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Exploring pathways through and beyond alcohol treatment among Polish women and men in a London Borough

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Find out more at alcoholchange.org.uk.

Opinions and recommendations expressed in this report are those of the authors.

Contents

Executive summary.....	1
Background.....	1
Methods	1
Findings	2
Implications.....	4
Conclusion	5
Introduction	6
Methodology	7
Findings	12
Discussion	35
Conclusion	37
References.....	38

Executive summary

Background

Concerns have been repeatedly raised about high alcohol use and alcohol related harm among Polish migrants (e.g. Byrne, et al., 2008; Kreft and Ritchie, 2009; Garapich, 2010; Thom, et al., 2010). In 2018 the Polish born population living in the UK stood at 889,000 (ONS 2018a). In the most recent statistics there was a decrease in the number of all EU citizens immigrating to the UK and for the first time the number of A8 migrants leaving the UK is slightly higher than the number entering the country (ONS, 2018b). However, Poland remains the most common non-UK country of birth, taking over from India in 2015 and Polish has been the most common non-British nationality in the UK since 2007 (ONS, 2018a). Studies on access to health care amongst migrants have identified a number of barriers including, confusion over entitlement to NHS services, lack of understanding on the NHS structures, problems registering with primary care services, language and interpretation problems and limited access to reliable transport due to poverty and poor services in areas of deprivation where many recent migrants live (Johnson, 2006). Some of the barriers such as information, language and transport, seem to cut across length of residence, affecting longer established migrants as well as newly arrived ones (Jayaweera, 2014). Our understanding of drinking patterns, help seeking behaviour and experience of treatment services amongst this minority group of Polish migrants remains limited.

Methods

The primary aim of this research study was to further understanding of the pathways into, through and out of treatment, with a focus on sustaining recovery to inform the design and delivery of services for this minority group.

We used three methods of data collection for this study:

- 1 A scoping review of the literature to better understand current knowledge of prevalence of problematic alcohol use and treatment availability and pathways for Polish migrants in the UK.
- 2 A qualitative study consisting of interviews with 13 Polish migrants (9 male; 4 female) with experience of alcohol treatment services and four professionals working across support services for Polish migrants in North London.
- 3 A practitioners workshop that brought together a range of professionals (N = 8) working with Eastern European migrants living in London through alcohol (and related) support services to discuss our qualitative research findings and to help develop recommendations for future service provision.

Findings

Literature review

- Prevalence data on problematic drinking among Polish (and other) migrants is not routinely collected. Definitions of problematic drinking may differ across British and Polish cultures and many Polish migrants may not recognise a problem with alcohol until it has caused serious physical or social consequences.
- There is little published literature on specific treatment interventions targeting Polish migrants although Polish speaking AA groups have been in place for some time, statutory or community services are less well known and there is some suggestion that services are reluctant to offer services to migrants due to restrictions on access to healthcare and welfare (Mills and Knight, 2010)
- Common barriers to accessing treatment reported in the literature include; normalisation of heavy drinking in Polish culture making identifying a problem less likely to happen; a belief that the individual should be able to control their own drinking without outside help; perceived poor cultural competence in services; language barriers; lack of understanding of British healthcare and treatment service pathways and; 'no recourse to public funds (NRPF) leading to restricted access to services.
- Some evidence suggests that there is generalised mistrust of UK healthcare services amongst Polish migrants (Osipovic, 2013) which can extend to alcohol treatment services meaning that many migrants are reluctant to access treatment even through medical referrals via their GP.

Interviews

- Participants in this study tended to only seek help for their alcohol use once it had led to serious physical health complications or they had experienced negative social consequences such as unemployment or homelessness.
- Differences in the development of problematic drinking for women and men were seen where women were more likely to drink alone and to keep their drinking hidden. For men, drinking large amounts was often a social experience and was not seen to be problematic until it interfered with work for example.
- Women were more likely to come to services through GP or social services referral compared to men who tended to self-refer into services.
- Cultural influences could lead to delays in seeking treatment. For men it took longer to recognise a problem with alcohol as it was deeply embedded in everyday life. For women with children a fear of being seen as a 'bad' mother or the possibility of social services becoming involved acted as barriers to seeking help.
- Other factors that affected the likelihood of accessing treatment included having a Polish key worker in a service, shifting attitudes towards alcohol that was partly influenced by changing work rules on alcohol use and, being unable to work due to drinking either because of a health issue or losing accommodation.
- Two main options were taken by our participants to get help to stop drinking, HAGA services which offer a one to one therapeutic intervention or, AA meetings offered through the local Catholic church in the Polish language. Choice of which service to attend appeared to be based on personal preference rather than any access issues.

- Just two of the service users we interviewed had maintained stable housing and employment. The remaining eleven participants had experienced multiple negative life events, such as the breakup of relationships, estrangement from children, loss of employment and homelessness. It was thought by both service users and professionals that these issues needed to be dealt with in the first instance if they were to fully engage with alcohol treatment, however for some, this was not sufficient in itself to prevent relapse.
- Two key factors were reported by participants to have influence over their pathways through treatment, their relationship with a key worker, which helped them maintain sobriety and their family which could be a negative or positive influence.
- Participants stated that their ultimate goal was to achieve abstinence as opposed to reduce their drinking to safer levels. This was echoed by professionals who made distinctions between the ways that alcohol problems are treated in Poland and in the UK. It was reported by professionals that Polish service users would not expect to be given the option of either reducing or stopping drinking and this would seem puzzling to them if they were offered these choices.
- The concept of a 'normal' life was a common feature of participant interviews as a goal to work towards. This included regaining, or maintaining, employment, being able to provide for their family, or entering a new relationship and having stable and secure housing.
- Ongoing support after treatment was not always available to Polish service users, although the existence of Polish language AA meetings offered recovery support to those who accessed it. Alongside attending AA meetings, or if they were not used, some participants made dramatic changes to their lives in order to avoid drinking again such as moving home or changing their friendship groups.

Workshop

- From the perspectives of the professionals attending the workshop the main challenge being faced by services centred around changes to their own funding and resources and entitlements of migrants in the UK. The impact of reduced funding to community and alcohol treatment services can be seen in increased waiting time for people to access treatment and in some cases, people being turned away from services that are at capacity and cannot meet service user's needs when they are required.
- An important factor that impacts on treatment providers is the shame and stigma that is attached to admitting to having problems with alcohol. Women in particular face challenges in this respect as there is still pressure on them to be 'good' mothers and look after their children. The phrase 'Matka Polka' refers to an idealised version of a woman/motherhood that still persists in Polish culture but may be starting to shift both in the UK and in Poland but there are still entrenched opinions about how a woman should behave.
- One of the main factors that needed to be considered was that many Polish women with drinking problems were experiencing domestic violence and there is a need to address this in the first place. Many Polish women were dependent on their partners financially and socially and this creates difficulties for them if they wish to leave a relationship. It was suggested that some women used alcohol as a way of coping with these situations. It can take many attempts to leave an abusive relationship so services need to be open to women seeking help multiple times.

