, Ms M Williams		02 December 2008
Northern HSC Trust agreement to project, Ms M McConway		07 September 2008
Southern HSC Trust agreement to project, Miss I Knox		24 October 2008
Western HSC Trust agreement to project, Dr M O'Kane		12 June 2008
Investigator CV, Mr S Roddy		
Investigator CV Dr A Campbell		
Peer Review RG3, Dr B Taylor; RG2 Dr M Duffy		
Letter of invitation to participant Questionnaire	1	01 November 2008
Letter of invitation to participant Service providers	1	01 November 2008
Statistician Comments Dr M Shevlin		24 November 2008
Translator confidentiality agreement	1	
Response to Request for Further Information Covering email, Mr S Roddy		16 February 2009
Participant Information Sheet: Service providers	2	01 February 2009
Participant Information Sheet: Interview	2	01 February 2009
Letter of invitation to participant	2	01 November 2008
Questionnaire		
Translator confidentiality agreement, letterhead	1	
Response to Request for Further Information Covering letter, Mr S Roddy		
Participant Information Sheet: Interview participant, letterhead	2	01 February 2009
Participant Information Sheet: Service providers, letterhead	2	01 February 2009
Letter of invitation to participant Letterhead	2	01 November 2008

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review –guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/NIR03/1	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Dr Stanley Hawkins
Alternate Vice Chair, HSC REC 3

Email: daleyj@orec.n-i.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to:

Mr Nick Curry
Senior Administrative Officer
Research Governance
Research Office
University of Ulster Jordanstown
Shore Road
Newtownabbey
Co Antrim
BT37 0QB

Ms Mary McDonald
Research Governance Administrator
R & D Office
Bush House
Antrim Area Hospital
Antrim
BT41 2RL

Ms Mary Williams
Research Administrator
Royal Research Office
Royal Victoria Hospital
Grosvenor Road
Belfast
BT12 6BA

Bridgeen Rutherford
The Clinical Translational Research and Innovation Centre
Western HSC Trust

Altnagelvin Hospital

Glenshane Road
Londonderry
BT47 6SB

Miss I Knox
Research Manager
St Luke's Hospital
Loughgall Road
Armagh
BT61 7NQ

Appendix 2
QUESTIONNAIRE PARTICIPANT INFORMATION SHEET

University of Ulster

Alcohol and Substance Use/Misuse amongst the Polish Community in Northern Ireland

Shaun Roddy

Why is the Research Taking Place?
It is being carried out to explore and understand the extent of alcohol and substance use/misuse amongst the Polish community in Northern Ireland. There are two parts to the study: the first is a survey to establish the extent of substance misuse in the Polish community in Northern Ireland; the second is a series of face-to-face interviews with Polish service users of addiction services.

This second part of the research focuses on the personal experiences of members of the Polish Community who have accessed services for help and support for problems associated with alcohol or substance misuse.

The reasons why the research is taking place are:
1. Because the migrant population in Northern Ireland is expanding and we want to see to what extent Health and Personal Services are responding to the needs of the identified migrant population:
2. International research has indicated that people who migrate to new countries can sometimes suffer problems with alcohol or substance abuse:
3. It is part of an educational research project - PhD thesis.

Why the Polish Community?
1. The Polish population is the biggest migrant group in Northern Ireland at this time, so the research may be easier to carry out with a larger population. Therefore, it is important to provide an overview of the extent of substance misuse and consider the current level of service provision for Polish substance misusers in Northern Ireland
2. A number of the voluntary support organisations that work with people who have problems substance and alcohol use in Belfast area have indicated that the majority of migrants who are seeking help are from the Polish community.

Who will be invited to take part in the research?
Polish nationals who work and/ or live in Northern Ireland will be invited to complete a questionnaire which will be made available on an easily accessible website. A hard copy will also be given out through community groups who work with members of the Polish population
The information from the questionnaires will be used to find out the extent of alcohol and use in the Polish community in Northern Ireland. This information could also be used to help provide the appropriate level and type of substance misuse related help needed for the Polish population in Northern Ireland.

Who will carry out the research?
Shaun Roddy has compiled the questionnaires, which will be posted on the website or administered via community groups. Shaun will input the data into a computer based programme and subsequently analyse the findings to inform the final written report.

When will the research happen?
The questionnaires will be administered between January 2009 and June 2009.

What is the questionnaire about?
The questionnaire contains questions about your age, how long you have lived in Northern Ireland and if you work and if you married or single. There are further questions about alcohol and substance use. These questions focus in how often you drink or take substances, and how you use has changed.

Will anyone be able to tell that its me who has answered the questionnaire?
NO!! YOU WILL NOT BE ASKED TO FILL IN YOUR NAME OR ANY OTHER DETAILS WHICH MAY BE USED TO IDENTIFY YOU!

What will happen to the information?
The information will contribute to the conclusions of a study. The information will be published in an academic report and shared with those people who organise and arrange services who help people with alcohol and substance misuse problems. Results from the study will also be made available to the Polish people who completed the questionnaire and /or participated in the one to one interviews. It is hoped that the results from the study will provide the basis for a series of recommendations to improve services to the studied population.

Thank you.
Shaun Roddy
University of Ulster Magee
Northland Road
Derry

Appendix 3

Questionnaire

Investigation of alcohol use/misuse amongst the Polish Community in Northern Ireland

November 2008

This questionnaire is to be completed voluntarily.
All information is confidential and is to be used solely for the purposes of this research.

In most of these questions just tick the appropriate box corresponding to the answer Some questions require you to write in a figure. You may stop filling out questionnaire at any time. Thank you.

I have received and understand the information contained in the Participant Information Sheet. Please tick.

Q1   *What is your date of birth*

Q2

Please circle one of the following:	Male	1
	Female	2

Q3   *Are you working, unemployed, home maker, student*

Working	1	Visiting	5
Unemployed	2		
Home maker	3		
Student	4		

Q4   *What is your current status*

Married	1	Co-habiting	5
Single	2	Widowed	6
Divorced	3		
Separated	4		

Q5   *What best describes your accommodation*

Owner Occupier	1	Homeless	5
Public Housing	2	Hostel	6
Private rented	3		
B&B	4		

Q6   *What best describes your educational attainment*

Degree	1	Other	5
A-level	2	None	6
Education to 16years	3		
Skilled trade	4		

Q7		What best describes your annual income	
Less than 10,000	1	25,000-30,000	5
10,000 – 15,000	2	30,000 +	6
15,000-20,000	3		
20,000-25,000	4		

Alcohol

Q8   Do you drink alcohol?

Yes	1	GO TO Q.10
No	2	CONTINUE

Q9   Have you ever drunk alcohol?

Yes	1	CONTINUE
No	2	GO TO Q16

Q10   At what age did you first drink alcohol?

Don't know	-1

Q11   During the last 12 months, have you drunk any alcohol?

Yes	1	CONTINUE
No	2	GO TO Q15

Q12   During the last 30 days have you drunk any alcohol?

Yes	1	CONTINUE
No	2	GO TO Q15

Q13   During the last 30 days, on how many days have you drunk alcohol?

Don't know	-1

Q14a   Using the list provided please state approximately how many units of alcohol you have consumed in the last:

Week	

Drinks	Units
Pint of beer (5%)	2.8
Bottle of beer (5%)	1.7
Alco pop (5%)	1.4
Strong Cider (8.5%)	2.3
Wine Small bottle 187.5ml (12%)	2.3
Wine bottle 750ml (12%)	9
Vodka measure 35ml (37.5%)	1.3
Vodka bottle 350ml (half bottle (37.5%)	13

Q14b   What is your normal pattern of consumption?

Daily	1
Weekly	2
Monthly	3
Rarely	4
Never	5

Q14c   When you drink what do you normally drink?

Beer Larger	1
Cider	2
Wine	3
Sprits	4
Alco pops	5
Combination	6
Other	7

Q14d   When you drink where do you normally drink?

At home	1
At a friends house	2

Pub/Bar	3
Nightclub	4
Sports club	5
Combination	6
Other	7

Q14e   When you drink who do you normally drink with?

Friends	1
Family	2
On your own	3
Fellow Poles	4

Q15   Using the scale provide please indicate since coming to Northern Ireland, has your consumption of alcohol increased or decreased, or stayed the same

Decrease   **Stayed the same**   **Increased**

1   2   3   4   5   6   7   8   9   10

Cannabis

Q16   Have you ever heard of any of these ……………?
Cannabis, Marijuana, Pot, dope, grass, blow.

Yes	1	CONTINUE
No	2	GO TO Q26

Q17   Do you personally know people who take cannabis?

Yes	1
No	2

Q18   Have you ever taken cannabis?

Yes	1	CONTINUE
No	2	GO TO Q26

Q19   At what age did you first take cannabis?

		← INSERT AGE
Don't know	-1	

Q20   During the last 12 months have you taken cannabis?

Yes	1	CONTINUE
No	2	GO TO Q26

Q21   During the last 30 days have you taken cannabis?

Yes	1	CONTINUE
No	2	GO TO Q26

Q22   During the last 30 days, on how many days have you taken cannabis?

		← INSERT FIGURE
Don't know	-1	

Q23 What type of cannabis do you most commonly use?

Grass	1	Resin	7
Weed	2	Other (specify)	8
Skunk	3	_____	
Hash Oil	4		
Herb	5	Don't know	9
Hash	6		

Q24 What method do you most commonly use to take cannabis?

Joint	1
Pipe	2
Bong	3
Eat	4
Other (specify) _____	5
Don't know	6

Q25 Using the scale provide please indicate since coming to Northern Ireland, has your cannabis use increased or decreased, or stayed the same

Decrease   **Stayed the same**   **Increased**

1   2   3   4   5   6   7   8   9   10

Prescription drugs and over the counter drugs

26 Do you use any of the following?

Diazepam	1
Temazepam	2
Df118's	3
Other sleeping tablets	4
Other sedatives	5
Combination	6
No	7

Q27 At what age did you first take them

Don't know	-1

← **INSERT AGE**

Q28 If you have replied yes to question 26, do you use the drug:

daily	1
weekly	2
monthly	3
rarely	4

Q29a Is the drug prescribed by a Doctor:

Yes	1
No	2

Q29b   If not, is the drug purchased from;

Chemist	1
Supermarket	2
Other…..please specify	

Q30   What method do you commonly use to take these drugs

Tablets	1
Injection with a needle	2
Other (specify) _____	3
Don't know	4

Q31   Using the scale provide please indicate since coming to Northern
has your use of sedatives, tranquillisers , DF118's, diazepam, or codeine based painkillers increased or decreased or
stayed the same

Decrease   **Stayed the same**   **Increased**

1   2   3   4   5   6   7   8   9   10

Access to Services

32. Who would your first contact be if you believed you were drinking too much alcohol? (Tick one)

Talk to a friend……………………………………………………☐

Talk to your partner…………………………………………………..☐

Talk to a Doctor……………………………………………………☐

Talk to a social Worker………………………………………………☐

Talk to a support work in one of the community organisations..☐

Other…………………………………………………………………..☐

33. Have you ever accessed or used support services

Yes………………………………………………………………☐

No…………………………………………………………………..☐

34. If yes what services ………………………………………………………………………

35. Were these services …………………………………Voluntary ☐
Statutory ☐
Don't Know ☐

36. If you have accessed these services, have they helped you to reduce your alcohol/substance misuse. On a scale of 1 to 10 how would you rate the services

No help at all   Helped greatly

1   10

This is a general health questionnaire. We want to know about your health in the last few weeks. Please read the questions below and each of the four answers. Circle the response that best applies to you.
Have you recently:

37. Have you recently been able to concentrate on what you are doing?

better than usual   same as usual   less than usual   much less than usual

38. Have you recently lost much sleep over worry?

Not at all   no more than usual   rather more than usual   much more than usual

39. Have you recently felt that you are playing a useful part in things?

more so than usual   same as usual   less so than usual   much less than usual

40. Have you recently felt capable of making decisions about things?

more so than usual   same as usual   less than usual   much less than usual

41. Have you recently felt constantly under strain?

Not at all   no more than usual   rather more than usual   much more than usual

42. Have you recently felt you couldn't overcome your difficulties?

Not at all   no more than usual   rather more than usual   much more than usual

43. Have you recently been able to enjoy your normal day to day activities?

more so than usual   same as usual   less so than usual   much less than usual

44. Have you recently been able to face up to your problems?

more so than usual   same as usual   less than usual   much less than usual

45. Have you recently been feeling unhappy or depressed?

not at all   no more than usual   rather more than usual   much more than usual

46 Have you recently been losing confidence in yourself?

not at all   no more than usual   rather more than usual   much more than usual

47. Have you recently been thinking of yourself as a worthless person?

not at all   no more than usual   rather more than usual   much more than usual

48. Have you recently been feeling reasonably happy, all things considered?

more so than usual   same as usual less so than usual   much less than usual

Thank you for you help and co-operation. This information is confidential and will be used for statistical use only.

Shaun Roddy

Appendix 4
Zaproszenie do wzięcia udziału w badaniu naukowym.

Badanie mające na celu określenie natury i ilości spożywania/nadużywania alkoholu oraz narkotyków pośród polskiej społeczności w Irlandii Północnej.

Przeprowadzający badanie: Shaun Roddy

Historia przeprowadzającego badanie: student doktoryzujący się na Uniwersytecie Ulster, pod opieką dr Anne Campbell.

Badanie to jest prowadzone jako część moich studiów doktoranckich. Celem jest poznanie i zrozumienie spożywania/ nadużywania alkoholu i innych substancji wśród społeczności polskiej w Irlandii Północnej. Ta część badania skupia się ogólnie na informacjach dotyczących spożycia alkoholu i innych substancji prze polską społeczność.

Szacuje się że 919 członków polskiej społeczności w Irlandii Północnej weźmie udział w wypełnianiu kwestionariusza. Dostarczone informacje będą analizowane w celu zidentyfikowania rodzaju i ilości spożywania/nadużywania alkoholu i innych substancji pośród polskiej społeczności w Irlandii Północnej. Informacje mogą również być pomocne w celu zidentyfikowania potrzeb oraz udoskonalenia usług w dziedzinie zdrowia i dobrostanu psychicznego.

Zarówno kwestionariusz do wypełnienia jak i informacja wyjaśniająca szczegóły badania są załączone.

Raport będzie opublikowany w 2010 roku, a kopie będą dostępne w Twoim lokalnym biurze organizacji polonijnej.

Jeśli życzyłbyś sobie dalszego wyjaśnienia skontaktuj się proszę na podany poniżej adres lub zadzwoń.

Dziękuję za Twoją pomoc

Shaun Roddy
University of Ulster Magee
Northernland Road
Derry
Tel: 02871 375137

Appendix 5

KWESTIONARIUSZ

SPOŻYCIE ALKOHOLU WSRÓD POLSKIEJ SPOŁECZNOŚCI W IRLANDII PÓŁNOCNEJ

LISTOPAD 2009

Niniejszy kwiestionariusz wypełniany jest dobrowolnie. Zgromadzone informacje są poufne   i wykorzystane będą tylko i wyłącznie w celach badań.