- Issues associated with Brexit were thought to be creating uncertainty for Polish and other Eastern European people who have made the UK their home and for services themselves in how it may affect their funding and commissioning priorities.
- In the local area an increase in the number of people from Lithuania was noted and that they are presenting to services with similar needs to Polish people such as having wider and complex intervention needs. However, it was less likely that services would have a native Lithuanian speaker or access to an interpreter compared to Polish and this was creating problems in providing care.
- All professionals stated that the goal for this group was likely to be abstinence as this was how alcohol treatment is generally approached in Poland (and potentially other Eastern European countries also). The 'medical model' of treatment was discussed as being the predominant approach within Poland and most migrants would anticipate a similar approach to treatment in the UK based on their own experiences and understandings.
- We asked professionals what initiatives they used to help to encourage more people into alcohol treatment services and the things they felt were important to have in place to facilitate this. Three factors were discussed; culturally competent staff; ensuring people are aware of the options available to them and; being able to provide practical activities or employment opportunities to service users.

Implications

In line with previous research the importance of cultural competence within services was highlighted by service users and professionals, however Polish migrants may have difficulties navigating the treatment system to get to the point of service intervention and there is a need to ensure individuals are aware of what is available to them.

Polish community organisations are well placed to offer signposting to appropriate services and to work towards shifting cultural attitudes to drinking and help seeking. Public health policy needs to consider prevention approaches in consultation with the Polish community and a broad range of professionals.

On the whole, problematic drinking is only one of a myriad of problems experienced by Polish drinkers and this necessitates a person centred and multi-agency approach as currently offered by HAGA-Blenheim. Moreover, service users and professionals noted that steps need to be taken to address other needs, for example, mental health as well as practical needs (e.g. housing, money) *before* individuals were able to engage effectively with alcohol treatment. There is also a need to consider different means of support for women and men given the apparent gender differences in drinking patterns and pathways into treatment.

Conclusion

Denial of problem drinking and delay in help seeking was evident for both men and women in this study and this impacts on individuals, families, communities and services. The desire for a 'normal life', underpinned by a strong work ethic seems to provide a foundation for recovery. Work is valued and routes into employment and other meaningful occupation (e.g. voluntary work, study) should be an integral part of treatment. Professionals raised significant concerns about the limited help available for those with NRPF, most of whom were reluctant to return to Poland and without appropriate treatment were likely to experience a deterioration in health and even die. This presents a profound challenge not only for practitioners and service providers, but also needs to be a policy consideration for society more broadly.

Introduction

Although much of the published literature concerning Polish migration to the UK focuses on those who arrived in the post accession years, Poles have been migrating to Western Europe since the first quarter of the 19th century largely as refugees fleeing conflict or persecution (Duvell and Garapich, 2011). However, it was not until 2005 when free movement for the A8 countries was established within the EU that the UK became a prominent destination for Polish migrants (Duvell and Garapich, 2011). It has been repeatedly reported that such a surge in A8 migrants (of which Polish individuals make up the majority going from approximately 10,000 in London in 2001 to almost 150,000 by 2011 – Census data) was unexpected and London boroughs, who saw the largest increase, were unprepared for such an increase in particular in terms of school places, housing and health services. In 2018 the Polish born population living in the UK stood at 889,000 (ONS 2018a). In the most recent statistics there was a decrease in the number of all EU citizens immigrating to the UK and for the first time the number of A8 migrants leaving the UK was slightly higher than the number entering the country (ONS, 2018b). However, Poland remains the most common non-UK country of birth, taking over from India in 2015 and Polish has been the most common non-British nationality in the UK since 2007 (ONS, 2018a).

Concerns have been repeatedly raised about high alcohol use and alcohol related harm among Polish migrants (e.g. Byrne, et al., 2008; Kreft and Richie, 2009; Garapich, 2010; Thom, et al., 2010). Agencies working with homeless people reported increasing numbers of Eastern European Accession (EEA) nationals who were destitute with complex needs and who are among the most excluded from accessing support (Byrne, et al., 2008; EERC, 2010). Research has identified that migrant homelessness is linked with other problems such as mental health issues, problematic substance use and experiences of institutions (Fitzpatrick, et al., 2013; Thickett and Bayley, 2013). Street drinking among Polish and East European (EE) migrants was identified as a perceived problem in several UK regions accompanied by reports of heavy dependency on alcohol and drugs among street drinkers (Thom, et al., 2010).

A scoping and consultation study in 2010 highlighted the problematic alcohol consumption and lack of engagement with services among recent Polish migrants (Thom, et al., 2010). Cultural perceptions of alcohol use and alcohol related harms may influence drinking behaviours and cultural factors such as belief systems are likely to play a role, for example, fatalism about health status (Thom, et al., 2010). A health needs assessment of EE migrants in Warrington highlighted that people were neither familiar nor comfortable with preventative approaches, for example, they did not expect GPs to ask questions about behaviour such as drinking and found this intrusive (Madden, et al., 2014). There appeared to be a stigma associated with accessing certain services including alcohol, mental health and sexual health services and alcohol problems were thought to be something a person sorted out for themselves and few people thought that a service could help support someone to reduce drinking (Madden, et al., 2014).

Studies on access to health care amongst migrants have identified a number of barriers including, confusion over entitlement to NHS services, lack of understanding on the NHS structures, problems registering with primary care services, language and interpretation problems and limited access to reliable transport due to poverty and poor services in areas of deprivation where many recent migrants live (Johnson, 2006). Some of the barriers such as information, language and transport, seem to cut across length of residence, affecting longer established migrants as well as newly arrived ones (Jayaweera, 2014). Findings from studies focusing on EE migrants are broadly similar

(DASL, 2015; HPA, 2010; Healthwatch Reading, 2014; Madden, et al., 2014) and these highlight delays in seeking help for mental health issues until 'crisis' point is reached. Research has also shown that Polish migrants will return to Poland for medical treatment (Goodwin, et al., 2013; Osipovic, 2013; Healthwatch Reading, 2014). Our understanding of drinking patterns, help seeking behaviour and experience of treatment services amongst this minority group remains limited.

Methodology

Aims and Objectives

The primary aim of this research study was to further understanding of the pathways into, through and out of treatment, with a focus on sustaining recovery to inform the design and delivery of services for this minority group. Ethical approval for this study was obtained from Health and Social Care Research Ethics Committee, Middlesex University.

The objectives were:

- 1 To examine pathways into treatment and identify facilitators and barriers to entering treatment.
- 2 To investigate which factors contribute to or hinder the completion of treatment
- 3 To examine what recovery means for Polish women and men and what factors help sustain or undermine recovery once treatment has been completed.
- 4 To consider whether the pathways through treatment and recovery differ for men and women and the implications of any differences for the provision and delivery of services
- 5 To include service users, practitioners and Polish community representatives throughout the research process to ensure that the project and its outputs are culturally appropriate and applicable to community-based services.

Methods

This was a qualitative exploratory study of the experiences of Polish women and men using alcohol treatment services in one London Borough. In addition, we conducted a comprehensive narrative literature review, using systematic review methods, to determine the current standing of knowledge of Polish people's pathways into, through and beyond alcohol treatment services. For this review we included primary research, review papers and reports and grey literature (e.g. health needs assessments) that were published within the past ten years with a focus on research conducted within the UK. In the final phase of the research project we hosted a practitioners workshop which brought together eight professionals working in the field of alcohol treatment, advocacy and advice and welfare support to people from Eastern European countries living in North London to discuss the initial findings from the research and to provide input into recommendations for practitioners, commissioners and service providers. The methods for each strand of the research are outlined separately below.

Literature review

The primary objective of the literature review was to assess the current understanding of the needs of Polish migrants in terms of alcohol misuse treatment, what services are available, or how existing services adapt to their needs and what is known about their outcomes.

To guide the literature search and provide a focus for determining the relevance of identified literature four review questions were developed:

- 1 What is known about the prevalence and trends of problem drinking among Polish migrants in the UK?
- 2 What alcohol treatment services are available to Polish migrants living in the UK and how/when are they accessed?
- 3 What are the barriers and facilitators to accessing and sustaining engagement with alcohol treatment services for Polish migrants living in the UK?
- 4 What is known about the treatment pathways for Polish migrants in the UK who experience problems with alcohol?

Papers were included if they met required inclusion criteria:

- Published in English
 - Published in the last 10 years
 - Included Polish migrants living in the UK as part of the sample
- OR
- Included professionals working with Polish migrants living in the UK in the capacity of alcohol treatment services or advice
 - Had a focus on access, experiences or outcomes of alcohol treatment services for Polish migrants living in the UK
- OR
- Included information on the prevalence of alcohol problems in this group and/or alcohol treatment needs

We conducted searches in seven databases (Cambridge Online; Emerald Insight; IBSS; OVID; Oxford Journals; PsychInfo and Web of Science) using a combination of the keywords; Polish OR migrant OR immigrant AND alcohol* OR alcohol misuse OR problematic alcohol use AND alcohol treatment OR alcohol intervention OR alcohol addiction service* OR alcohol support AND abstinence OR sobriety OR alcohol addiction OR alcohol detox*.

We also conducted separate searches using the keywords Polish OR minority OR A8 OR ethnicity within individual journals (Addiction; Contemporary Drug Problems; Drugs: Education, Prevention and Policy; Substance Use and Misuse).

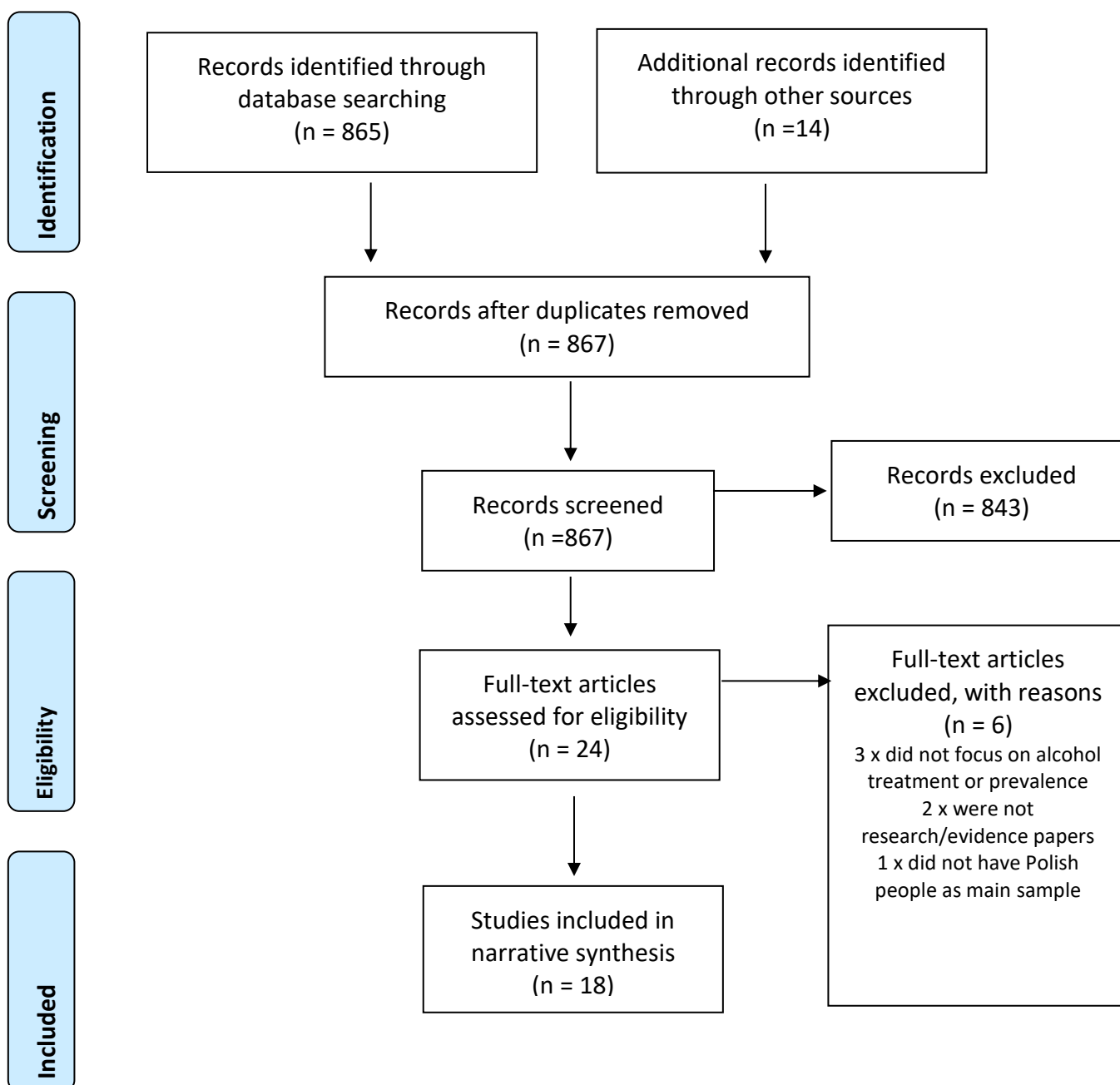
Grey literature was sourced through online searches using combinations of the same keywords and from hand searches of reference lists of papers and reports. Hand

searches of the reference lists of some papers and reports were also conducted to identify further relevant literature for inclusion.

Abstracts and summaries were read to screen papers/reports for relevance and those thought to meet the inclusion criteria and answer one of the review questions were then read in their entirety and included or excluded based on an assessment made at this stage. The review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher, Liberati, Tetzlaff and Altman, 2009). Figure 1 provides details on the numbers of papers included and excluded for final review.

Figure 1

PRISMA Flow diagram



Interviews

The interview strand of the research study was developed in collaboration between Middlesex University and Haringey Advisory Group on Alcohol (HAGA)¹ a charity that provide a specific service for Polish people and employs a Polish speaking key worker. Middlesex University and HAGA had previously collaborated on a study of Polish street drinkers (Thickett and Bayley, 2013)². The aim was to draw the main sample of service users from those already in contact with HAGA services as this would allow for those who were not proficient in English to have the Polish speaking key worker present during the interview to act as a translator. However, unforeseen and unavoidable circumstances³ meant that sufficient numbers of interviewees could not be accessed through this route and five participants were recruited in this way. As an alternative the Middlesex University research team contacted other local services that were aimed at providing alcohol support, advocacy and advice to Polish migrants living in London for their help in recruiting participants. Through the Polish and Eastern European Christian Family Centre (PEEC) in North London we interviewed a further eight Polish people who had experience of alcohol treatment services in the UK.

In total we interviewed four women and nine men with experiences of alcohol treatment services, with three of these requiring a key worker to be present to interpret for participants. We also interviewed four professionals from different organisations within the borough who worked with Polish migrants with problematic alcohol use. Interviews took place at the offices of the service that participants were recruited through (i.e. either HAGA or PEEC). All interviews were recorded and later transcribed for analysis. Service user participants were given a £20 supermarket voucher as a reimbursement for their time and travel.

We had initially planned to use a timeline method to provide a visual representation of pathways into, through and beyond treatment. This method has been useful in previous research among Polish street drinkers (Thickett and Bayley, 2013) in encouraging disclosure of drinking behaviours especially among women. In the previous study, participants were encouraged to reflect on events they portrayed via the timeline but this often created emotional distress and required considerable concentration on their part. It was decided that the standard interview format would be adopted after the third interview without use of the timeline. Participants needed to focus more on their immediate histories in our current enquiry while the timeline encouraged them to dwell on events from their distant past.