W większości pytań zaznacz odpowiednią dla Ciebie odpowiedź. Niektóre z pytań wymagają podania określonej przez Ciebie liczby. Możesz zaprzestać wypełniania formularza kiedykolwiek zechcesz.

Otrzymałem/am i zrozumiałem/am informacje zawarte we wprowadzeniu do badania. Proszę zaznaczyć.

Q1   1. *Twoja data urodzenia*

Q2

Proszę zaznaczyć jedną z opcji:	Mężczyzna	1
	Kobieta	2

Q3   *Czy pracujesz aktualnie, jesteś bezrobotny/a, zajmujesz się domem, jesteś studentem?*

Pracuję	1	Jestem tutaj tymczasowo, odwiedzam znajomych/rodzinę	5
Bezrobotny/a	2		
Zajmuję się domem	3		
Studiuję	4		

Q4   *Twój status cywilny*

Żonaty/za	1	Mieszkam	5

mężna		z partnerem	
Samotny/a	2	Owdowiał y/a	6
Rozwiedzio ny/a	3		
W separacji	4		

Q5   *Które z poniższych najlepiej opisuje rodzaj Twojego zamieszkania:*

Jestem właścicielem	1	Bezdomny	5
Mieszkanie socjalne	2	Hostel	6
Prywatny najemca	3		
B&B (wynajmuję na nocleg plus śniadanie)	4		

Q6

Które z poniższych najlepiej opisuje Twoje wykształcenie?

Wykształcen ie wyższe	1	inne	5
Wykształcen ie maturalne	2	Żadne	6
Wykształcen ie ponadposta we	3		
Wykształcen ie zawodowe/t echniczne	4		

Q7   *Które z poniższych najlepiej opisuje Twoj roczny dochód?(w Funtach Szterlingach)*

Mniej niż 10,000	1	25,000-30,000	5
10,000 – 15,000	2	30,000 +	6
15,000-20,000	3		
20,000-25,000	4		

Alcohol

Q8   Czy pijesz alkohol?

Tak	1	Przejdź do pytania nr10
nie	2	kontynuuj

Q9   Czy kiedykolwiek piłeś/aś alkohol?

Tak	1	kontunuuj
Nie	2	Przejdź do pytania nr 16

Q10   Ile miałeś/aś lat kiedy pierwszy raz wypiłeś/aś alkohol?

Nie pamiętam	-1

Q11   Czy przez ostatnie 12 miesięcy piłeś/aś alkohol?

tak	1	kontynuuj
nie	2	Przejdź do pytania nr 15

Q12   Czy w ciągu ostatnich 30 dni piłeś/aś jakikolwiek alkohol?

tak	1	kontunuuj
nie	2	Przejdź do pytania nr 15

Q13   Jaką ilość alkoholu spożyłeś/aś w ciągu ostatnich 30 dni?

Nie wiem	-1

Q14a   Na podstawie poniższej tabeli określ jaką ilość alkoholu wypiłeś/as w ostatnich tygodniach:

Week	

Rodzaje napojów alkoholowych	Jedno stki
	2.8
Butelka/puszka piwa (5%alk)	1.7
Gotowy drink (tzw.Alco pop) (5%)	1.4
Mocny Cider (8.5%)	2.3
Mała butelka wina187.5ml (12%)	2.3
Duża butelka wina 750ml (12%)	9
Kieliszek wódki 35ml (37.5%lub więcej)	1.3
Butelka wódki 350ml (37.5% lub więcej)	13

Q14b   Jak często pijesz alkohol?

Codziennie	1
Co tydzień	2
Co miesiąc	3
Rzadko	4
Nigdy	5

Q14c   Jaki alkohol spożywasz najczęściej?

Piwo	1
Cider	2
Wino	3
Spirytus	4
Gotowe drinki (Alco pop)	5
Mieszanki	6
Inne	7

Q14d   Gdzie najczęściej spożywasz alkohol?

W domu	1
U znajomych	2
Pub/Bar	3
Klubie nocnym	4
Klubie sportowym	5
Różnie	6
Inne	7

Q14e   Z kim zazwyczaj pijesz ?

Przyjaciele	1
Rodzina	2
Sam/a	3
Znajomymi Polakami	4

Q15   Na podstawie poniższej skali określ czy Twoje

spożycie alkoholu od momentu przyjazdu do Irlandii Północnej zwiększyło się, zmniejszyło, czy też w ogóle nie uległo zmianie

Spadek   **Bez zmian**   **Wzrost**

1   **2**   **3**   **4**   **5**   **6**   **7**   **8**   **9**   **10**

Kanabinole

Q16   Czy kiedykolwiek słyszałeś o poniższych używkach? trawa, zioło, Marihuana, Cannabis, Pot, dope, grass, blow.

Tak	1	kontynuuj
Nie	2	Przejdź do pytania nr 26

Q17   Czy osobiście znasz ludzi którzy zażywają kanabinole?

Tak	1
Nie	2

Q18   Czy kiedykolwiek zażywałeś kanabinole?

Tak	1	kontynuuj
Nie	2	Przejdź do pytania nr 26

Q19   W jakim wieku po raz pierwszy zażywałeś kanabinole?

     ← WSTAW WIEK

Nie wiem	-1

Q20   Czy w ciągu ostatnich 12 miesięcy zażywałeś kanabinole?

Tak	1	kontynuuj
Nie	2	Przejdź do pytania nr 26

Q21   Czy w ciągu ostatnich 30 dni zażywałeś kanabinole?

Tak	1	kontynuuj
Nie	2	Przejdź do pytania nr26

Q22   W przeciągu ostatnich 30 dni, ile dni zażywałeś kanabinole?

     ← podaj liczbę

Nie wiem	-1

Q23   Jaki rodzaj kanabinoli spożywasz

Trawa	1		7
	2	Inne (podaj)	8
Skun	3	_____	
Olejek haszyszowy	4		
Ziele	5	Nie wiem	9
Haszysz	6		

Q24   W jaki sposób najczęściej spożywasz kanabinole?

Skręt/Joint	1
Fajka	2
Fajka wodna	3

Jedząc	4
inne (podaj)	5
_____	
Nie wiem	6

Q25 Na podstawie poniższej skali określ czy Twoje spożycie kanabinoli od momentu przyjazdu do Irlandii Północnej zwiększyło sie, zmniejszyło, czy też w ogóle nie uległo zmianie

spadek **bez zmian** **wzrost**

1   2   3   4   5   6   7   8   9   10

LEKI NA RECEPTĘ ORAZ ZDOBYWANIE NIELEGALNIE

26 Czy spożywasz poniższe leki?

Diazepam	1
Temazepam	2
Df118's	3
Inne nasenne tabletki	4
Inne uspokajające	5
różne	6
nie	7

Q27 W jakim wieku pierwszy raz je spożyłeś?

		← **podaj wiek**
Nie wiem	-1	

Q28 Jeśli odpowiedziałeś pozytywnie na pytanie nr 26, jak często spożywasz leki:

Codziennie	1
Raz na tydzień	2
Raz na miesiąc	3
rzadko	4

Q29a Czy lek jest przepisany przez lekarza?:

Tak	1
Nie	2

Q29b Jeśli nie czy lek jest zakupiony w ...:

aptece	1
markecie	2
Inne, proszę podaj	

Q30 W jakiej formie spożywasz leki?

Tabletki	1
zastrzyk	2
Inne(podaj)	3
_____	

Nie wiem	4

Q31 Na podstawie poniższej skali określ czy Twoje spożycie środków uspokajających, nasennych, DF118's, diazepamu czy leków przeciwbólowych zawierających kodeinę od momentu przyjazdu do Irlandii Północnej zwiększyło się, zmniejszyło, czy też w ogóle nie uległo zmianie

spadek   **bez zmian**   **wzrost**

1   2   3   4   5   6   7   8   9   10

Dostęp do różnego usług, agencji/ organizacji.

32. Z kim byś się skontaktował gdybyś uznał, że pijesz zbyt dużą ilość alkoholu? (zaznacz jedną)

         Rozmowa z przyjacielem………………………………… ☐

         Rozmowa z partnerem……………………………………☐

         Rozmowa z doktorem……………………………………☐

         Rozmowa z pracownikiem pomocy społecznej…..................... ☐

         Rozmowa z pracownikiem jednej z organizacji zajmujących się☐ problemami grup mniejszościowych

         Inne……………………………………………………...☐

33. Czy kiedykolwiek korzystałeś z usług jakiegokolwiek centrum wsparcia?
         Tak…………………………………………………………☐

         Nie…………………………………………………………☐

34. Jeśli tak podaj jakie to agencje
………………………………………………………………

35. Czy były one ………………………………….........wolontaryjne ☐
                         państwowe ☐

Nie wiem ☐

36. Jeśli kiedykolwiek korzystałeś z ich pomocy, czy uważasz, że pomogły Ci zmniejszyć nadużycie alkoholu? W skali 1 do 10 jakbyś ocenił taką pomoc?

W ogóle niepomocne   bardzo pomocne

1   10
_____

Poniżej znajduje się kwestionariusz dotyczący ogólnego stanu zdrowia.

Chcielibyśmy się dowiedzieć więcej na temat Twojego zdrowia w ostatnich kilku tygodniach. Przeczytaj poniższe pytania i cztery możliwe odpowiedzi. Zaznacz tą, która najlepiej oddaje Twoje odczucia.

Czy ostatnio:

37. Czy ostatnio potrafiłeś/aś skoncentrować się na tym co robiłeś/aś?

lepiej niż zwykle   tak samo jak zwykle   gorzej niż zwykle   znacznie gorzej niż zwykle

38. Czy ostatnio zmartwienia nie pozwalały Ci spać?

 nie   nie bardziej niż zwykle   raczej bardziej niż zwykle   o wiele bardziej niż zwykle

39. Czy ostatnio odczuwałeś/aś, że to, co robisz jest pożyteczne?

bardziej niż zwykle   jak zwykle   mniej niż zwykle   o wiele mniej niż

                                                                        zwykle

40. Czy ostatnio czułeś/aś się zdolny/a do podejmowania decyzji?

bardziej niż zwykle   jak zwykle   mniej niż zwykle   znacznie mniej niż
zwykle

41. Czy ostatnioczułeś/aś się stale przemęczony/a?

wcale   nie bardziej niż zwykle   raczej bardziej niż zwykle   znacznie bardziej

niż zwykle

42. Czy ostatnio czułeś/aś, że nie potrafisz pokonać trudności?

wcale   nie bardziej niż zwykle   raczej bardziej niż zwykle   znacznie bardziej niż

zwykle

43. Czy ostatnio potrafiłeś/aś cieszyć się swoimi zwykłymi codziennymi zajęciami?

bardziej niż zwykle   jak zwykle   mniej niż zwykle   znacznie mniej niż zwykle

44. Czy ostatnio byłeś/aś zdolny/a stawić czoła swoim problemom?

bardziej niż zwykle   jak zwykle   mniej niż zwykle   znacznie mniej niz zwykle

45. Czy ostatnio czułeś/aś nieszczęśliwy/a i przygnębiony/a?

w ogóle nie   nie bardziej niż zwykle   raczej bardziej niż zwykle   znacznie bardziej

niż zwykle

46. Czy ostatnio straciłeś/aś wiarę w siebie?

w ogóle nie   nie bardziej niż zwykle   raczej bardziej niż zwykle   znacznie bardziej
niż zwykle

47. Czy myślałeś/aś ostatnio o sobie, że jesteś osobą bezwartościową?

w ogóle nie   nie bardziej niż zwykle   raczej bardziej niż zwykle   znacznie bardziej

niż zwykle

48. Czy ostatnio biorąc wszystkie sprawy pod uwagę, czułeś/aś się względnie
szczęśliwy/a?

bardziej niż zwykle   jak zwykle   mniej niż zwykle   znacznie mniej niż zwykle

Dziękuję za Twoją pomoc i współpracę. Informacje są poufne i będą przeznaczone
tylko i wyłącznie do celów statystycznych.

Shaun Roddy

Appendix 6
<u>Invitation to take part in a piece of Research/Study</u>

Title of Research: Investigation into the nature and extent of substance use/misuse within the Polish community in Northern Ireland

Name of Researcher: Shaun Roddy

Research background: I am a PhD student at the University of Ulster being supervised by Dr Anne Campbell.

This research is being conducted as part of my PhD programme of study. The aims of the research study are to explore and understand the extent of alcohol and substance use/misuse amongst the Polish community in Northern Ireland. This part of the research focuses on the general alcohol and substance use of members of the Polish Community.

It is planned that 16 members of the Polish community in Northern Ireland will be interviewed. The collected information will be analysed to identify any service requirements or improvements in relation to health and well-being.

An information sheet is enclosed explaining the details of the study together in particular the questionnaire for your completion

Please contact me at the address or telephone number below if you require further clarification

Many thanks for your help

Shaun Roddy
University of Ulster Magee
Northland Road
Derry

Tel: 02871 375137

Appendix 7

INTERVIEW PARTICIPANT INFORMATION SHEET

University of Ulster

Alcohol and Substance Use/Misuse amongst the Polish Community in
Northern Ireland

Shaun Roddy

Why is the Research Taking Place?
It is being carried out to explore and understand the extent of alcohol and substance use/misuse amongst the Polish community in Northern Ireland. There are two parts to the study: the first is a survey to establish the extent of substance misuse in the Polish community in Northern Ireland; the second is a series of face-to-face interviews with Polish service users of addiction services.

This second part of the research focuses on the personal experiences of members of the Polish Community who have accessed services for help and support for problems associated with alcohol or substance misuse.

The reasons why the research is taking place are:
4. Because the migrant population in Northern Ireland is expanding and we want to see to what extent Health and Personal Services are responding to the needs of the identified migrant population:
5. International research has indicated that people who migrate to new countries can sometimes suffer problems with alcohol or substance abuse:
6. It is part of an educational research project - PhD thesis.

Why the Polish Community?
3. The Polish population is the biggest migrant group in Northern Ireland at this time, so the research may be easier to carry out with a larger population. Therefore, it is important to provide an overview of the extent of substance misuse and consider the current level of service provision for Polish substance misusers in Northern Ireland
4. A number of the voluntary support organisations that work with people who have problems substance and alcohol use in Belfast area have indicated that the majority of migrants who are seeking help are from the Polish community.

Who will be invited to take part in the research?
Members of the Polish Community who have in the past, or who are currently accessing services for support with alcohol or substance misuse will asked take part in the interviews.

Who will carry out the research?
Shaun Roddy from the University of Ulster will carry out the interviews with the support of a Polish Translator. The interviews will be recorded to enable all information to be collected

When will the research happen?
The research will happen between September 2009 and January 2010. You will be asked to take part in the interview and the interview will last no longer than 1 hour

What are the interviews about?
The interviews will be semi structured, in that the questions are preset. However there is the flexibility to expand and discuss in depth some topics if you require. The interviews will begin by asking you about your current personal life, accommodation, marital status, number of children (if applicable)
Then you will be asked about your use of alcohol or substances.
The final part of the interview will discuss with you about your path to support services.