Data from the interviews were analysed using a thematic analysis approach and we first analysed data from the service user transcripts to understand their journeys through treatment and then incorporated and compared the data from professionals to the themes that were developed from the service user data.

Practitioner workshop

A practitioner workshop was organised towards the end of the project so that local stakeholders could be brought together to discuss initial findings and advise on the development of recommendations for policy and practice among Eastern European

¹ During the course of the research, in April 2018 HAGA merged with another charity Blenheim CDP but continues to provide alcohol services in Haringey.

² Funded by Alcohol Research UK forerunner to Alcohol Change UK.

³ This included a short period where there was no worker in post whilst a maternity cover was recruited for the post holder.

people in need of alcohol support services. This was held at Shine, a community café⁴ in North London as it was a central location for participants. It was attended by eight professionals including two Polish alcohol workers based at HAGA, two representatives from PEEC, one Polish homeless outreach worker, one local commissioning manager and two people from a local NHS alcohol service provider.

The research team presented emergent findings from the interview data collected and asked participants to reflect on these in light of their own experiences and views on working with Polish migrants in alcohol treatment services. We then asked participants to form into two groups to discuss key issues around providing alcohol treatment services to Polish and other Eastern European people with particular emphasis on current challenges/impacts on services and key facilitators to encouraging people into services. Finally, we asked groups to outline their views on best practice in services and what an 'ideal' alcohol treatment service for this group would look like.

The discussion was recorded in two ways, audio recording for later write up (with permission from participants) and graphically by two artists from 'More than Minutes' who illustrated key discussion points as they evolved by drawing them on a large poster attached to the wall and visible to the participants throughout the workshop. Throughout the course of the workshop participants and the research team were invited to reflect and comment on the ways in which the artists had represented discussion points in their illustrations, for example, if there were misrepresentations, omissions, lack of clarity etc. How discussion points were illustrated thematically was also probed to try and best represent themes emerging in the research findings. Images from the final artwork are used throughout the report to illustrate points and the entire artwork is reproduced on page 34.

⁴ Shine was set up by HAGA and supported by a capital grant from Public Health England. The project is now delivered by Blenheim CDP

Findings

Literature review

Much of the retrieved literature that included Polish migrants in the UK as their sample focused exclusively on economic or employment issues within this group and did not address any healthcare or additional service use or needs. This literature was especially prolific in the years immediately after A8 accession (between 2005 and 2010) and appears to have reduced considerably in the intervening years to date. From the existing literature a number of general trends in the experiences of Polish migrants can be determined.

A survey conducted shortly after A8 accession reported that approximately 25% of Polish migrants in the UK stated that they did not feel as though they were part of British society (Eade, et al., 2007 – cited in Duvell and Garapich, 2011). For a sizeable number of migrants their experiences were not positive, evidenced by the rise in Polish homeless people particularly in the years after the global financial crash of 2008 (Garapich, 2010). A recent systematic review of the mental health needs of Polish migrants in the UK noted that one paper reviewed reported that males were more likely to abuse alcohol without seeking help as a means of dealing with acculturative stress compared to women (Maciagowska and Hanley, 2017). Excessive drinking has been linked to high rates of depression and suicide among Polish migrants in various European countries, although the direction of causation is not clear (Thom, et al., 2010).

Prevalence and trends in problematic drinking among Polish migrants in the UK

A high level of denial of problematic drinking and a strong sense of social stigma have been noted within Polish migrant communities where cultural attitudes towards drinking may reduce rates of admission of the need for intervention (Thom, et al., 2010). As many Polish migrants drink at home with friends, rather than in pubs or clubs, there may also be the view that drinking in this way is not problematic and there is little need for them to consider alcohol treatment services (Madden, et al., 2014; Strobbe, et al., 2013). There is some suggestion that younger generations of Poles drink much less than their older counterparts and the stereotype of drinking large amounts of vodka to excess no longer exists (Madden, et al., 2014).

Other factors cited as influencing a reduction or limiting of drinking amongst Poles in the UK include the difference in acceptability of coming to work with a hangover, or in some cases still drunk from the night before. Maintaining secure employment becomes an overriding concern for many who adapt their drinking behaviour to ensure they do not lose their jobs (Kreft and Ritchie, 2009)

Specific data on the use of alcohol treatment services by those from individual A8 countries is not routinely collected in the NHS or local authorities. For the most part, those from A8 countries are recorded as 'white, other' when this information is collected, so that any statistical assessment of the level of need for alcohol treatment for Polish migrants is difficult to determine. Some estimates can be inferred from local needs assessments that have been conducted in various locations across the UK. Latest statistics from the National Drug Treatment Monitoring System (NTMS) in England report that 5% (approximately 13,260 people) of those in alcohol and/or drug treatment recorded their ethnicity as 'White; other' (UK Government, 2018)

A 2014 needs assessment conducted in Bradford reported that 9% of people in alcohol treatment in the local area were 'white, other' from an estimated population of 12,000 individuals which is cited as an indication of the prevalence of problematic drinking among Polish migrants (Ingold, 2014). A number of authors have argued that cultural perceptions and practices of drinking alcohol can mean that attitudes toward the potential harms of frequent or heavy drinking are not acknowledged amongst Polish migrant groups (e.g. Kreft and Ritchie, 2009; Thom, et al., 2010). Additionally there is some evidence that Poles only consider problematic drinking to refer to alcoholics and would not consider other forms of heavy drinking as a problem. There are also reports that if regular drinking does not interfere with an individual's ability to work and generally function on a daily basis it may be assumed to be unproblematic at least within Poland (Thickett and Bayley, 2013).

In contrast, street drinking, which is often associated with homelessness, has been identified as a particular problem for Polish migrants in the UK (Fitzpatrick, Johnsen and Bramley, 2013). However, as has been reported from various regions across the country, Poles tend not to drink in pubs and street drinking or drinking outside their own house can be common (Ingold, 2014; Kreft and Ritchie, 2009; Madden, et al., 2014). Polish culture can be a factor also, where not drinking or refusing a drink when offered can be seen to be an insult and result in the individual being excluded from social gatherings.



Alcohol treatment services available to Polish migrants living in the UK

Research from the years directly after A8 accession suggest that some substance misuse services were reluctant to offer treatment interventions directly to new EU migrants due to restrictions on access to welfare and healthcare services (Mills and Knight, 2010). The lack of precise information available as to the numbers of migrants in a local area and their specific alcohol treatment needs further compounded the ability of community services to adapt to changing local demographics (Mills and Knight, 2010). Alcoholics Anonymous (AA) groups targeted specifically at Polish people in Britain have been in existence for some time and are usually operated through Polish Catholic Church organisations (Thom, et al., 2010). These may not have established links to other treatment services and may be the only alcohol intervention accessed by those who cannot, or do not know about, other services available. Due to the anonymous nature of AA, outcomes, rates of abstinence, or other measures of successful intervention for example, are not recorded.

One study reported that some homeless Polish migrants had been advised to seek help for their alcohol use at local substance misuse charities and a small number may be offered medical detox when attending hospitals but this appears not to be consistent nationally (Thickett and Bayley, 2013). This in particular appears to be a lost opportunity for referring Polish people into alcohol or drug therapy as injuries and accidents requiring hospital treatment were common in the group interviewed for this study.

Barriers and facilitators to accessing and sustaining engagement with alcohol treatment services for Polish migrants living in the UK

A number of studies have noted the high levels of alcohol consumption within Poland (Strobbe, et al., 2013; Thickett and Bayley, 2013; Thom, et al., 2010) that has created a normalised view of alcoholism, especially among men. This could act as a barrier to help seeking when Polish migrants either fail to see their drinking as problematic or the stigma attached to alcoholism prevents attempts to find support to stop. A feature noted in Thickett and Bayley's (2013) qualitative study, and reported elsewhere (Madden, et al., 2014), was a reluctance on the part of some Polish interviewees to attend alcohol services as they believed it was something they should be able to deal with by themselves.

Cultural familiarity was important to some of the 62 Polish participants in Osipovič's study (2013) which explored the use of healthcare services by migrants living in London. For these participants, they stated they preferred to return to Poland when they were ill as they found the NHS confusing and difficult to access, however, other factors also played a part (e.g. lack of English and fear of deportation). For those who could not afford to return to Poland or to pay for private healthcare there, they reported being dissatisfied with the NHS services they felt they were forced to use. A needs assessment carried out in Reading in 2014 reported that 64% of respondents to a survey of Polish migrants in the area had returned to Poland at least once for health treatment (Healthwatch Reading, 2014). A review conducted in Hertfordshire found that this can create difficulties in accessing appropriate care subsequently in the UK as test results or diagnoses are often not shared by individuals (Coakley, 2011).

Restricted access and entitlement to services for some A8 migrants was a major factor in the lack of culturally competent service availability in Mills and Knight's (2010) study exploring substance misuse services in London. This study also speculated that there was a fear among providers that if they were to offer culturally specific services to

particular migrant groups they would quickly become over-subscribed and would not be able to cope with the demand for these services. Similar difficulties were described in accessing alcohol services in Thickett and Bayley's (2013) study exploring alcohol treatment engagement among Polish street drinkers. Related to this are the current difficulties experienced by some migrants who have 'no recourse to public funds' and are not eligible for medical detox services, or are not aware if they are eligible and can end up in A&E due to alcohol related problems but do not enter the treatment system from here (Thom, et al., 2010).

Language barriers are reported in much of the literature (Ingold, 2014; Madden, et al., 2014; Thickett and Bayley, 2013) as presenting two issues, the ability of services to communicate the potential dangers of excessive drinking and the likelihood of Polish migrants being able to navigate the treatment services sector. Mistrust of UK healthcare services was reported in a number of local needs assessment investigations, although this tended to focus on GP services where Polish migrants felt they were not given the type of care they would expect from similar services in Poland (e.g. Madden, et al., 2014). Again, this research focused on healthcare more broadly and it can only be assumed that similar attitudes towards other related health services are present among Polish migrants. For example, a needs assessment from Warrington (Madden, et al., 2014) reported that Eastern European participants who took part in focus groups or interviews found it difficult to talk about healthcare services beyond hospital, GP or dentist services and there was limited understanding of wider public health approaches.

[What is known about treatment pathways for Polish migrants in the UK who have problems with alcohol?](#)

A recent systematic review of the mental health needs of Polish migrants in the UK noted that one paper reviewed reported that males were more likely to abuse alcohol without seeking help as a means of dealing with acculturative stress compared to women (Maciagowska and Hanley, 2017). This is supported by findings from a needs assessment in Warrington (Madden, et al., 2014) that found Eastern European migrants in this borough felt that alcohol problems should be dealt with by themselves rather than through professional services. This study also reported a lack of understanding of the pathways available to individuals who wish to seek help with alcohol use, with many believing they can only access these services through their GPs. In light of additional findings from this, and other, studies (e.g. Osipovič, 2013) that report Eastern European participants both mistrusted GPs in the UK and felt that they were dismissive of their concerns, it is possible some migrants are reluctant to seek help, or referral, from GPs until their alcohol use creates physical health problems.

It is likely that for some migrants heavy drinking is a feature of their everyday lives before leaving Poland but this may not become problematic (by affecting employment for example) until they live in the UK (Thickett and Bayley, 2013). This could mean that for many Polish migrants in need of alcohol treatment it is not acknowledged until there have been physical health implications. In addition, a 2008 report by Shelter argued that a considerable proportion of migrants arriving in the UK have existing substance misuse problems that are not treated due to having 'no recourse to public funds' in many cases leaving individuals without access to appropriate treatment services (Byrne, Everitt and McKeown, 2008).

Interviews

In total we conducted 13 (9 males; 4 females) interviews with Polish migrants currently living in North London who were either receiving treatment or had previous experience of alcohol treatment services in the UK. Most interviews were conducted in English as the participant was comfortable conversing in the language and just three were conducted with the help of a translator. In addition, we conducted interviews with four professionals working across support services for Polish migrants in North London, including one Polish key worker based at HAGA, one support worker with PEEC and two people based at a local Polish Catholic Church that hosted AA groups.

1. Moving towards treatment

Recognising the problem

The recognition that drinking was becoming a problem was a slow process for participants. For women, they often drank alone and at home, and drinking could remain hidden for some time before it was seen to be impacting on other aspects of their lives;

So whenever I was still working as a waitress, whenever I was going back, coming back home, so let's say night bus, 2 or 3 in the morning, buying a bottle of wine. But then no one saw it was happening and everyone was asleep, so I was sitting on my own with some cigarettes and that was it. (Int3_female_HAGA)

No, I was drinking first at home, by my own. I was drinking like very little, like two or three beers, but every time, overnight, just night time, to relax me, I got depressed. I was feeling a little bit lonely, the kids were upstairs you know. (Int6_female_PEEC)



In contrast, for men, while problematic drinking also built up over time, their initial drinking behaviour was a social experience and was part of everyday life. For many, as long as they were still capable of working and their drinking was not interfering with this it was not seen to be a problem:

But first few years I'm working, just very hard job on the building sites. After job I finished at 5 O'clock, all free time just drinking alcohol really. No family here. Yeah, the friends which one I know at this time, a couple of years ago, just everyone drinking. This is how we spent the free time and all money. (Int10_male_PEEC)

Okay after a couple of years, there were lots of problems start, slowly, slowly and at that time I don't see these problems. I think, I'm thinking everything is alright, I'm working, my free time I spent with the friends we're drinking. I think okay it's normal. Month by month, year by year, problems start bigger. (Int10_male_PEEC)

Looking for help

Cultural issues could also play a part in how and when men or women seek help with their alcohol use, for men it was thought that due to the more public nature of their drinking it was easier for men to gain wider support to stop drinking and they were more likely to be congratulated on their decision. Women, in contrast, were more stigmatised and may be criticised by their social circle for 'allowing' themselves to develop problems with alcohol in the first place. This could add to a reluctance to seek help themselves amongst women who were fearful of admitting a problem or having others know they might need help.