Will anyone be able to tell that its me who has answered the questions
NO!! YOU WILL NOT BE ASKED TO FILL IN YOUR NAME OR ANY OTHER DETAILS WHICH MAY BE USED TO IDENTIFY YOU!

What will happen to the information?
The information will contribute to the conclusions of a study. The information will be published in an academic report and shared with those people who organise and arrange services who help people with alcohol and substance misuse problems. Results from the study will also be made available to the polish people who completed the questionnaire and /or participated in the one to one interviews. It is hoped that the results from the study will provide the basis for a series of recommendations to improve services to the studied population.

Thank you.
Shaun Roddy
University of Ulster Magee
Northland Road
Derry

Tel 02871 375137

Appendix

Polish Service Users of Voluntary and Statutory Addiction Support Services

Semi Structured Interview Schedule

Introduction

Introduce myself and the translators (if the respondent does not speak good English).
Confirm the client's name and confirm that he/she is there of their own free will and
has signed consent form.
Reaffirm with the client the purpose of the interview and the reasons for conducting
the interview.
Clarify with the client the topics for discussion.
Confirm with the client that they have agreed for the interview to be tape-recorded.
Explain the confidentiality clause, i.e. all information is confidential and used for the
purposes of the research. However if the respondent divulges information that is an
indication that he/she or others may be at risk then the information may need to
passed on to the support organisation.
Clarify with the respondent that he or she can at any time stop the interview and no
reason will be sought for the termination. The information provided can be withdrawn
by the respondent without reason. The respondent does not need to answer any
questions they do not want to.
Explain that the interview will last for approximately 1 hour
Before the interview commences, the client will be asked do you wish to continue, if
they agree then continue.

Section One
Personal information.
1. What age are you?

2. Are you married, single, co-habiting, divorced, separated, widowed?

(probe present and past partnership eg partner still in Poland)

3. Have you any children?

(probe living with you or apart ; in Northern Ireland or Poland)

4. If yes, how old are they?

(probe again whether living as a family unit or split)

5. Who do live with?

(probe type and quality of living arrangements and satisfaction)

6. Do you own your own home, co-ownership, renting, living with friends and families?

7. What is your occupation?

(probe level of qualification skills match present occupation in NI)

8.Are you currently employed, unemployed, receiving benefits, retired, off work due to illness?
(probe employment history both in NI and back in Poland

Section Two
Migration History
.
1. How long have you lived in Northern Ireland?

(probe story of migration, previous countries live in etc)

2. Where did you live back home in Poland?

(probe city, country, industry, agriculture)

3. Did you come here with friends, family on your own?

(probe plans for family to join)

4. What made you leave Poland and come to Northern Ireland?

 (probe push factors – poverty, unemployment, peer pressure, persecution etc; probe pull factors - better wages, life style, experience living in another country)

5. What have been the good and bad things about leaving Poland and coming here to NI to live and work?

(probe loneliness, health, better standard of living.

Section Three

Alcohol/ Substance abuse/misuse

6. Can you share with me your drinking pattern back home in Poland?

(probe length of drinking, what drinking, where drinking etc)

7. In what ways has your drinking changed since coming to Northern Ireland?

(probe where drinking, amounts and what drinking)

8. Can you share with me your substance misuse back home in Poland?

(probe age of using, length of time amounts etc)

9. In what ways has your use of drugs changed since coming to Northern Ireland?

(probe where drinking, amounts and what drinking)

10. When were you using substance/alcohol most frequently?

(probe link with migration)

11. Would you link your alcohol/substance misuse to particular events in your life?

(probe trauma of emigration as stress factor)

12. What has been the impact of your substance misuse?

(probe impact on family, work, driving, relationships etc)

Section Four
Help Seeking

1. What made you seek help with your substance misuse?

(probe relationship break-up, criminal charges, ill-health etc)

2. Have you tried seeking help in the past for alcohol/substance use/misuse?

(probe where and when)

3. Can you describe the path to you current support/help service?

(probe effective person who got him to seek help; probe journey through the health and personal social services; probe use of voluntary sector)

4. How difficult was it to access services?

(probe how and whether intervention has helped)

5. Has language been a problem for you in accessing services?

(probe linguistic ability)

6. What does your treatment or intervention consist of?

(probe medication, CBT, motivational interviewing, twelve step programme etc).

7. Are you currently still getting help and support?

(probe length of contact, nature of follow-up)

8. Discuss the benefits, if any, that you have received since seeking support and help?

(probe if still misusing substances)

9. Are there any areas of your treatment that you feel could have been better/ improved

upon?
(probe how local services differ from Polish addiction services)

10. Are there any other comments or issues that you would like to raise in relation to the services provided.

Appendix 9   Invite for Polish service users to take part in research
Zaproszenie do wzięcia udziału w części badania naukowego.

Tytuł pracy: Eksploracja natury oraz ilości spożywania/nadużywania alkoholu oraz narkotyków pośród polskiej społeczności w Irlandii Północnej.

Prowadzący badanie: Shaun Roddy

Specyfika badania: Badanie to jest przeprowadzane jako część mojej pracy doktorskiej. Jednym z celów mojej pracy jest zrozumienie i zapoznanie się ze stopniem używania/nadużywania alkoholu oraz innych substancji odurzających wśród polskiej społeczności w Irlandii Północnej. Ta część badania skupia się na osobistych doświadczeniach członków polskiej społeczności, którzy korzystali z wszelkiego rodzaju usług oferujących pomoc i wsparcie dla osób z problemem uzależnienia od alkoholu lub innych substancji.

Przewidywane jest, że 40 członków polskiej społeczności zamieszkujących w Irlandii Północnej weźmie udział w indywidualnych wywiadach w celu przedyskutowania ich doświadczeń na temat dostępu oraz korzystania z wspomnianych serwisów. Informacje zdobyte w trakcie wywiadów będą wykorzystane w celu zidentyfikowania potrzeb oraz udoskonalenia usług świadczonych w dziedzinie zdrowia i dobrostanu psychicznego.

Informacje dotyczące badania, w szczególności na temat przeprowadzanych wywiadów są dołączone na osobnej stronie.

Dziękuję

Shaun Roddy
University of Ulster Magee
Northernland Road
Derry
02871 375137

Appendix 10 Service Users Participant Information Sheet

ARKUSZ INFORMACYJNY DLA OSÓB BIORĄCYCH UDZIAŁ W
WYWIADZIE.

University of Ulster

Spożywanie/nadużywanie alkoholu oraz innych substancji wśród polskiej
społeczności w Irlandii Północnej.

Dlaczego przeprowadzane jest badanie?
Badanie jest przeprowadzane aby lepiej poznać i zrozumieć naturę oraz wielkość
zjawiska jakim jest spożywanie/nadużywanie alkoholu oraz narkotyków pośród
polskiej społeczności w Irlandii Północnej. Badanie składa się z dwóch części:
pierwsza to określenie stopnia występowania problemów związanych z
nadużywaniem substancji psychoaktywnych przy pomocy kwestionariusza, druga
część obejmuje indywidualne wywiady z Polakami będącymi użytkownikami
serwisów Służby Zdrowia i pokrewnych.

Druga część badania skupia się na osobistych doświadczeniach członków polskiej
społeczności, którzy korzystali lub korzystają z pomocy i wsparcia instytucji
nastawionych na pracę w dziedzinie uzależnień.

Powodami dla których badanie ma miejsce są:
1. Ponieważ zwiększa się populacja imigrantów w Irlandii Północnej chcemy
    dostrzec w jakim stopniu spełniane są potrzeby imigrantów ze strony
    Służby Zdrowia oraz innych instytucji.

2. Wyniki badań przeprowadzonych w różnych krajach wskazują, iż ludzie
    przebywający na emigracji mogą mieć problemy z nadużywaniem alkoholu
    lub innych substancji.
3. Jest ono częścią edukacyjnego projektu badawczego- teza doktorska.

Dlaczego polska społeczność?
1. W chwili obecnej populacja Polaków jest najliczniejszą wśród grup
    imigrantów w Irlandii Północnej. Dlatego ważne jest, aby dokonać
    przeglądu informacji na temat uzależnień z uwzględnieniem oferty
    serwisów kierowanych do Polaków w Irlandii Północnej
    nadużywających alkoholu oraz innych substancji.
2. Wiele wolontaryjnych organizacji w rejonie Belfastu, nastawionych na
    pracę z ludźmi mającymi problemy z nadużywaniem alkoholu oraz
    innych substancji wskazuje, iż większość imigrantów szukających
    pomocy to Polacy.

Kto będzie zaproszony do wzięcia udziału w badaniu?
Do wzięcia udziału w wywiadach będą proszeni członkowie polskiej społeczności,
którzy korzystali lub obecnie korzystają z usług serwisów dostarczających wsparcie
dla osób nadużywających alkoholu oraz innych substancji.

Kto przeprowadzi badanie?
Wywiady będą przeprowadzone przez Shauna Roddy'ego z pomocą polskiego tłumacza. Rozmowy będą nagrywane, aby umożliwić zapis zdobytych informacji.

Kiedy badanie będzie miało miejsce?
Badanie przeprowadzone zostanie w okresie od stycznia 2009 do czerwca 2009. Będziesz poproszony, aby wziąć udział w wywiadzie, który będzie trwał nie dłużej niż jedną godzinę.

Jak wygląda wywiad?
Wywiad będzie tzw. częściowo ustrukturyzowany. Oznacza to, iż pytania są wcześniej ustalone, jednakże, jeśli tego wymagasz elastyczna forma wywiadu pozwala na rozwinięcie i szersze przedyskutowanie niektórych tematów. Wywiad zacznie się od pytania Ciebie o aktualne życie osobiste, miejsce zamieszkania, status cywilny, ilość dzieci (jeśli dotyczy).
Następnie, będziesz pytany o Twoje doświadczenia związane z zażywaniem alkoholu lub innych substancji.
Końcowa część wywiadu będzie miała na celu dyskusję na temat Twojej drogi do skontaktowania się z instytucjami wsparcia. Uczestnictwo jest dobrowolne oraz w każdym momencie masz prawo do wycofania się z badania bez podawania powodu, nie naruszając Twoich praw cywilnych oraz programu leczenia.

Czy ktokolwiek będzie w stanie stwierdzić, iż odpowiedzi na pytania należą do mnie?
NIE! NIE BĘDZIESZ PROSZONY ABY PODAĆ SWOJE IMIĘ, NAZWISKO LUB INNE DANE, KTÓRE MOGŁYBY BYĆ UŻYTE ABY CIĘ ZIDENTYFIKOWAĆ!

Co stanie się ze zgromadzonymi informacjami?
Informacje te przyczynią się do wyciągnięcia wniosków z przeprowadzonego badania. Zostaną one opublikowane w raporcie akademickim oraz będą dzielone z osobami odpowiedzialnymi za organizację i zapewnienie serwisu, który pomoże ludziom z problemem uzależnienia.
Wyniki będą również dostępne dla Polaków, którzy wypełnili kwestionariusz i/lub brali udział w wywiadach. Przewidywane jest, iż raport z badań będzie opublikowany w październiku 2010. Mamy nadzieję, że wyniki badania dostarczą podstaw do polepszenia jakości serwisu dostępnego dla populacji objętej badaniem.

Dziękuję

Shaun Roddy
University of Ulster Magee
Northernland Road
Derry
02871 375137

Appendix 11
Research: Investigation into the nature and extent of substance misuse amongst the Polish population in Northern Ireland.

Interview with Service Providers

Dear Service Provider

I am undertaking doctoral research with the University of Ulster at Magee, into the nature and extent of substance misuse amongst the Polish population in Northern Ireland. The Research is being supervised by Dr Anne Campbell
I am requesting your participation in a semi-structured interview which will focus on the provision of alcohol and substance misuse services for members of our migrant communities. Within the interview I hope to explore with you, the experiences of providing a service to an ever-changing population, particularly with reference to different language and cultural needs.

The overall aim of the research is to identify any service needs through user and service provider led research. So that evidence based research can help to change and shape best practice.

The interview will take approximately 45minutes and your participation is completely voluntary.

Your responses within the interview will be strictly confidential and data from this research will be reported in the aggregate.

If you have any questions at any time about the interview or the topics for discussion, you may contact the researcher, Shaun Roddy, University of Ulster at Magee, Phone 02871 375137, or email at roddy-s@email.ulster.ac.uk.

Thank you for your time and support in investigating this issue. I realise your time is limited, however I believe through you contribution, experience and knowledge, some of the issues may be addressed that face you as a practitioner in providing a world class service to some of the most vulnerable members of our society.

Thank you,

Shaun Roddy
University of Ulster at Magee
Northland Road
Derry
Tel: 02871 375137

Appendix

SERVICE PROVIDERS PARTICIPANT INFORMATION SHEET

University of Ulster

Alcohol and Substance Use/Misuse amongst the Polish Community in
Northern Ireland

Shaun Roddy

Why is the Research Taking Place?
It is being carried out to explore and understand the extent of alcohol and substance
use/misuse amongst the Polish community in Northern Ireland. There are two parts to the
study which involves service users. The first is a survey to establish the extent of substance
misuse in the Polish community in Northern Ireland; the second is a series of face-to-face
interviews with Polish service users of addiction services.

This second part of the research focuses on the personal experiences of members of the
Polish Community who have accessed services for help and support for problems associated
with alcohol or substance misuse.

This part of the research which involves service providers, focuses on the experiences of
providing a service to an ever-changing population, particularly with reference to different
language and cultural needs.

The reasons why the research is taking place are:
7. Because the migrant population in Northern Ireland is expanding and we want to see
   to what extent Health and Personal Services are responding to the needs of the
   identified migrant population:
8. International research has indicated that people who migrate to new countries can
   sometimes suffer problems with alcohol or substance abuse:
9. It is part of an educational research project - PhD thesis.

Why the Polish Community?
5. The Polish population is the biggest migrant group in Northern Ireland at this time, so
   the research may be easier to carry out with a larger population. Therefore, it is
   important to provide an overview of the extent of substance misuse and consider the
   current level of service provision for Polish substance misusers in Northern Ireland
6. A number of the voluntary support organisations that work with people who have
   problems substance and alcohol use in Belfast area have indicated that the majority of
   migrants who are seeking help are from the Polish community.

Who will be invited to take part in this part of the research?
Members of staff who work for those voluntary and statutory organisations who provide
support and treatment for people who suffers problems due to alcohol and substance misuse.

Who will carry out the research?
Shaun Roddy from the University of Ulster will carry out the interviews. The interviews will
be recorded to enable all information to be collected

When will the research happen?
The research will happen between January 2009 and June 2009. You will be asked to take part in the interview and the interview will last no longer than 1 hour

What are the interviews about?
The interviews will be semi structured, in that the questions are preset. However there is the flexibility to expand and discuss in depth some topics if you require. The interviews are an opportunity for you to discuss what you may view are the strengths and weaknesses of the service in relation to provision to members of society who are migrants.

Will anyone be able to tell that its me who has answered the questions
NO!! YOU WILL NOT BE ASKED TO FILL IN YOUR NAME OR ANY OTHER DETAILS WHICH MAY BE USED TO IDENTIFY YOU!