For both men and women the point at which most participants sought help for their problematic drinking tended to come only after a series of negative life events had occurred including; losing a job, the break-up of a relationship, intervention from social services, becoming homeless or serious physical illness due to alcohol use. A number of interviewees referred to Polish culture as one of the reasons why they failed to see a problem in their own drinking, that it was such a normalised part of socialising and it was only after it had impacted to such a degree on their lives that they felt they needed outside help. Many participants had to begin treatment with medicated detox before they could engage with therapy:

I think you know my physical addiction, they withdraw and that's with the medicine, which I couldn't do any time, maybe because of the Polish culture and the drink, like between Polish people it's all the time. There is some alcohol on the table all the time. So it's like, that helped me a lot because you know I stopped shaking, stopped thinking about this ... Yeah now I have had since 2nd October, I finished the detox. (Int2_male_HAGA)

You know like I've said I'm 33 and doing this and a lot of people who don't have very good language and are coming here are completely lost because they may not even understand what the issues are. And when you tell someone who is 40 years old, who is a Polish man that he has a problem, he will laugh at you and this is just because there is no awareness. There was no awareness when we were growing up. (Int3_female_HAGA)

For some, previous offers of help or suggestions from their GP, friends or family suggest problematic drinking for some time before they felt ready to look for help themselves. This aligns with experiences of one professional reporting that a number of appointments

made via GP referral were missed and that they were generally not followed up further by services when this happened. Some of the participants expressed the opinion that the decision to stop drinking and to seek support with this must come from the individual and there was a strong sense that it needs to be a personal choice rather than directed by health or other professionals:

...because I have a problem. I know myself, I see myself in the mirror. I see myself how pretty I am, how I damage myself because of alcohol and how alcoholic I am. (Int13_female_HAGA)

Yes so with a bit of a prompting the answer is that the previous GP would have suggested treatment, perhaps many times with him, but the client believed that maybe he could resolve it on his own. (Int7_male_HAGA_interpreter)

Of course after the institution like rehab, HAGA, something they help you, because if you stay alone, no chance. But first we have to change our life, we, nobody do it, nobody. If somebody puts you to the prison, you sit in the prison, there's alcohol and drugs as well, because I know I've been in the prison, Pentonville here, I know. But if you come back, you have a choice to go left or right, you go to the shop and pub, or you go to the church. Everything is you. (Int10_male_PEEC)

Facilitators and barriers

As with earlier studies, for those with no/limited English, language was seen as presenting a major barrier for accessing health and social services, including alcohol treatment. The presence of a Polish speaking worker at HAGA was regarded as a key factor in enabling Polish people to access treatment.

The main motivation for many participants to stop drinking was expressed as a wish to have a 'normal' life, to return to a stable job, accommodation and a future with a family:

[when homeless and alcohol dependent] I go and see the restaurants, you know a couple of people eat something, nice food and talking together and spend normal time, like normal people you know. I be wet, no money, nothing, hungry and I say what are you do with yourself, you know what I mean. Yes, I have really, really enough of life like this. (Int10_male_PEEC)

So where to start, so I really have reached the point in my life where I wanted to step up with the quality of my life and the quality of my prospects. The chaos beforehand was partly due to a difficult relationship that was very important, but very chaotic and at some point it was just time to make some final decisions and know that it's either way and that I do not have opportunities in Poland. I don't have much to go back to there, so I knew that I needed a radical change to improve quality of life. (Int7_male_HAGA)

A shift in attitudes toward seeking help for alcohol problems, at least amongst Polish men, was also noted by professionals. Stricter rules around working in construction and drinking had been seen which to an extent made abstinence easier to maintain and be respected by work colleagues:

I think there is some kind of shift, yes, yes, there is some kind of shift. Also that the bosses are employing breathalysers in the morning often randomly or even when they leave. Because I also see on the Polish work sites that the advertisements also have changed and it does say like if you drink problematically, don't bother coming for this

interview, which it used to be that the Polish construction, everybody would be drunk. And it would be just no discussion about it, it's vodka for breakfast and it's vodka for lunch and it's just everywhere to see you through the day. But then I think the working culture has shifted. (Professional interview 1)

For those who were no longer in work and especially those who had become homeless, continuous drinking was more common and was seen as way of both coping with homelessness and of ensuring social support while on the streets:

For homeless people it is not possible to not drink and to live on the street, because there's so many factors. So it's very, it almost goes together the homeless with drink...Just, maybe just a few occasions where some homeless people, but just homeless, or getting homelessness and he doesn't want to be involved with this group of homeless, you know just to, he wants to kind of stay separate. I don't know how long he could ... If we managed to help him quickly to get out from this homeless situation, yeah he would be safe from this danger of getting into this group. (Professional interview 2)



Pathways into treatment

Professionals stated that men and women had different pathways into services. Men were more likely to self-refer, whilst women were reported to be more likely to come to alcohol treatment through referral by GPs, social services or probation services compared to men:

But women maybe are a little bit more likely to be referred by health professionals, social services or dual diagnosis, whereas men can also just come because they just know they drink too much, or something, somewhere got out of hand, whereas women would usually be referred. (Professional interview 1)

Women were also reported to have additional difficulties to overcome alongside their alcohol use, in particular if they had children and social services had intervened. All professionals spoke of cases of women in their treatment services who had children removed from them as a direct result of their drinking. Other common patterns were seen by some professionals where women were in abusive relationships that they found difficult to leave or were highly dependent on their male partners, making leaving those relationships an added source of stress and anxiety:

But the problem with women I think it's, often they are very dependent on the man here as like in our group of people the same happens, usually man is working and all the benefits and agreements is on him and she's kind of attached. So it kind of, we have some ladies come and when, at some point when the relationship is broken and he left her, she's alone and she has, she doesn't know how to live even here. She doesn't have for example even bank account (Professional interview 3)

Summary

There appear to be different pathways into treatment for women and men due to their patterns of drinking. Women were more likely to keep their drinking hidden, while men's social lives tended to include regular drinking occasions. This was linked to Polish drinking culture by both service users and professionals. However, some changes in attitudes towards drinking, at least within the work sphere, were also noted and it was reported that drinking at work, or coming to work hungover, was no longer acceptable. Many still felt however, that the decision to stop drinking, or to look for help, needed to be their own and there was evidence that referrals from other services or encouragement from friends or partners did not generally lead to engaging with treatment services. Most participants did not seek help for their problematic alcohol use until it had negatively impacted their lives or their physical health to a serious extent. Motivation to stop drinking was reflective of this where most participants spoke of a desire to return to a 'normal' life, with good health, relationships, stable housing and work being their goals.



2. Experiencing treatment

Discovering what works

In our sample, once someone had decided to seek help with their drinking there were two main treatment options that they were likely to be referred to or access themselves. One

option, HAGA services, offered psycho-social interventions, often preceded by medical detox and additional support for example, with claiming benefits or housing support. HAGA offers a specific service for Polish people. The other option was Alcoholics Anonymous which operated in the local area with many providing Polish language groups. Some participants had experience of both services and expressed strong preferences for one or the other.

Many of the participants had made several attempts to get help to stop drinking. There was a divide amongst participants as to the best approach for them with a number finding the AA model unsuitable and unhelpful. For some, they felt it had a negative impact on their mental health, suggesting an unmet need for psychological support alongside alcohol treatment intervention:

I had like you know, I was very down and drinking a lot a few years ago, seven years ago and I went to a meeting that was one of my clients who and my boss introduced me to AA and I went for the meetings and after a few sessions I get completely crazy. I cannot go there anymore, I was so down, I was so depressed and you know instantly if I stop drinking this time you know. So I make a few months where I'm completely go back on the track. (Int 2_male HAGA)

I was there [AA] just a few times and you know like I've seen this is not good for those people, you know if help is okay for them. It didn't work with me, I couldn't go and come out of my home, I was like for a few hours depressed after I listened to the people's talk. It was like more fear than real help. Here in HAGA knowing people are sharing, it's completely different (Int2_male_HAGA)

For others, there was a sense that the people who attend AA meetings were not heavy enough drinkers, in a sense not 'real' alcoholics, and it would not be of benefit to the participant to continue to attend:

[on AA] Talk, talk, talk, talk. Of course, this maybe help people, but help people who is just drunk or drinks, who is like let's go to the pub, drinking fun, dancing or something like this and morning of course it's headache, blah, blah, blah. For me beer is like a breakfast, it's a standard. I'm not enjoying for this, I must do it, like a medication. (Int8_male_PEEC)

Other participants had very different views and felt that the approach used at HAGA was not helpful to them, some admitting that they attended meetings but had never actually stopped drinking. Some participants felt that they should have been able to access other support services that were not offered to them, although it should be noted that most of those attending HAGA did also talk about the support they had received through the services for housing, benefits and mental health difficulties:

No this is like three years now I drink. I've calmed down a little bit. I went to HAGA two years ago by my own, I was thinking I need help. I went for a few meetings then, I quite enjoy, but I never stopped drinking. I was lying then, because when I went in morning for the meeting I didn't, I usually didn't drink in the morning, now I've started a little bit. (Int6_female_PEEC)

[on experiences with HAGA group therapy] I think you know, the addicts and I'm an addict as well are very manipulative and they know how to pull the strings for themselves. And I know that many people were using these services to get you know what they want and I think there were opportunities to do that, you know. I'm not

saying everybody, because I know some people which have good help and in a way they was locking people in addiction as well, because they have this kind of soft touch and kind of easy access to benefits and stuff. Then they didn't hit the rock bottom and they didn't need to change anything and they were staying in this bubble, yeah everything is fine you know, I got this, I need to come to this, I need to do this and that's working fine. (Int9_male_PEEC)

Factors facilitating treatment

In addition to support for practical issues that most participants stated they had received from various organisations (including PEEC, housing officers, Department of Work and Pensions (DWP) officers and the police), the relationship created with key workers was the main factor in their ability to continue with treatment and to be able to see a more positive future for themselves:

So there was an impression that somebody actually cares and wants to help, so that is contributing to me remaining abstinent. I have also have severe health complications, jaundiced and alcohol related epilepsy, so that is a high risk situation and I wouldn't like for that to continue. I have a strong belief that my life and my future will be better, but yeah there is at the moment ongoing contact and some good intentions that are coming my way and have helped in that regard. (Int1_Male_HAGA)

Just two of the service users we interviewed had maintained stable housing and employment. The remaining eleven participants had experienced multiple negative life events, such as the breakup of relationships, estrangement from children, loss of employment and homelessness. Both professionals and service users referred to the need to ensure stability across these aspects of their lives before being able to fully engage with alcohol treatment services, although this had become more difficult in recent times:

No maybe 50% or 40%, like many people have problems on the edge of homelessness, or are already homeless. It's really hard actually recently to help them because services are, the council doesn't have much and all these shelters also needs to go through the council referral and some will get rejection. (Professional interview 2)

...because it always, it's not happening in a day, so it's a kind of process you have to wait for some decisions to be made or get some benefits and step by step you build a future full of hope. If they, maybe if they found the hope, okay let's hope for me to be different, to be more comfortable, not like I used to do. They are more willing, I think they are more open to stop drinking. (Professional interview 2)

However, even when additional support had been received by some individuals going through treatment, there was still a danger that they could relapse and be brought back into services after spending some time sober and in employment:

I guess dependent drinkers really, heavy dependent drinkers that have had very chaotic, traumatising lives. Even if we look after them to the point where they are actually housed, maybe back in a job, or back in training, or on benefits, but fairly alright, but if there was a heavy dependence and if they lapse even and the dependence, the physical aspect kicks back in, then they usually spiral down very quickly. So it's mainly long term chaotic drinkers I would say that we would worry about. (Professional interview 1)



Recovery pathways

Children and families played a large part in the recovery process for some participants in both positive (as discussed in the next section) and negative ways. The potential for embarrassment in admitting an alcohol problem was keenly felt by one female participant who ended her sessions with HAGA when her children and their friends saw her coming out of the building:

And I feel like my girls feel embarrassed as well. My daughter come once and say mummy please don't let my friends see you coming out from HAGA or going there. So I feel like they feel embarrassed as well. (Int6_female_PEEC)

Male participants appeared to be better able to focus on the positive aspect of stopping drinking rather than the negative behaviour associated with drinking and spoke about becoming 'strong' again. Perceptions of masculinity were important for male participants who viewed being able to provide for themselves and their families as necessary, and as a reason to remain sober in order to be able to work:

Absolutely nothing [no financial support]. My girlfriend is helping. I cannot live like this, you know I'm, yes, I'm a man, I'm supposed to be, I must go to job, I must do the working, I must get the money, not girlfriend. It's not good. It's not good. (Int8_male_PEEC)

In the context of some of the quotations above regarding the impact of attending AA meetings however, it may be that they were trying to forget rather than face up to, the harms that might have been done while they were drinking problematically.

Summary

There was no consensus among participants in this study as to the best pathway through alcohol treatment. For some the group based, abstinent focus of AA was preferable while

for others the one to one psycho-social treatment approach offered by HAGA was deemed more suitable for them. Many had tried both services before choosing one that they felt most comfortable with, and some had made multiple attempts to stop drinking through one or both services. Difficulties in achieving or maintaining sobriety were related to problems in other areas of service user's lives, most notably housing and access to benefits or employment. It was thought by both service users and professionals that these issues needed to be dealt with in the first instance if they were to fully engage with alcohol treatment, however for some, this was not sufficient in itself to prevent relapse. Two key factors were reported by participants to have influence over their pathways through treatment, their relationship with a key worker, which helped them maintain sobriety and their family which could be a negative or positive influence.

3. Beyond treatment

Trying to remain abstinent

Some of the participants we spoke to were continuing to drink while also attending treatment, although most felt that they were approaching the point of abstinence. None of our participants referred to a future goal of being able to regulate their drinking or reduce the amount of alcohol they drank to a safer level. The general aim was to become abstinent, although some struggled at times, partly because they were not accessing additional support for psychological or mental health needs:

If everything okay I not drink. My life is normal, it's normal. Every time I make up, it's normal. If it's one problem, it's for me no problem, I not drink. But if it's one, two, three it's, for me it's a lot of problem, because I not sleep, I can't eating, nothing. My depression I not, I don't have friend, no, if you have problem, you will speak with somebody it's better, it's better. If you take everything inside on you, on you, on you, it's not as good. (Int12_female_PEEC)

Differences in approaches to alcohol treatment were discussed by professionals in considering the ultimate goals of those coming for support regarding abstinence. While, in the UK, patient centred care approaches advocate allowing the individual to choose whether they wished to reduce their drinking to a safe level or to stop entirely, this would not be an option in Poland. Alcohol interventions would likely be delivered through psychiatric services and would only promote abstinence. Cultural expectations of treatment therefore seemed to have an influence on how Polish individuals came to services, what they anticipated would be required of them and how they understood and envisioned their goals beyond treatment:

I cannot believe in that [offering a choice of reduction in drinking] and I avoid that kind of care plan as much as possible and my Polish drinkers if they are dependent they wouldn't insist on any such thing, but I see the English people have that kind of trial and error, we have to follow, clinically speaking we have to follow that kind of client centred option of, if that's your goal, if that's what you're ready for, let's try. I don't know about it, but with my Polish ones I don't do that, with dependent ones and they wouldn't expect that and they would never heard about any such thing. In Poland it's also either you're abstinent or you go home, so the same here, because even, they can always relapse, but if they are dependent, physically dependent, then there's no point playing with fire. (Professional interview 1)