What will happen to the information?
The information will contribute to the conclusions of a study. The information will be published in an academic report and shared with those people who organise and arrange services who help people with alcohol and substance misuse problems.
Results from the study will also be made available to the Polish people who completed the questionnaire and /or participated in the one to one interviews. It is anticipated that the report will be published in October 2010. It is hoped that the results from the study will provide the basis for a series of recommendations to improve services to the studied population.

Thank you.
Shaun Roddy
University of Ulster Magee
Northland Road
Derry

Tel 02871 375137

Appendix 13

Service Providers – Interview Schedule

1. What is your position within the service?

2. What is your professional background, (e.g. Dr, nurse, social worker, housing officer, care assistant, counsellor)

3. How long have you been in the current position within this service?

4. Can you describe the service and the aims - e.g. In-patient treatment, community based treatment, housing,

5. Has there been any help seeking from members of the Polish community.

6. In your service in the last 3 months how many members from the Polish community would have accessed the service.

7. In your service in the last 6 months how many members from the Polish community would have accessed the service.

8. In your service in the last 12 months how many members from the Polish community would have accessed the service.

9. What do you see are the main barriers to effective service provision for members of the migrant population?

10. The Bamford review of Mental Health Service Provision identified migrant workers and those from minority cultures are in particular specific need in order to access services. Do you feel these needs are being addressed? If so, how. If no, why not?

11. Do you feel your service is equipped to deliver a full service to those people from different migrant groups such as the Polish community?

12. To date, how well were you able to provide a service to those members of the Polish community who have accessed the service?

13. What specific issues arose, if any, in delivering a full service to those clients?

14. Do you see an increasing role in the provision of voluntary (specific) services to minority groups?

15. Do you have any additional comments that you feel need to be considered in terms of this study

Thank you for your time and help.

Shaun Roddy

Appendix 14 - Participant consent form
Centre Number:
Study Number:

Title of Project: Investigation into the nature and extent of substance use/misuse within the Polish community in Northern Ireland

Name of Researcher: Shaun Roddy

1. I confirm that I have read and understand the information sheet dated November 2008 for the above study.

2. I understand that my participation is voluntary and I am free to withdraw at any time without giving any reason.

3. I understand that relevant data collected during the study may be looked at by individuals from the University of Ulster, from Regulatory Authorities or from the National Health Service Trusts.

4. I agree to take part in the above study

_____   _____   _____
Name   Date   Signature

_____   _____   _____
Name of   Date   Signature
person taking consent

Appendix 15 : Correlations of GHQ and Alcohol

Correlations

		Since coming to NI has your alcohol consumption increased or decreased	GHQ score
Since coming to NI has your alcohol consumption increased or decreased	Pearson Correlation	1	.282(**)
	Sig. (2-tailed)	.	.000
	N	231	231
GHQ score	Pearson Correlation	.282(**)	1
	Sig. (2-tailed)	.000	.
	N	231	231

** Correlation is significant at the 0.01 level (2-tailed).

Correlations

		Since coming to NI has your alcohol consumption increased or decreased	Social dysfunction base on GHQ subscales
Since coming to NI has your alcohol consumption increased or decreased	Pearson Correlation	1	.344(**)
	Sig. (2-tailed)	.	.000
	N	231	231
Social dysfunction base on GHQ subscales	Pearson Correlation	.344(**)	1
	Sig. (2-tailed)	.000	.
	N	231	231

** Correlation is significant at the 0.01 level (2-tailed).

Correlations

		During the last 30 days, on how many days have you drunk alcohol	anxiety/depression base on GHQ subscales
During the last 30 days, on how many days have you drunk alcohol	Pearson Correlation	1	.266(**)
	Sig. (2-tailed)	.	.000
	N	225	225
anxiety/depression base on GHQ subscales	Pearson Correlation	.266(**)	1
	Sig. (2-tailed)	.000	.
	N	225	231

** Correlation is significant at the 0.01 level (2-tailed).

Correlations

		During the last 30 days, on how many days have you drunk alcohol	Social dysfunction base on GHQ subscales
During the last 30 days, on how many days have you drunk alcohol	Pearson Correlation	1	.404(**)
	Sig. (2-tailed)	.	.000
	N	225	225
Social dysfunction base on GHQ subscales	Pearson Correlation	.404(**)	1
	Sig. (2-tailed)	.000	.
	N	225	231

** Correlation is significant at the 0.01 level (2-tailed).

Correlations

		Using the list provided please state the amount of units of alcohol consumed in the last week	GHQ score
Using the list provided please state the amount of units of alcohol consumed in yhr last week	Pearson Correlation	1	.033
	Sig. (2-tailed)	.	.619
	N	227	227
GHQ score	Pearson Correlation	.033	1
	Sig. (2-tailed)	.619	.
	N	227	231

Appendix 16: ANOVAS of GHQ		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Upper	Lower
GHQ score	Equal variances assumed	.341	.560	-.717	229	.474	-.4269	.59531	-1.59985	.74612
	Equal variances not assumed			-.737	193.878	.462	-.4269	.57935	-1.56950	.71577
Alcohol consumption	Equal variances assumed	336.981	.000	6.310	223	.000	.3744	.05934	.25745	.49131
	Equal variances not assumed			7.373	221.579	.000	.3744	.05078	.27431	.47445
anxiety/depression base on GHQ subscales	Equal variances assumed	1.047	.307	-1.068	229	.287	-.2622	.24547	-.74590	.22144
	Equal variances not assumed			-1.101	195.438	.272	-.2622	.23822	-.73204	.20758
Social dysfunction base on GHQ subscales	Equal variances assumed	1.641	.202	1.062	229	.290	.2997	.28229	-.25653	.85589
	Equal variances not assumed			1.104	200.628	.271	.2997	.27136	-.23540	.83476
Loss of confidence base on GHQ subscales	Equal variances assumed	6.554	.011	-1.717	229	.087	-.2949	.17175	-.63328	.04355
	Equal variances not assumed			-1.794	203.126	.074	-.2949	.16433	-.61889	.02915

Appendix 17 : ANOVAS with alcohol use and arrival in NI		Using the list provided please state the amount of units of alcohol consumed in the last week	During the last 30 days, on how many days have you drunk alcohol	Since coming to NI has your alcohol consumption increased or decreased	GHQ score	Alcohol consumption	anxiety/de pression base on GHQ subscales	Social dysfuncti on base on GHQ subscales	Loss of confidence base on GHQ subscales
Using the list provided please state the amount of units of alcohol consumed in yhr last week	Pearson Correlation	1	.536(**)	.529(**)	.033	.823(**)	-.125	.128	.055
	Sig. (2-tailed)	.	.000	.000	.619	.000	.059	.053	.406
	N	227	225	227	227	221	227	227	227
During the last 30 days, on how many days have you drunk alcohol	Pearson Correlation	.536(**)	1	.427(**)	.415(**)	.579(**)	.266(**)	.404(**)	.395(**)
	Sig. (2-tailed)	.000	.	.000	.000	.000	.000	.000	.000
	N	225	225	225	225	219	225	225	225
Since coming to NI has your alcohol consumption increased or decreased	Pearson Correlation	.529(**)	.427(**)	1	.282(**)	.479(**)	.117	.344(**)	.219(**)
	Sig. (2-tailed)	.000	.000	.	.000	.000	.076	.000	.001
	N	227	225	231	231	225	231	231	231
GHQ score	Pearson Correlation	.033	.415(**)	.282(**)	1	.065	.836(**)	.869(**)	.790(**)
	Sig. (2-tailed)	.619	.000	.000	.	.329	.000	.000	.000
	N	227	225	231	231	225	231	231	231
Alcohol consumption	Pearson Correlation	.823(**)	.579(**)	.479(**)	.065	1	-.072	.114	.097
	Sig. (2-tailed)	.000	.000	.000	.329	.	.279	.089	.149
	N	221	219	225	225	225	225	225	225
anxiety/depression base on GHQ subscales	Pearson Correlation	-.125	.266(**)	.117	.836(**)	-.072	1	.621(**)	.661(**)
	Sig. (2-tailed)	.059	.000	.076	.000	.279	.	.000	.000
	N	227	225	231	231	225	231	231	231

Social dysfunction base on GHQ subscales	Pearson Correlation	.128	.404(**)	.344(**)	.869(**)	.114	.621(**)	1	.573(**)
	Sig. (2-tailed)	.053	.000	.000	.000	.089	.000	.	.000
	N	227	225	231	231	225	231	231	231
Loss of confidence base on GHQ subscales	Pearson Correlation	.055	.395(**)	.219(**)	.790(**)	.097	.661(**)	.573(**)	1
	Sig. (2-tailed)	.406	.000	.001	.000	.149	.000	.000	.
	N	227	225	231	231	225	231	231	231

References

Agic, B., Mann, R.E., Tuck, A., Ialomiteanu, A., Bondy, S., Simich, L. and Ilie, G. (2016) Alcohol use among immigrants in Ontario, Canada. Drug and Alcohol Review, 35 (2), 196-205.

AJZEN, I. (1991) The Theory of Planned Behavior. Organizational behavior and human decision processes, 50 (2), 179-211.

Ajzen, I. (2011) The theory of planned behaviour: Reactions and reflections. Psychology & Health, 26 (9), 1113-1127.

American Psychiatric Association (2013) Diagnostic and statistical manual of mental disorders.: DSM-5. Washington DC. American Psychiatric Publicating

Anderson, K.K., Cheng, J., Susser, E., McKenzie, K.J. and Kurdyak, P. (2015) Incidence of psychotic disorders among first-generation immigrants and refugees in Ontario. Canadian Medical Association journal, 187 (9), E279-E286.

Andersen RM. (1995) Revisiting the behavioral model and access to medical care: does it matter? Journal Health Social Behaviour ;36(1):1–10

Aliens Restrictions Act 1905

ARK. 2009 . Northern Ireland Life and Times Survey

Arango, J. (2000) Explaining migration: a critical view. International Social Science Journal, 52 (3), 283-+.

Aspinall, P. (2002) Suicide amongst Irish migrants in Britain: A review of the identity and integration hypothesis. International Journal of Social Psychiatry, 48 (4), 290-304.

Aung, N.C., Rechel, B. and Odermatt, P. (2010) Access to and utilisation of GP services among Burmese migrants in London: a cross-sectional descriptive study. Bmc Health Services Research, 10 285.

Australian Psychological Society (2011) . Working with Interpreters. A Practice Guide for Interpreters

Baily, C.D.R., Henderson, S.W. and Tayler, R. (2016) Global Mental Health in Our Own Backyard: An Unaccompanied Immigrant Child's Migration From El Salvador to New York City. Journal of clinical psychology, 72 (8), 766-778.

Baines, T. and Wittkowski, A. (2013) A Systematic Review of the Literature Exploring Illness Perceptions in Mental Health Utilising the Self-Regulation Model. Journal of Clinical Psychology in Medical Settings, 20 (3), 263-274.

Bamford Review of Mental Health and Learning Disability (2006). Human Rights and Equality of Opportunity. Belfast: DHSSPS.

Bamford Review of Mental Health and Learning Disability (2007). A Comprehensive Legal Framework for Mental Health and Learning Disability. Belfast: DHSSPS.

Bandura, A. (1977). Social learning theory. Englewood Cliffs, NJ: Prentice Hall.

Bandura, A. (1977) Self-Efficacy - Toward a Unifying Theory of Behavioral Change. Psychological review, 84 (2), 191-215.

Bebbington, P., Bhugra, D., Brugha, T., Singleton, N., Farrell, M., Jenkins, R., Lewis, G. and Meltzer, H. (2004) Psychosis, victimisation and childhood disadvantage - Evidence from the second British National Survey of Psychiatric Morbidity. British Journal of Psychiatry, 185 220-226.

Becker, G. and Murphy, K. (1988) A Theory of Rational Addiction. Journal of Political Economy, 96 (4), 675-700.

Becker MH, Kaback MM, Rosenstock IM, (1975) Some influences on public participation in a genetic screening program. J Community Health 1:3-14.

Ben-Ari, A. and Strier, R. (2010) Rethinking Cultural Competence: What Can We Learn from Levinas? British Journal of Social Work, 40 (7), 2155-2167.

Bengoa, R. Stout, A. Scott, B.; McAlinden, M.; Taylor, M. (2016) Systems Not Structures: Changing Health and Social Care. Depratment of Health , Northern Ireland.

Berry, J.W. (2008) Globalisation and acculturation. International Journal of Intercultural Relations, 32 (4), 328-336.

Berry, J.W. (2010) Intercultural Relations and Acculturation in the Pacific Region. Journal of Pacific Rim Psychology, 4 (2), 95-102.

Berry, J.W. (2009) A critique of critical acculturation. International Journal of Intercultural Relations, 33 (5), 361-371.

Berry, J.W. and Hou, F. (2017) Acculturation, discrimination and wellbeing among second generation of immigrants in Canada. International Journal of Intercultural Relations, 61 29-39.

Berry, J.W. and Hou, F. (2016) Immigrant Acculturation and Wellbeing in Canada. Canadian Psychology-Psychologie Canadienne, 57 (4), 254-264.

Berry, J. W. (1997).Immigration, acculturation, and adaptation. Applied Psychology: An International Review, 46, 5-34

Berry, J.W., Phinney, J.S., Sam, D.L. and Vedder, P. (2010) Immigrant Youth: Acculturation, Identity and Adaptation. Zeitschrift Fur Padagogik, 17-43.

Berry, J.W., Phinney, J.S., Sam, D.L. and Vedder, P. (2006) Immigrant youth: Acculturation, identity, and adaptation. Applied Psychology-an International Review-Psychologie Appliquee-Revue Internationale, 55 (3), 303-332.

Berry, J.W. and Sabatier, C. (2011) Variations in the assessment of acculturation attitudes: Their relationships with psychological wellbeing. International Journal of Intercultural Relations, 35 (5), 658-669.

Berry, J.W. and Sabatier, C. (2010) Acculturation, discrimination, and adaptation among second generation immigrant youth in Montreal and Paris. International Journal of Intercultural Relations, 34 (3), 191-207.

Berry, J., Zheng, Y. and Gui, Y. (2012) Migrant worker acculturation in China. International Journal of Psychology, 47 234-235.

Berry, J. (2005) Acculturation: Living successfully in two cultures. International Journal of Intercultural Relations, 29 (6), 697-712.

Berry, J. (1997) Constructing and expanding a framework: Opportunities for developing acculturation research. Applied Psychology-an International Review-Psychologie Appliquee-Revue Internationale, 46 (1), 62-68.

Berry, J. W. (1997).Immigration, acculturation, and adaptation. Applied Psychology: An International Review, 46,5-34

Berry, J. (1994) Acculturation and Psychological Adaptation - an Overview.

Berry, J. (1992) Acculturation and Adaptation in a New Society. International Migration, 30 69-85.

Berry, J. (1990) Acculturation and Adaptation - a General Framework.

Berry, J., Kim, U., Power, S., Young, M. and Bujuki, M. (1989) Acculturation Attitudes in Plural Societies. Applied Psychology-an International Review-Psychologie Appliquee-Revue Internationale, 38 (2), 185-206.

Berry, J. and Sinha, D. (1992) Psychological Acculturation - the Generalizability of Theories and Findings. International Journal of Psychology, 27 (3-4), 656-656.

Bhugra, D. (2015) Culturally Sensitive Classification of Mental Disorders. European Psychiatry, 30

Bhugra, D. (2005) Cultural identities and cultural congruency: a new model for evaluating mental distress in immigrants. Acta Psychiatrica Scandinavica, 111 (2), 84-93.

Bhugra, D. (2005) The global prevalence of schizophrenia. Plos Medicine, 2 (5), 372-373.

Bhugra, D. (2004) Cultural diversity, mental health and psychiatry: the struggle against racism. Acta Psychiatrica Scandinavica, 110 (4), 318-318.

Bhugra, D. (2004) Migration, distress and cultural identity. British medical bulletin, 69 129-141.

Bhugra, D. (2003) Migration and depression. Acta Psychiatrica Scandinavica, 108 67-72.

Bhugra, D. (2003) Paediatric psychopharmacology: Principles and practice. International Review of Psychiatry, 15 (3), 292-292.

Bhugra, D. and Arya, P. (2005) Ethnic density, cultural congruity and mental illness in migrants. International Review of Psychiatry, 17 (2), 133-137.

Bhugra, D. and Bhui, K. (2003) Eating disorders in teenagers in East London: A survey. European Eating Disorders Review, 11 (1), 46-57.

Bhugra, D. and Mastrogianni, A. (2004) Globalisation and mental disorders - Overview with relation to depression. British Journal of Psychiatry, 184 10-20.

Bhugra, D., Still, R., Furnham, A. and Bochner, S. (2004) Migration and mental health. Acta Psychiatrica Scandinavica, 109 (4), 243-258.

Bhugra, D. (2016) Mental health for nations. International Review of Psychiatry, 28 (4), 342-374.

Bhugra, D., Thompson, N., Piracha, S., Kapoor, J., Oommen, G. and Wing, J.C. (2003) Mental Health of Ethnic Minority Elders in West London : Pathways into secondary care. Indian journal of psychiatry, 45 (2), 27-30.

Blomstedt, Y., Johansson, S. and Sundquist, J. (2007) Mental health of immigrants from the former Soviet Bloc: a future problem for primary health care in the enlarged European Union? A cross-sectional study. Bmc Public Health, 7 27.

Borges, G., Medina-Mora, M., Orozco, R., Fleiz, C., Cherpitel, C. and Breslau, J. (2009) The Mexican migration to the United States and substance use in northern Mexico. Addiction, 104 (4), 603-611.

Boyd, M. (1989) Family and Personal Networks in International Migration - Recent Developments and New Agendas. International Migration Review, 23 (3), 638-670.

Brady, H. (2008), EU Migration Policy: An A-Z. Centre for European Reform.

Bradley, E., Curry, L., McGraw, S., Webster, T., Kasl, S. and Andersen, R. (2004) Intended use of informal long-term care: The role of race and ethnicity. Ethnicity & health, 9 (1), 37-54.

Braun, V., Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3, 77–101

Brearley, P. (1982). Risk and Social Work. Hazards and Helping. Routledge and Kegan Paul. London

Brewer, J., & Hunter, A. (1989). Multimethod research: A synthesis of styles. Newbury Park, NJ: Sage.

Brewin, J., Cantwell, R., Dalkin, T., Fox, R., Medley, I., Glazebrook, C., Kwiecinski, R. and Harrison, G. (1997) Incidence of schizophrenia in Nottingham - A comparison of two cohorts, 1978-80 and 1992-94. British Journal of Psychiatry, 171 140-144.

British Nationality Act, 1948

Brown SA, Chung T, Martin CS, Winters KC.(2006) Frontlines: Linking Alcohol Services Research & Practice, National Institute on Alcohol Abuse and Alcoholism. Washington, DC: National Institute n Alcohol Abuse and Alcoholism; 2006. Treated Adolescents' Trajectories of Substance Involvement Through Young Adulthood

Brugha, T.S., Bebbington, P.E., Singleton, N., Melzer, D., Jenkins, R., Lewis, G., Farrell, M., Bhugra, D., Lee, A. and Meltzer, H. (2004) Trends in service use and treatment for mental disorders in adults throughout Great Britain. British Journal of Psychiatry, 185 378-384.

Bryman, A. (2004). Social Research Methods. Oxford University Press. Oxford

Bryman, A. (2015). Social Research Methods. Oxford University Press. Oxford

Bourdieu, R. and Wacquant, L. 1992 An Invitation to Reflexive Sociology. Polity Press. London

Buckley, P. (1998) Substance abuse in schizophrenia: A review. Journal of Clinical Psychiatry, 59 26-30.

Bundy, C. (2004) Changing behaviour: using motivational interviewing techniques. Journal of the Royal Society of Medicine, 97 43-47.

Burke, A. W. (1976). Attempted suicide among the Irish-born population in Birmingham. The British Journal of Psychiatry, 128,534-537

Burns, R. (2000) Introduction to Research methods. Sage. London

Burrell, K. (2008) Managing, learning and sending : The material lives and journeys of Polish women in Britain. Journal of Material Culture, 13 (1), 63-83.

Burrell, K. 2009. Polish Migration to the UK in the 'New' European Union: After 2004. London. Routledge

Burrell, K. (2006) Histories and Memories: Migrants and their History in Britain. London, IB Tauris

Burrell, K. (2008) Materialising the Border: Spaces of Mobility and Material Culture in Migration from Post-Socialist Poland. Mobilities, 3 (3), 353-373.

Burrell, K. (2010) 'Staying, returning, working and living: key themes in current academic research in the UK on migration movements from Eastern Europe. Social Identities Vol.16 no.3 p287-208

Campbell, D.T. and Fiske, D.W. (1959) Convergent and discriminant validation by the multitrait-multimethod matrix. Psychological bulletin, 56 (2), 81-105.

Canales, G. (2013) Transformative, Mixed Methods Checklist for Psychological Research With Mexican Americans. Journal of Mixed Methods Research, 7 (1), 6-21.

Carmel, S., Shani, E. and Rosenberg, L. (1994) The Role of Age and an Expanded Health Belief Model in Predicting Skin-Cancer Protective Behavior. Health education research, 9 (4), 433-447.

Castles, Stephen; Miller, Mark J, (2003), The Age of Migration, Castles, Stephen; Miller, Mark J Basingstoke: Palgrave Macmillan

Castles, Stephen; Miller, Mark J, (2009) The age of migration: international population movements in the modern world Basingstoke: Palgrave Macmillan

Chataway, C. and Berry, J. (1989) Acculturation Experiences, Appraisal, Coping, and Adaptation - a Comparison of Hong-Kong Chinese, French, and English Students in Canada. Canadian Journal of Behavioural Science-Revue Canadienne Des Sciences Du Comportement, 21 (3), 295-309.

Cheung, Y. (1991) Ethnicity and Alcohol Drug-use Revisited - a Framework for Future-Research. International Journal of the Addictions, 25 (5A-6A), 581-605.

Cheung, Y. (1991) Sharpening the Focus on Ethnicity - Overview. International Journal of the Addictions, 25 (5A-6A), 573-579.

Clarke PN, Yaros PS. (1988) Research blenders: Commentary and response. Nursing Science Quarterly.;1:147–149

Cloninger, C. (1987) A systematic method for clinical description and classification of personality variants. Archives of General Psychiatry 44:573–588, 1987b

Cloninger, C., Przybeck, T. and Svrakic, D. (1991) The Tridimensional Personality Questionnaire - United-States Normative Data. Psychological reports, 69 (3), 1047-1057.

Cloninger, C., Sigvardsson, S. and Bohman, M. (1996) Type I and type II alcoholism: An update. Alcohol Health & Research World, 20 (1), 18-23.

Close, C.M., Bosqui, T., O'Reilly, D., Donnelly, M. and Kouvonen, A. (2018) Migrant mental health and representation in routine administrative registers. International Journal of Migration Health and Social Care, 14 (1), 82-95.

Close, C.M., Bosqui, T., O'Reilly, D., Donnelly, M. and Kouvonen, A. (2016) The Health and Well-being of first generation migrants : a systematic review of reviews. Globalisation and Health 12: 47

Commonwealth Immigrants Act 1962

Cordero, A. and Kurz, B. (2006) Acculturation and the mental health of Latina women in the Women, Infant, and Children Program. Affilia-Journal of Women and Social Work, 21 (1), 46-58.

Creswell, J. W. (2003). Research design: Qualitative, quantitative, and mixed methods approaches (2nd ed.). Thousand Oaks, CA: Sage

Creswell, J. W. (2007). Qualitative inquiry & research design: Choosing among five approaches (2nd ed.). Thousand Oaks, CA: Sage

Crotty, M. (1998). The foundations of social research: Meaning and perspective in the researchprocess. Thousand Oaks, CA: Sage.

Czabala, C., Charzynska, K. and Mroziak, B. (2011) Psychosocial interventions in workplace mental health promotion: an overview. Health promotion international, 26 I70-I84.

Czabala, J. Dudek, B., Krasucki, P., Pietrzykowska, P., Brodniak, W. (2000) Mental Health in the Workplace: Situation Analyses, Poland. GLADNET Collection

Dalgard, O.S. & Thapa, S.B. (2007). Immigration, social integration and mental health in Norway, with focus on gender differences. Clinical Practice and Epidemiology in Mental Health, 3, 24

Danesi M. Teen talk: (1996)What are the implications for second-language teaching? Mosaic 3 (4):1–10

Datta, L. (1994). Paradigm wars: A basis for peaceful coexistence and beyond. In C. S. Reichardt & S. F. Rallis (Eds.), The qualitative-quantitative debate: New perspectives (pp. 53-70). San Francisco, CA: Jossey-Bass

DEL (2009), The Economic, Labour Market and Skills Impacts of Migrant Workers in Northern Ireland. Oxford Economics Northern Ireland

Demes, K.A. and Geeraert, N. (2014) Measures Matter: Scales for Adaptation, Cultural Distance, and Acculturation Orientation Revisited. Journal of Cross-Cultural Psychology, 45 (1), 91-109.

Denzin, N. &Lincoln, Y. (2008) Strategies of Qualitative Inquiry Sage London.

Department of Health, Social Services and Public Safety (1992). Code of Practice for the Mental Health (Northern Ireland) Order 1986. Belfast

Department of Health, Social Services and Public Safety (2011). The New Strategic Direction for Alcohol and Drugs 2011. Belfast

Department of Health, Social Services and Public Safety (2005) Provision of Health Services to Persons not Ordinarily Resident Regulations (Northern Ireland). Belfast

Devlin R, & McKenna, S. (2009), No Home From Home. Northern Ireland Human Rights Commission

Dole, V. P., & Nyswander, M. (1965). A medical treatment for diacetytmorphine (heroin) addiction; A clinical trial with methadone hydrochloride. Journal of the American Medical Association, 193, 80-84

Dona, G. and Berry, J. (1994) Acculturation Attitudes and Acculturative Stress of Central-American Refugees. International Journal of Psychology, 29 (1), 57-70.

Donnelly, J.S. Jr (2001) The Great Irish Potato Famine, Sutton, Stroud

Drummond, D. (2001) Theories of drug craving, ancient and modern. Addiction, 96 (1), 33-46.

Durkheim, E (1967) Le suicide: etude de sociologie. 2. 1. Paris: Presses Universitaires de France;. 1897

Duvell, F. and Jordan, B. (2002) Immigration, asylum and welfare: the European context. Critical Social Policy, 22 (3), 498-517.

Duvell, F. (2008) Clandestine migration in Europe. Social Science Information Sur Les Sciences Sociales, 47 (4), 479-497.

Eade , J. & Valkanova, Y . (2009). Accession and migration: changing policy, society and culture in an enlarged Europe Ashgate, Farnham

Elam, G. and Fenton, K.A. (2003) Researching sensitive issues and ethnicity: Lessons from sexual health. Ethnicity & health, 8 (1), 15-27.

Erens, B. and Laiho, J. (2001) 'Alcohol consumption' in Erens, B., Primatesta, P. and Prior, G. (eds) Health Survey for England: The Health of Minority Ethnic Groups (1999). London: The Stationery Office

Erim, Y. and Braehler, E. (2016) Flight, Migration and Mental Health. Psychotherapie Psychosomatik Medizinische Psychologie, 66 (9-10), 347-348.

Esping-Anderson, G. (2002). Why We Need a New Welfare State. Oxford. London

European Commission (2011) The State of Men's Health in Europe.

European Monitoring Centre for Drugs and Drug Addiction (ECMDDA), 2010. Annual report on the state of the drugs problem in Europe. Lisbon

Eurostat (2017), Population Structure and Aging. European Commission

Fassaert, T., de Wit, M.A.S., Verhoeff, A.P., Tuinebreijer, W.C., Gorissen, W.H.M., Beekman, A.T.F. and Dekker, J. (2009) Uptake of health services for common mental

disorders by first-generation Turkish and Moroccan migrants in the Netherlands. Bmc Public Health, 9 307.

Feilzer, M.Y. (2010) Doing Mixed Methods Research Pragmatically: Implications for the Rediscovery of Pragmatism as a Research Paradigm. Journal of Mixed Methods Research, 4 (1), 6-16.

Finer, L. and Henshaw, S. (2006) Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. Perspectives on Sexual and Reproductive Health, 38 (2), 90-96.

Fitzgerald, P. & Lambkin, B. (2008) Migration in Irish History, 1607 -2007. Basingstoke. Palgrave Macmillan

Flick, U. (2007) Managing Quality in Qualitative Research. London: Sage

Foliaki, S. (1997) Migration and mental health: The Tongan experience. International Journal of Mental Health, 26 (3), 36-54.

Fortuna, L.R., Alvarez, K., Ortiz, Z.R., Wang, Y., Mozo Alegria, X., Cook, B.L. and Alegria, M. (2016) Mental health, migration stressors and suicidal ideation among Latino immigrants in Spain and the United States. European Psychiatry, 36 15-22.

Furnham, A and Bochner, S, (1986). Culture Shock: Psychological Reactions to Unfamiliar Environments. Taylor & Francis. London

Garcia-Retamero, R. and Dhami, M.K. (2011) Pictures speak louder than numbers: on communicating medical risks to immigrants with limited non-native language proficiency. Health Expectations, 14 46-57.

Gelkopf, M., Levitt, S. and Bleich, A. (2002) An integration of three approaches to addiction and methadone maintenance treatment: The self-medication hypothesis, the disease model and social criticism. Israel Journal of Psychiatry and Related Sciences, 39 (2), 140-151.

Georgas, J., Berry, J., Shaw, A., Christakopoulou, S. and Mylonas, K. (1996) Acculturation of Greek family values. Journal of Cross-Cultural Psychology, 27 (3), 329-338.

Ghaffarian, S. (1998) The acculturation of Iranian immigrants in the United States and the implications for mental health. Journal of Social Psychology, 138 (5), 645-654.

Gilbert, M. (1987) Alcohol-Consumption Patterns in Immigrant and Later Generation Mexican-American Women. Hispanic Journal of Behavioral Sciences, 9 (3), 299-313.

Gilbert, M. and Cervantes, R. (1986) Patterns and Practices of Alcohol-use among Mexican-Americans - a Comprehensive Review. Hispanic Journal of Behavioral Sciences, 8 (1), 1-60.

Gitta H. Lubke & Bengt O. Muthén (2004): Applying Multigroup Confirmatory Factor Models for Continuous Outcomes to Likert Scale Data Complicates Meaningful Group Comparisons, Structural Equation Modelling: A Multidisciplinary Journal, 11:4, 514-534

Glass, G. V., Peckham, P. D. and Sanders, J. R. (1972) Consequences of failure to meet assumptions underlying the fixed effects analyses of variance and covariance, Review of Educational Research, 42(3), pp. 237-288

Graetz, B. (1991) Multidimensional Properties of the General Health Questionnaire. Social psychiatry and psychiatric epidemiology, 26 (3), 132-138.

Green-Pedersen, C., van Kersbergen, K. and Hemerijck, A. (2001) Neo-liberalism, the 'third way' or what? Recent social democratic welfare policies in Denmark and the Netherlands. Journal of European Public Policy, 8 (2), 307-325.

Griffin, J. and Soskolne, V. (2003) Psychological distress among Thai migrant workers in Israel. Social science & medicine, 57 (5), 769-774.

Griffith, J. (1983) Relationship between Acculturation and Psychological Impairment in Adult Mexican-Americans. Hispanic Journal of Behavioral Sciences, 5 (4), 431-459.

Goldberg P & Williams P (1988) A Users Guide to the General Health Questionnaire. Windsor. Nfer-Neslon.

Gorard. S (2003). Quantitative Methods in Social Science Research. Continuum. London

Gossop, M. (2003). Drug Addiction and its Treatment. Oxford University Press

Guba, E. (1990) The Alternative Paradigm Dialogue. In Guba, E. (Ed.) The Paradigm Dialogue. London, Sage

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.),Handbook of qualitative research(pp. 105-117). London: Sage.

Gubrium, J. and Holstein, J. (1997). The New Language of Qualitative Method . Oxford University Press. Oxford

Gui, Y., Berry, J.W. and Zheng, Y. (2012) Migrant worker acculturation in China. International Journal of Intercultural Relations, 36 (4), 598-610.

Han, L., Berry, J.W. and Zheng, Y. (2016) The Relationship of Acculturation Strategies to Resilience: The Moderating Impact of Social Support among Qiang Ethnicity following the 2008 Chinese Earthquake. Plos One, 11 (10), e0164484.

Han, L., Berry, J.W. and Zheng, Y. (2016) The Relationship of Acculturation Strategies to Resilience: The Moderating Impact of Social Support among Qiang Ethnicity following the 2008 Chinese Earthquake. Plos One, 11 (10), e0164484.

Hanson, W., Creswell, J., Clark, V., Petska, K. and Creswell, J. (2005) Mixed methods research designs in counseling psychology. Journal of Counseling Psychology, 52 (2), 224-235.

Harrison, G., Brewin, J., Cantwell, R., Dalkin, T., Fox, R., Medley, I. and Walder, C. (1996) The increased risk of psychosis in African-Caribbean migrants to the UK: A replication. Schizophrenia research, 18 (2-3), IIC1-IIC1.

Harrison, G., Glazebrook, C., Brewin, J., Cantwell, R., Dalkin, T., Fox, R., Jones, P. and Medley, I. (1997) Increased incidence of psychotic disorders in migrants from the Caribbean to the United Kingdom. Psychological medicine, 27 (4), 799-806.

Harrison, G. and Turner, R. (2011) Being a 'Culturally Competent' Social Worker: Making Sense of a Murky Concept in Practice. British Journal of Social Work, 41 (2), 333-350.

Harrison, L., Sutton, M. and Gardiner, E. (1997) Ethnic differences in substance use and alcohol-use-related mortality among first generation migrants to England and Wales. Substance use & misuse, 32 (7-8), 849-876.

Harrison, L., Carr-Hill, R. & Sutton, M. (1993) 'Consumption and harm: drinking patterns of the Irish, the English and the Irish in England' Alcohol and Alcoholism, 28(6): 715-23

Harrison-Read, P. (1997) Prejudice against providers of psychiatric services for Black people. British Journal of Psychiatry, 171 582-582.

Hasse, J. & Myers, S. (1988) Reconciling Paradigm Assumptions of Qualitative & Quantitative Research. Western Journal of Nursing Research 10 (2) 128-137

Hatim, B. (1997). Communication Across Cultures: Translation Theory and Contrastive Text Linguistics, Exeter: University of Exeter Press

Hatim, B. and Mason, I. (1997). The Translator as Communicator, London: Routledge.

Hazelrigg, L. (2009). Inference. In: M. Hardy and A. Bryman (eds.). The Handbook of Data Analysis. Sage, London, UK

Hemerijck, A. (2013) Changing Welfare States, Oxford University Press

Hilty, D.M., Ferrer, D.C., Parish, M.B., Johnston, B., Callahan, E.J. and Yellowlees, P.M. (2013) The Effectiveness of Telemental Health: A 2013 Review. Telemedicine and E-Health, 19 (6), 444-454.

Hix, S. and Noury, A. (2007) Politics, not economic interests: Determinants of migration policies in the European Union. International Migration Review, 41 (1), 182-205.

Hole R. (2007) Working between languages and cultures: Issues of representation, voice, and authority intensified. Qualitative Inquiry. 2007;13:696–710

Homeless Link (2006). A8 Nationals in London's Homeless Services; Research Report

Horenczyk, G. (1997) Immigrants' perceptions of host attitudes and their reconstruction of cultural groups. Applied Psychology-an International Review-Psychologie Appliquee-Revue Internationale, 46 (1), 34-38.

Howe, K. (1988). Against the quantitative-qualitative incompatibility thesis (or dogmas die hard). Educational Researcher, 17(8),10-16

Huang, B., Appel, H. and Ai, A.L. (2011) The Effects of Discrimination and Acculturation to Service Seeking Satisfaction for Latina and Asian American Women: Implications for Mental Health Professions. Social Work in Public Health, 26 (1), 46-59.

Hurcombe, R.; Bayley, M; &Goodman, A. (2010). Ethniticy and Alcohol, A review of the UK Literature

Iglicka, K. (2001) Migration movements from and into Poland in the light of East-West European migration. International Migration, 39 (1), 3-32.

Iglicka K. 2001. Poland's post-war dynamic of migration by. Ashgate, Hampshire

Iglicka, K, Kazmierkiewicz P., and A. Weinar (2005), 'Poland' in: Niessen J. Schibel Y. and C. Thompson (eds), Current immigration Debates in Europe, Migration Policy Group, Brussels; Office for Repatriation and Immigration data.

Iglicka, K. & Ziolek-Skrzypczak, M. (2010) EU Membership Highlights Poland's Migration Challenges. Migration Policy Institute

Irwin, G. and Dunne, S. (1997) Ethnic Minorities in Northern Ireland. Centre for Study of conflict. University of Ulster

Islam, Z., Rabiee, F. and Singh, S.P. (2015) Black and Minority Ethnic Groups' Perception and Experience of Early Intervention in Psychosis Services in the United Kingdom. Journal of Cross-Cultural Psychology, 46 (5), 737-753.

International Organization for Migration; (2018). World Migration Report 2018

Iversen, T. and Wren, A. (1998) Equality: Employment, and budgetary restraint - The trilemma of the service economy. World Politics, 50 (4), 507-+.

JANZ, N. and BECKER, M. (1984) The Health Belief Model - a Decade Later. Health education quarterly, 11 (1), 1-47.

Jamieson, S.(2004) Likert scales: how to (ab)use them? Medical Education, 38(12), pp. 1217-1218.

Johnson, R.B., Onwuegbuzie, A.J. and Turner, L.A. (2007) Toward a Definition of Mixed Methods Research. Journal of Mixed Methods Research, 1 (2), 112-133.

Johnson. R, and. Onwuegbuzie. J,(2004) Mixed Methods Research: A Research Paradigm Whose Time Has Come. Educational Researcher, Vol. 33, No. 7 pp. 14-26

Jordan, B. & Düvell F. (2002),Irregular Migration: The Dilemmas of Transnational Mobility, Cheltenham, UK and Northampton

Juel, K. and Christensen, K. (2008) Are men seeking medical advice too late? Contacts to general practitioners and hospital admissions in Denmark 2005. Journal of Public Health, 30 (1), 111-113.

Karyotis, G. (2007) European migration policy in the aftermath of September 11 - The security-migration nexus. Innovation-the European Journal of Social Science Research, 20 (1), 1-17.

Kasia E Maciagowska & Terry Hanley (2018) What is known about mental health needs of the post-European Union accession Polish immigrants in the UK? A systematic review, International Journal of Culture and Mental Health, 11:2, 220-235

Kashyap, G.C. and Singh, S.K. (2017) Reliability and validity of general health questionnaire (GHQ-12) for male tannery workers: a study carried out in Kanpur, India. Bmc Psychiatry, 17 102.

Kawalek, S. (1992). The dictatorial supplier. In J.R. Wedel (Ed.) The unplanned society: Poland during and after communism. New York: Columbia University Press.

Kempny, M. (2013) Tales from the Borderlands: Polish Migrants' Representations of the Northern Irish Conflict in Belfast. Space and Culture 16 (4) 435 446

Kemtes KA, Smith K, Donohue B, Alvarez KM, Carpin KM, Sinchak J. (2003) A systematic approach to conducting educational literature searches. Journal of Continuing Higher Education;51(2):26–32

Kendler, K., Heath, A., Neale, M., Kessler, R. and Eaves, L. (1992) A Population-Based Twin Study of Alcoholism in Women. Jama-Journal of the American Medical Association, 268 (14), 1877-1882.

Kirmayer, L.J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A.G., Guzder, J., Hassan, G., Rousseau, C., Pottie, K. and CCIRH (2011) Common mental health problems in immigrants and refugees: general approach in primary care. Canadian Medical Association journal, 183 (12), E959-E967.

Knab, S. (1986). Polish Americans: Historical and cultural perspectives of influence in the use of mental health services. Journal of Psychosocial Nursing and Mental Health Services, 24(1), 31-34.

Knipscheer JW, Kleber RJ (2005) Help-seeking behaviour regarding mental health problems of Mediterranean migrants in the Netherlands: familiarity with care, consultation attitude and use of services. International Journal of Social Psychiatry. 51: 372-38

Koser, K. and Lutz, H. (1998) The New Migration in Europe; Social Constructions and Social Realities. Palgrave Mcmillan

Kosic, A. and Triandafyllidou, A. (2004) Albanian and Polish migration to Italy: The micro-processes of policy, implementation and immigrant survival strategies. International Migration Review, 38 (4), 1413-1446.

Kosic A. (2006). Migrant identities. In Contemporary Polish Migration in Europe, Triandafyllidou A (ed.). Edwin Mellen Press: New York; 245–266

Koss-Chioino, J. (1999) Depression among Puerto Rican women: Culture, etiology and diagnosis. Hispanic Journal of Behavioral Sciences, 21 (3), 330-350.

Kouvonen, A, Donnelly, M, and Bell, J. (2014) Mental Health and Well-Being of Polish Migrants in Northern Ireland . Policy Briefing KESS

Kritz, M., L. L. Lim and H. Zlotnik. (1992) International Migration Systems. A Global Approach. Oxford: Clarendon Press

Kunst, J.R., Thomsen, L., Sam, D.L. and Berry, J.W. (2015) "We Are in This Together": Common Group Identity Predicts Majority Members' Active Acculturation Efforts to Integrate Immigrants. Personality and Social Psychology Bulletin, 41 (10), 1438-1453.

Kuay, J., Chopra, P., Kaplan, I., & Szwarc, J. (2015). Conducting psychotherapy with an interpreter. Australasian Psychiatry, 23(3), 282-286.

Kwak, K. and Berry, J. (2001) Generational differences in acculturation among Asian families in Canada: A comparison of Vietnamese, Korean, and East-Indian groups. International Journal of Psychology, 36 (3), 152-162.

Kwak, K. and Berry, J. (2001) Generational differences in acculturation among Asian families in Canada: A comparison of Vietnamese, Korean, and east-Indian groups (vol 36, pg 152, 2001). International Journal of Psychology, 36 (5), 340-340.

Kwak, K. and Berry, J. (2001) Generational differences in acculturation among Asian families in Canada: A comparison of Vietnamese, Korean, and east-Indian groups (vol 36, pg 152, 2001). International Journal of Psychology, 36 (5), 340-340.

Laird, S. (2008) Anti-oppresive social work: A Guide for Developing Cultural Competence. London. Sage

Larkin, P.J., de Casterle, B.D. and Schotsmans, P. (2007) Multilingual translation issues in qualitative research: Reflections on a metaphorical process. Qualitative health research, 17 (4), 468-476.

Lazardis, K. (1988) Epidemiologische Aspekte der Suchterkrankungen bei Ausländern. Hospitalismusinzidenz in Niedersachsen. Suchtgefahren, 34: 396–400

Leavey, G. (1999) Suicide and Irish migrants in Britain: identity and integration. International Review of Psychiatry, 11 (2-3), 168-172.

Leavey, G., Rozmovits, L., Ryan, L. and King, M. (2007) Explanations of depression among Irish migrants in Britain. Social science & medicine, 65 (2), 231-244.

Lee, S.K., Sulaiman-Hill, C.R. and Thompson, S.C. (2014) Overcoming language barriers in community-based research with refugee and migrant populations: options for using bilingual workers. Bmc International Health and Human Rights, 14 11.

Lemmens,P; Dupont , H. and Roosen. I; (2017) Migrants, asylum seekers and refugees: an overview of the literature relating to drug use and access to services. European Monitoring Centre for Drugs and Drug Addiction

Lennox, R. and Wolfe, R. (1984) Revision of the Self-Monitoring Scale. Journal of personality and social psychology, 46 (6), 1349-1364.

Leonard, C. and Cheung, Y. (1991) Selected References on Topics Related to Ethnicity and Adaptation. International Journal of the Addictions, 25 (5A-6A), 767-774.

Leventhal, H., Nerenz, D., & Steele, D. (1984). Illness representations and coping with health threats. In A. Baum & J. Singer (Eds.), A handbook of psychology and health Vol. 4, pp.219-252.Hillsdale, NJ:Erlbaum

Lofland, J. (1971). Analyzing Social Settings: A Guide to Qualitative Observation and Analysis . Wadsworth Publishing

Lysaght, K. (2005). Catholics, Protestants and office workers from the town: The experience and negotiation of fear in Northern Ireland. In K. Milton & M. Svašek (Eds.), Mixed emotions: Anthropological study of feeling (pp. 127-144). Oxford, England: Berg.

Madden, H. Harris, J. , Blickem, C; Harrison. R; Timpson, H;.(2017) "Always paracetamol, they give them paracetamol for everything": a qualitative study examining Eastern European migrants' experiences of the UK health service. BMC Health Services Research 17:604

Mallett, R., Leff, J., Bhugra, D., Takei, N. and Corridan, B. (2004) Ethnicity, goal striving and schizophrenia: A case-control study of three ethnic groups in the United Kingdom. International Journal of Social Psychiatry, 50 (4), 331-344.

Manwell, L., Czabala, J., Ignaczak, M. and Mundt, M. (2004) Correlates of depression among heavy drinkers in Polish primary care clinics. International journal of psychiatry in medicine, 34 (2), 165-178.

Manwell, L., Ignaczak, M. and Czabala, J. (2002) Prevalence of tobacco and alcohol use disorders in Polish primary care settings. European journal of public health, 12 (2), 139-144.

Markey, K., Tilki, M. and Taylor, G. (2012) Strategies to surmount the potential barriers to providing anti-discriminatory care in Irish healthcare settings. Contemporary Nurse, 40 (2), 269-276.

Marlatt, G.; & Gordon, J., Ede (1985). Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors. New York: Guilford Press,

Martin, M.A., Shalowitz, M.U., Mijanovich, T., Clark-Kauffman, E., Perez, E. and Berry, C.A. (2007) The effects of acculturation on asthma burden in a community sample of Mexican American schoolchildren. American Journal of Public Health, 97 (7), 1290-1296.

Massey, D.S., Arango, J., Hugo, G., Kouaouci, A., Pellegrino, A. and Taylor, J.E. (1993) Theories of International Migration - a Review and Appraisal. Population and Development Review, 19 (3), 431-466.

Massey, D. S. (1990). "Social Structure, Household Strategies, and the Cumulative Causation of Migration." Population Index 56(1): 3-26.

Massey, D. S.,& Arango,J. (1998). Worlds in Motion. Oxford, Clarendon Press

Mastrogianni, A. and Bhugra, D. (2003) Globalization, cultural psychiatry and mental distress. International Journal of Social Psychiatry, 49 (3), 163-165.

May, T. (2001) Social Research Issues, methods and process. Open University Press. Buckingham

McAreavey, R. (2010). Transcending Cultural Differences: the Role of Language in Migrants Integration. Translocations: Migration and Social Change, vol 6 no. 2

McAuliffe WE, Gordon RA. (1980) Reinforcement and the combination of effects: summary of a theory of opiate addiction.NIDA Res Monogr.;30:137–141

McCusker, C. (2001) Cognitive biases and addiction: an evolution in theory and method. Addiction, 96 (1), 47-56.

McMahon, T.J. and Rounsaville, B.J. (2002) Substance abuse and fathering: adding poppa to the research agenda. Addiction, 97 (9), 1109-1115.

Meleady, R., Seger, C.R. and Vermue, M. (2017) Examining the role of positive and negative intergroup contact and anti-immigrant prejudice in Brexit. British Journal of Social Psychology, 56 (4), 799-808.

Mendoza, R. H.(1989).An empirical scale to measure type and degree of acculturation in Mexican American adolescents and adults. Journal of Cross-Cultural Psychology, 4: 372–385.

Mental Health Foundation, (2016) Fundamental Facts about Mental HealthMental Health Foundation . London

Mertens, M. (2005) Research and Evaluation in Education and Psychology: Integrating Diversity with Quantitative, Qualitative, and Mixed Methods. Sage. London

Mertens, D.M. (2010) Transformative Mixed Methods Research. Qualitative Inquiry, 16 (6), 469-474.

Mertens, J.R., Weisner, C., Ray, G.T., Fireman, B. and Walsh, K. (2005) Hazardous drinkers and drug users in HMO primary care: Prevalence, medical conditions, and costs. Alcoholism-Clinical and Experimental Research, 29 (6), 989-998.

Meyers, E. (2002) The causes of convergence in Western immigration control. Review of International Studies, 28 (1), 123-141.

Migration Policy Institute . (2010) EU Membership Highlights Poland's Migration Challenges, Migration Information Source, Washington

Miller, W. and Kurz, E. (1994) Models of Alcoholism used in Treatment - Contrasting Aa and Other Perspectives with which it is often Confused. Journal of studies on alcohol, 55 (2), 159-166.

Miller, W & Rollnick. S, (2002) Motivational Interviewing: Preparing People For Change. New York: Guilford Press

Miller, W & Rollnick. S, (2013) Motivational Interviewing: Helping People Change. New York: Guilford Press

Mills,K.; Knight,T; Green, R.(2007) Centre Beyond Boundaries: offering substance misuse services to new migrants in London. Centre for Community Research University of Hertfordshire . National Treatment Agency

Mills, K. and Knight, T. (2010) Offering substance misuse services to Accession Eight migrants in London: Findings from a qualitative study. Drugs-Education Prevention and Policy, 17 (6), 853-869.

Mills, K. (2009) 'Racism, Ethnicity and Drug Misuse: A Brief Introduction', in H.S. Bhui (ed.) Race and Criminal Justice. London: SAGE

Mirsky, J. (2009) Mental health implications of migration. Social psychiatry and psychiatric epidemiology, 44 (3), 179-187.

Miyoshi, M., Asner-Self, K., Sheng Yanyan and Koran, J.M. (2017) Psychometric Properties of the Abbreviated Multidimensional Acculturation Scale and the Multigroup Ethnic Identity Measure With Japanese Sojourners. Assessment, 24 (1), 104-114.

Moller-Leimkuhler, A. (2002) Barriers to help-seeking by men: a review of sociocultural and clinical literature with particular reference to depression. Journal of affective disorders, 71 (1-3), 1-9.

Montazeri, A., Harirchi, A.M., Shariati, M., Garmaroudi, G., Ebadi, M. and Fateh, A. (2003) The 12-item General Health Questionnaire (GHQ-12): translation and validation study of the Iranian version. Health and quality of life outcomes, 1 66-66.

Moreno FA. Chong J. Dumbauld J,(2012). Use of standard webcam and internet equipment for telepsychiatry treatment of depression among underserved Hispanics. Psychiatr Serv. 2012;63:1213–1217

Morris, L. (2007) New labour's community of rights: Welfare, immigration and asylum. Journal of social policy, 36 39-57.

Mucic, D. (2010) Transcultural telepsychiatry and its impact on patient satisfaction. Journal of telemedicine and telecare, 16 (5), 237-242.

Munk-Jorgensen, P., Sluzki, C., Kaprinis, G.S., Fountoulakis, K.N., Bloch, S., Tamber, P.S., Abbasi, K., Momen, H., Leventhal, J.M., Li, Y.X., Guan, J.L., Dunner, D.L., Good, M.J.D., Tansella, M., Thoret, Y., Goswami, U., Tremine, T., Bhugra, D., Ghodse, H., Flisher, A., Brody, E.B., McKnight, K., Gollogly, L., Lynch, S., Ursano, R., Buchsbaum, M., Paykel, E., Richardson, P., Gueye, M., Gadit, A.A., Mari, J., Perez-Rincon, H., Bebbington, P., Emsley, R., Hawkridge, S., Kirmayer, L.J., Tumwine, J.K., de Francisco, A., Marusic, A., Sahni, P., Saxena, S., Sharan, P., Saraceno, B., Aronson, B., Poznyak, V., Levav, I., Certain, E., Murthy, R.S. and Pang, T. (2004) Galvanizing mental health research in low- and middle-income countries: The role of scientific journals. American Journal of Orthopsychiatry, 74 (3), 389-392.

National Treatment Agency for Substance Misuse 2006

National Institute of Health and Care Excellence (2007). Drug misuse in over 16's: psychosocial interventions. Clinical Guideline CG51

Neff, J., Hoppe, S. and Perea, P. (1987) Acculturation and Alcohol-use - Drinking Patterns and Problems among Anglo and Mexican-American Male Drinkers. Hispanic Journal of Behavioral Sciences, 9 (2), 151-181.

Neff J. and Husaini , B. (1987) Urbanicity, Race, and Psychological Distress. Journal of community psychology, 15 (4), 520-536.

Newman, I., & Benz, C. R. (1998). Qualitative-quantitative research methodology: Exploring the interactive continuum. Carbondale: University of Illinois Press.

Ngo, V H. (2008). A critical examination of acculturation theories. Critical Social Work. Vol9. No.1

Oberg, K. (1960). Cultural Shock: Adjustment to New Cultural Environments. Missology. An International Review Vol. 7 Issue 4 P177-18

O'Brien, F. (2012). Dying fifteen years early – what can Traveller men and relevant agencies do? Southern Health and Social Care trust

Odegaard, O. (1932) Emigration and Insanity; A study of Mental Disease among the Norwegian Born Population of Minesota. Acta Psychiatrica Et Neurologica Supplementum IV

O'Cathain, A., Murphy, E. and Nicholl, J. (2007) Why, and how, mixed methods research is undertaken in health services research in England: a mixed methods study. Bmc Health Services Research, 7 85.

Office for National Statistics. (2012). Crime Survey for England and Wales. Available at Crime Survey for England and Wales

Olmedo, E. L. (1979). Acculturation: A psychometric perspective. American Psychologist, 34(11), 1061-1070

Olsen, J. (2000) Governing in Europe: Effective and democratic? Journal of European Public Policy, 7 (2), 310-316.

O'Hagan, K. (2001). Cultural Competence in the Caring Profession. London Kingsley

Omar,Y., Kuay, J. & Tuncer, C. (2017).Putting your feet in gloves designed for hands': Horn of Africa Muslim men perspective in emotional wellbeing and access to mental health services in Australia.' International Journal of Culture and Mental Health

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

Pallant, J. (2010). SPSS Survival Manual: a step by step guide to data analysis using SPSS. Maidenhead. Open University Press

Panayi, P (2010). An Immigration History of Modern Britain: Multicultural Racism Since 1800. Longman. London

Patel J. (2012) Understanding the health needs of central and eastern European migrants in Hertfordshire. Herefordshire: NHS Herefordshire.

Patton, M. (2002) Qualitative Research & Evaluation Methods Integrating Theory and Practice. Sage. London

Pernice, R. and Brook, J. (1996) Refugees' and immigrants' mental health: Association of demographic and post-immigration factors. Journal of Social Psychology, 136 (4), 511-519.

Pernice, R., Trlin, A., Henderson, A., North, N. and Skinner, M. (2009) Employment Status, Duration of Residence and Mental Health among Skilled Migrants to New Zealand: Results of a Longitudinal Study. International Journal of Social Psychiatry, 55 (3), 272-287.

Perry, B.L. and Pescosolido, B.A. (2015) Social network activation: The role of health discussion partners in recovery from mental illness. Social science & medicine, 125 116-128.

Pescosolido B. (1992) Beyond Rational Choice - the Social Dynamics of how People Seek Help. American Journal of Sociology, 97 (4), 1096-1138.

Pescosolido, B. (2007) Of pride and prejudice: The role of sociology and social networks in integrating the health sciences (vol 47, pg 189, 2006). Journal of health and social behavior, 48 (2),

Phillips, D. and Burbules, N. (2000). Postpositivism and Educational Research. Rowman & Littlefield Publishers

Ponizovsky, A.M., Radomislensky, I. and Grinshpoon, A. (2009) Psychological distress and its demographic associations in an immigrant population: findings from the Israeli National Health Survey. Australian and New Zealand Journal of Psychiatry, 43 (1), 68-75.

Prins, M. A., Verhaak, P. F. M., Bensing, J. M., & van der Meer, K. (2008). Health beliefs and perceived need for mental health care of anxiety and depression - The patients' perspective explored. Clinical Psychology Review, 28(6), 1038-1058

Prochaska J. and Diclemente, C. (1983) Stages and Processes of Self-Change of Smoking - Toward an Integrative Model of Change. Journal of consulting and clinical psychology, 51 (3), 390-395.

Qassem, T., Bebbington, P., Spiers, N., McManus, S., Jenkins,R., & Dean, S. (2015). Prevalence of psychosis in black ethnic minorities in Britain: Analysis based on three national surveys. Social Psychiatry and Psychiatric Epidemiology, 50(7), 1057–1064.,

Raleigh V.S., Balarajan R. (1992) Suicide and self-burning among Indians and West Indians in England and Wales.British Journal of Psychiatry;161:365–368

Rabiee, F., & Smith, P. (2014). Understanding mental health and experience of accessing services in African and African Caribbean users and carers in Birmingham UK. Diversity and Equality in Health and Care, 11, 125-134.

Rabiee, F., & Smith, P. (2013). Being understood, being respected: An evaluation of mental health service provision from service providers and users' perspectives in Birmingham, UK. Journal of Mental Health Promotion, 15, 162-177

Raval, H. (1996). A Systemic Perspective on Working with Interpreters. Clinical Child Psychology and Psychiatry. 1 (1) p29-43

Raval, H.(2003). "An overview of the issues in the work with interpreters". In Undertaking mental health work using interpreters, Edited by: Tribe, R. and Raval, H. London: Routledge

Reichardt, C., & Rallis, S. (1994). Qualitative and quantitative inquiries are not incompatible: A call for a new partnership. In C. Reichardt & S. Rallis (Eds.), The qualitative-quantitative debate: New perspectives (pp.1-98). San Francisco: Jossey-Bass

Resera,E. Tribe, R. & Lane, P. (2015) Interpreting in mental health, roles and dynamics in practice, International Journal of Culture and Mental Health, 8:2, 192-206

Ritchie, J. and Lewis, J. (Eds.) (2014) Qualitative Research Practice: A Guide for Social Science Students and Researchers. Sage, London.

Ritsner, M., Ponizovsky, A., Nechamkin, Y. and Modai, I. (2001) Gender differences in psychosocial risk factors for psychological distress among immigrants. Comprehensive psychiatry, 42 (2), 151-160.

Robert, A. & Gilkinson, T. (2012). Mental Health and Well-being of recent immigrants in Canada: Evidence from the Longitudinal Survey of Immigrants to Canada (LSIC). Citizenship and Immigration Canada

Rondelez, E., Bracke, S., Roets, G. and Bracke, P. (2016) Racism, Migration, and Mental Health. Theoretical Reflections from Belgium. Subjectivity, 9 (3), 313-332.

Rosenstock I., Strecher,V. and Becker, M. (1988) Social-Learning Theory and the Health Belief Model. Health education quarterly, 15 (2), 175-183.

Rounsaville BJ, Alarcón RD, Andrews G, Jackson JS, Kendell RE, Kendler K. Basic nomenclature issues for DSM-V. In: Kupfer DJ, First MB, Regier DA. (Eds) (2002)A research agenda for DSM-V. American Psychiatric Association, Washington DC:1-29.

Sabatier, C. and Berry, J.W. (2008) The role of family acculturation, parental style, and perceived discrimination in the adaptation of second-generation immigrant youth in France and Canada. European Journal of Developmental Psychology, 5 (2), 159-185.

Sale, J., Lohfeld, L. & Brazil, K. (2002). Revisiting the quantitative-qualitative debate: implications for mixed-methods research, Quality and Quantity, 36, 43–53.

Sales, R. (2007), Understanding Immigration and Refugee Policy: Contradictions and Continuities. Bristol: Policy Press

Salum, G.A., Kieling, C., Rohde, L.A., Gosmann, N.P. and Polanczyk, G.V. (2016) Global Migration Flows and Child Mental Health: The Urgent Need of Care. Journal of the American Academy of Child and Adolescent Psychiatry, 55 (7), 627-629.

Sam, D.L. and Berry, J.W. (2010) Acculturation: When Individuals and Groups of Different Cultural Backgrounds Meet. Perspectives on Psychological Science, 5 (4), 472-481.

Sanchez, J. (2015) Alcohol use among Latino migrant workers in South Florida. Drug and alcohol dependence, 151 241-249.

Sanchez, J. (2015) Alcohol use among Latino migrant workers in South Florida. Drug and alcohol dependence, 151 241-249.

Sanchez, Z.v.d.M. and Nappo, S.A. (2008) Religious intervention and recovery from drug addiction. Revista de saude publica, 42 (2),

Sarantakos, S. (1998) Social Research. 2nd Edition, MacMillan Education Australia, South Melbourne

Sarantakos, S. (2012) Social Research Palgrave Macmillan. Basingstoke

Santhanam-Martin, R., Fraser, N., Jenkins, A., & Tuncer, C. (2017). Evaluation of cultural responsiveness using a transcultural secondary consultation model. Transcultural Psychiatry**.**

Sarantakos, S. (1998) Social Research. 2nd Edition, MacMillan Education Australia, South Melbourne

Saravanan, B., David, A., Bhugra, D., Prince, M. and Jacob, K. (2005) Insight in people with psychosis: The influence of culture. International Review of Psychiatry, 17 (2), 83-87.

Saravanan, B., Jacob, K.S., Prince, M., Bhugra, D. and David, A.S. (2004) Culture and insight revisited. British Journal of Psychiatry, 184 107-109.

Schinina, G., Nunes, N., Birot, P., Giardinelli, L. and Kios, G. (2016) Mainstreaming mental health and psychosocial support in camp coordination and camp management. The experience of the International Organization for Migration in the north east of Nigeria and South Sudan. Intervention-International Journal of Mental Health Psychosocial Work and Counselling in Areas of Armed Conflict, 14 (3), 232-244.

Schuckit , M. (1987) Biological Vulnerability to Alcoholism. Journal of consulting and clinical psychology, 55 (3), 301-309.

Schweitzer, R.D., Brough, M., Vromans, L. and Asic-Kobe, M. (2011) Mental health of newly arrived Burmese refugees in Australia: contributions of pre-migration and post-migration experience. Australian and New Zealand Journal of Psychiatry, 45 (4), 299-307.

Searles, J. (1988) The Role of Genetics in the Pathogenesis of Alcoholism. Journal of abnormal psychology, 97 (2), 153-167.

Selkirk, M., Quayle, E., & Rothwell, N. (2012). Influences on Polish migrants' responses to distress and decisions about whether to seek psychological help. Counselling Psychology Review, 27, 40–54

Selten, J., Wierdsma, A., Mulder, N. and Burger, H. (2007) Treatment seeking for alcohol and drug use disorders by immigrants to the Netherlands - Retrospective, population-based, cohort study. Social psychiatry and psychiatric epidemiology, 42 (4), 301-306.

Shevlin, M. and Adamson, G. (2005) Alternative factor models and factorial invariance of the GHQ-12: A large sample analysis using confirmatory factor analysis. Psychological assessment, 17 (2), 231-236.

Shi, Y., Bai, Y., Shen, Y., Kenny, K. and Rozelle, S. (2016) Effects of Parental Migration on Mental Health of Left-behind Children: Evidence from Northwestern China. China & World Economy, 24 (3), 105-122.

Shimahara. N, Holowinsky. I, Tomlinson-Clarke.S, (2012) Ethnicity, Race, and Nationality in Education: A Global Perspective. Routledge. London

Sime, D. and Fox, R. (2015) Migrant Children, Social Capital and Access to Services Post-Migration: Transitions, Negotiations and Complex Agencies. Children & Society, 29 (6), 524-534.

Sinha, D., Mishra, R. and Berry, J. (1992) Emic Studies of Acculturation Attitudes and Acculturative Stress among Tribal Peoples of Bihar. International Journal of Psychology, 27 (3-4), 657-657.

Skeldon R. (1997). Migration and Development; A Global Perspective. Longman. London

Skog, O. (2000) Addicts' choice. Addiction, 95 (9), 1309-1314.

Sluzki, C. (1979) Migration and Family Conflict. Family process, 18 (4), 379-390.

Sluzki, C.E. (1986) Migration and family conflict. In Coping with Life Crises (ed. R.H. Moos).New York: Plenum,277-288

Smokowski, P.R., Rose, R. and Bacallao, M.L. (2008) Acculturation and Latino family processes: How cultural involvement, biculturalism, and acculturation gaps influence family dynamics. Family Relations, 57 (3), 295-308.

Song, M., & Parker, D. (1995). Cultural identity: Disclosing commonality and difference in in-depth interviewing. Sociology, 29 (2), 241-256

Soto, C., Unger, J.B., Ritt-Olson, A., Soto, D.W., Black, D.S. and Baezconde-Garbanati, L. (2011) Cultural Values Associated With Substance Use Among Hispanic Adolescents in Southern California. Substance use & misuse, 46 (10), 1223-1233.

Specka, M., Buchholz, A., Kuhlmann, T., Haasen, C. and Scherbaum, N. (2010) Outcome of inpatient opiate detoxification treatment in immigrants as compared to native Germans. European Psychiatry, 25 (4), 242-248.

Spencer S, Ruhs M, Anderson B, Rogaly B.(2007) Migrants' lives beyond the workplace. The experiences of central and east Europeans in the UK. York: Joseph Rowntree Foundation;.

Squires, A. (2009) Methodological challenges in cross-language qualitative research: A research review. International journal of nursing studies, 46 (2), 277-287.

Stagg, H.R., Jones, J., Bickler, G. and Abubakar, I. (2012) Poor uptake of primary healthcare registration among recent entrants to the UK: a retrospective cohort study. BMJ open, 2 (4),

Stallings, M., Hewitt, J., Cloninger, C., Heath, A. and Eaves, L. (1996) Genetic and environmental structure of the tridimensional personality questionnaire: Three or four temperament dimensions? Journal of personality and social psychology, 70 (1), 127-140.

Stalker, P, 2001, The No-Nonsesne Guide to International Migration, London: Verso

Stillman, S., McKenzie, D. and Gibson, J. (2009) Migration and mental health: Evidence from a natural experiment. Journal of health economics, 28 (3), 677-687.

Stolk, Y., Minas, H., & Kimidis, S(2008) Access to mental health services in Victoria: A focus on ethnic communities. Victoria Transcultural Psychiatry Unit

Sulaiman, S., Bhugra, D. and De Silva, P. (2003) Symptoms of depression in women in Dubai - a pilot study. European Journal of Psychiatry, 17 (1), 23-33.

Svasek, M. (2009). Shared History? Polish Migrant Experiences and the Politics of Display in Northern Ireland in Burrell (2009). Farnham. Ashgate

Sword, K. (1996). Identity in Flux, The Polish Community in Britain, University of London

Szporer, M. 2014. Solidarity: The Great Workers Strike of 1980. Lexington Books. Plymouth

Szczepura, A. (2005) Access to health care for ethnic minority populations. Postgraduate medical journal, 81 (953), 141-147.

Tashakkori, A. &, Teddlie,C. (1998). Mixed Methodology: Combining Qualitative and Quantitative Approaches. Sage London

Tashakkori, A. &,Teddlie,C. (2003) Handbook of Mixed Methods in Social & Behavioral Research. Sage London

Tarsitani, L. and Biondi, M. (2016) Migration and mental health: new challenges. Rivista Di Psichiatria, 51 (2), 45-46.

Taylor BJ (2010) Professional Decision Making in Social Work, Exeter: Learning Matters.

Taylor, B.J. (2012) Developing an Integrated Assessment Tool for the Health and Social Care of Older People. British Journal of Social Work, 42 (7), 1293-1314.

Temple, B. (2002). Interpreters/Translators and Cross-Language Research: Reflexivity and Border Crossings. International Journal of Qualitative Methods 1 (2) p1-12

Temple, B. (1997). Issues in translation and cross-cultural research. Sociology, 31 (3), 607-618

Temple, B. (1999). Diaspora, diaspora space and Polish women. Women's Studies International Forum, 22 (1), 17-24

Temple, B. (2001). Polish families: A narrative approach. Journal of Family Issues, 22 (3), 386-399.

Temple, B., & Young, A. (2004). Qualitative research and translation dilemmas. Qualitative Research, 4, 161-178.

Temple, B. (1997). Watch your tongue: Issues in translation and cross-cultural research. Sociology, 31, 607-618.

Temple B, Young A. (2004) Qualitative research and translation dilemmas. Qualitative Research;4 (2):161–78

Temple B. Crossed wires: (2002) Interpreters, translators, and bilingual workers in cross-language research. Qualitative Health Research;12 (6):844–54

Tilki, M. (2006) The social contexts of drinking among Irish men in London. Drugs-Education Prevention and Policy, 13 (3), 247-261.

Tobi P, Sheridan K, Lais S. (2010) Health and social care needs assessment of eastern European including Roma individuals living in barking and Dagenham. London: University of East London, Institute of Health and Human Development

Treaty of Rome, 1957. EEC

Trew, J. D (2013) Leaving the North: Migration and Memory, Northern Ireland 1921-2011. Liverpool, Liverpool University Press

Tribe, R. and Lane, P. (2009) Working with interpreters across language and culture in mental health. Journal of Mental Health, 18 (3), 233-241.

Tribe, R. and Tunariu, A. (2009) Mind your language: working with interpreters in healthcare settings and therapeutic encounters. Sexual and Relationship Therapy, 24 (1), 74-84.

Tribe, R., & O'Brien, P. (2014). Exploring Polish migrants' adaptation to life in the UK: An interpretative phenomenological analysis. International Journal of Culture and Mental Health, 7, 439–45

Tribe, R. (2009). Working with interpreters in mental health . International Journal of Culture and Mental Health Vol. 2, No. 2, 92-101

Twinn S. An exploratory study examining the influence of translation on the validity and reliability of qualitative data in nursing research. Journal of Advanced Nursing. 1997;26:418–423

Vale, P.H. (2010) Addiction - and rational choice theory. International Journal of Consumer Studies, 34 (1), 38-45.

Valente, R.R. and Berry, B.J.L. (2017) Acculturation of Immigrant Latinos into the US Workplace: Evidence from the Working Hours-life Satisfaction Relationship. Applied Research in Quality of Life, 12 (2), 451-479.

van Gelder, M.M.H.J., Bretveld, R.W. and Roeleveld, N. (2010) Web-based Questionnaires: The Future in Epidemiology? American Journal of Epidemiology, 172 (11), 1292-1298.

VanGeest, J.B. and Johnson, T.P. (1997) Substance use patterns among homeless migrants and nonmigrants in Chicago. Substance use & misuse, 32 (7-8), 877-907.

Vega W, Canino C, Zhun C, Alegria M. (2009) Prevalence and correlates of dual diagnoses in US Latinos. Drug Alcohol Depend.;100:32–38

Virgincar, A., Doherty, S. and Siriwardhana, C. (2016) The impact of forced migration on the mental health of the elderly: a scoping review. International Psychogeriatrics, 28 (6), 889-896.

Walls P (2005) The health of Irish descended Catholics in Glasgow : A qualitative study of the links between health risk and religious and ethnic identities. Unpublished PhD thesis. University of Glasgow.

Wallace, A.; McAreavey, R, Atkin, K. (2013). Poverty and Ethnicity in Northern Ireland, An Evidence Review. Joseph Rowntree Foundation

Wallace, P.M., Pomery, E.A., Latimer, A.E., Martinez, J.L. and Salovey, P. (2010) A Review of Acculturation Measures and Their Utility in Studies Promoting Latino Health. Hispanic Journal of Behavioral Sciences, 32 (1), 37-54.

Wallerstein, I. (1976) The Modern World-System: Capitalist Agriculture and the Origins of the European World-Economy in the Sixteenth Century. New York: Academic Press,

Wanigaratne, S. (2006). Psychology of Addiction. Psychiatry Vol 5, Issue 12, , Pages 455-460

Ward, C. , Okura, Y., Kennedy, A., & Kojima, T. (1998). The U-curve on trial: A longitudinal study of psychological and sociocultural adjustment during cross-cultural transition. International Journal of Intercultural Relations, 22, 277-291

Ward, C. (2004) Coming of age: The maturation of acculturation theory and research. International Journal of Psychology, 39 (5-6), 130-130.

Ward, C. and Rana-Deuba, A. (1999) Acculturation and adaptation revisited. Journal of Cross-Cultural Psychology, 30 (4), 422-442.

Ward, C., Bochner, S., & Furnham, A. (2001). The psychology of culture shock. East-Sussex, UK: Routledge.

Ward, C., & Kennedy, A. (1994). Acculturation strategies, psychological adjustment, and sociocultural competence during cross-cultural transitions. International Journal of Intercultural Relations, 18, 329-343.

Weishaar, H. B. (2008). Consequences of international migration: A qualitative study on stress among Polish migrant workers in Scotland. Public Health, 122, 1250–1256

West, R. (2006). Theory of Addiction. Blackwell Publising. Oxford

West, R and Brown, J. (2013) Theory of Addiction. Blackwell Publising. London

World Health Organisation (2009); International Migration Report 2006: A Global Assessment. United Nations, Department of Economic and Social Affairs, Population Division

World Health Organisation (1992) The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva. WHO

World Health Organisation (2007) Mental health in a changing world: the impact of culture and diversity. WHO. New York

Wise, R.A. and Koob, G.F. (2014) The Development and Maintenance of Drug Addiction. Neuropsychopharmacology, 39 (2), 254-262.

Woolsey, C.L. (2011) Tutorial: Using Motivational Interviewing to Improve Communication, Motivation, and Behavior Change. Research quarterly for exercise and sport, 82 (1), A7-A7.

Zea, M. C., Asner-Self, K. K., Birman, D., & Buki, L. P. (2003). The Abbreviated Multidimentional Acculturation Scale: Empirical validation with two Latino/Latina samples. Cultural Diversity and Ethnic Minority Psychology, 9(2), 107-12

Zemore, S.E. and Ajzen, I. (2014) Predicting substance abuse treatment completion using a new scale based on the theory of planned behavior. Journal of substance abuse treatment, 46 (2), 174-182.

Zhao, F. and Yu, G. (2016) Parental Migration and Rural Left-Behind Children's Mental Health in China: A Meta-Analysis Based on Mental Health Test. Journal of Child and Family Studies, 25 (12), 3462-3472.

Zilber, N. and Lerner, Y. (1996) Psychological distress among recent immigrants from the former Soviet Union to Israel .1. Correlates of level of distress. Psychological medicine, 26 (3), 493-501.

Baumeister et.al. 1994).

Larabie (2005)