Desire for a 'normal' life

Again, the idea of returning to a 'normal' life was expressed by a number of participants as their vision for their future goals. This included obtaining secure accommodation and employment, improving their health, and trying to reinstate relationships affected by their drinking. There was a clear sense that all of the various parts of participant's lives that they saw as having been 'broken' through their problematic drinking could eventually be fixed by becoming abstinent although it was anticipated to be a long process:

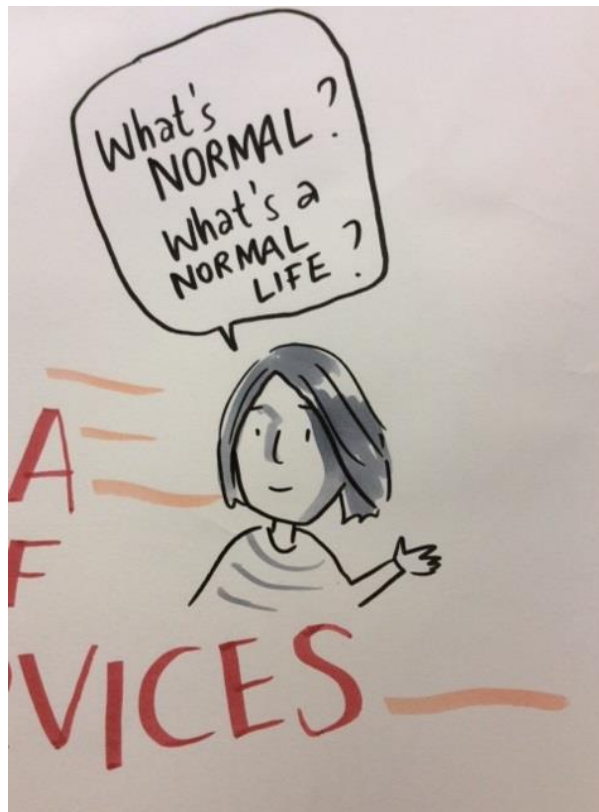
So the main agenda is about things returning to normal and the most urgent on the list is the homelessness. So first of all I would have somewhere to live and somewhere to stay and I would like to eventually go back to work, at the moment the health does not allow it. I would like to be an active and normal functioning person again. Possibly I can envision a family there. I used to have a family and possibly, maybe, potentially there is a reconciliation on the cards. But I don't know, at the moment I don't think about it much because I'm not in a position where my conditions would allow such thoughts. But I am essentially hoping for my life to go back to normal and be an employed person with an address and not drinking at all. (Int1_male_HAGA)

So I don't want to go back there [Poland], I want to sort out my life here like normal people you know. I can fix that, my legs, a healthy diet, my mental things is normal because I can speak with my partner do you know what I mean, with like people it's like easy speak, everything has come out of me yeah and that is good for me because if I go like that [injecting motion] it's one day and my brain is cut off and it's like grow up and I can't do everything forever, bad thing. (Int4_male_HAGA)

Some participants had begun to restore those things in their lives they thought were important, such as work, housing and relationships. In order to achieve this however, they tended to make considerable changes to their lives from the people they socialised with and/or where they lived:

Yeah, yeah everything changed. It's also like kind of, you see when I was drinking, I was thinking that everybody else is drinking, because all my friends used to drink and everybody around me used to drink. Then I didn't there were people who have like kind of normal life and they don't drink and now I see a lot of people don't drink and they live happy lives, they do their duties, they have families, they have kids and it's amazing, you know it's like a discovery these past few years. (Int9_male_PEEC)

No, I changed, I changed definitely, I changed the people. This is very important. I change, as well the place where I live, not town, because I live in London, I change the area, this is very important, because when you come back the same people are hi, hi, come on and drink something. If you ... you can come back the same, no, no I changed definitely. I changed definitely (Int10_male_PEEC)



The impact of being able to tackle their alcohol problems and make positive changes to their lives was evident in how participants expressed their feelings about their lives now without alcohol reflecting the goals of those quoted above who had hoped to return to 'normal' life after alcohol:

...it's a good time now [to visit Poland] as I said like my relationship with my parents and between my parents are good, so I just needed this and because I can be sober, I can wake up and you know. (Int3_female_HAGA)

I started having contact with my son, he is nine years old now. Now it's everything alright. I don't drink for three and a half years... Yeah. Enough. I don't need. I feel good. My health feel good. I have money, home, a beautiful fiancé, we're going to have marriage. I have very good contact with my son, with my mother. Everything is fine. (Int10_male_PEEC)

Ongoing recovery support was not usually available to those who had little or no English language ability as there were no Polish language recovery groups available outside of 12 step AA programme. Within HAGA this absence of follow-on support was compensated for by allowing for longer initial treatment services extended from the usual three months to a six month period. At PEEC, there were no specified time limits on how long someone could access the service and it was led by the particular needs of the individual.

Summary

Participants stated that their ultimate goal was to achieve abstinence as opposed to reduce their drinking to safer levels. This was echoed by professionals who made distinctions between the ways that alcohol problems are treated in Poland and in the UK. It was reported by professionals that Polish service users would not expect to be given the option of either reducing or stopping drinking and this would seem puzzling to them if they were offered these choices. However, some of the service users we interviewed

were at the stage of actively trying to control their alcohol use and had not yet fully stopped drinking despite most stating that this would be their aim. Participants spoke about wanting the opportunity to return to 'normal' life on becoming sober and for those who had stopped drinking, this was reflected in the ways they spoke about their lives now, new relationships, employment and stable housing were key features of these narratives. Ongoing support after treatment was not always available to Polish service users, although the existence of Polish language AA meetings offered recovery support to those who accessed it. Alongside attending AA meetings, or if they were not used, some participants made dramatic changes to their lives in order to avoid drinking again such as moving home or changing their friendship groups.

Practitioner workshop

The purpose of the practitioner workshop was to bring together a range of professionals working with Eastern European migrants living in London through alcohol (and related) support services to discuss our qualitative research findings and to help develop recommendations for future service provision. Eight professionals attended the workshop (details of attendees are given in the methodology section). Findings from the research study (as described in the previous chapter) were presented and the attendees were asked for their feedback on these findings and additional discussion questions relevant to the topics presented. Notes of the discussions were taken on the day and main themes were illustrated by artists from 'More than Minutes' as the workshop proceeded. Below are the main themes that arose during the course of the workshop. To maintain anonymity practitioner comments are labelled as P1 (Practitioner 1), P2 etc.

[Reflection on research findings](#)

From the perspectives of the professionals attending the workshop the main challenge being faced by services centred around changes to their own funding and resources and entitlements of migrants in the UK. The impact of reduced funding to community and alcohol treatment services can be seen in increased waiting time for people to access treatment and in some cases, people being turned away from services that are at capacity and cannot meet service user's needs when they are required. Professionals who work with homeless people through their services reported particular difficulties in this sense with one professional stating that she currently had 30 individuals waiting to access alcohol treatment with no planned date for them to start.

For individuals seeking support there were additional challenges to accessing treatment when they had no recourse to public funds (NRPF) and were not entitled to receive many of the treatment options available, for example medical detox or housing support. An alternative for some is to return to Poland to receive treatment but this was often not an option that migrants themselves would agree to.



A number of reasons for this were proposed by professionals including; having no family or friends still in Poland to go to; a sense of shame on having to return to Poland due to problematic alcohol use and; feeling that it is easier to remain homeless in England than in Poland. Combined, having no entitlement to certain services and not wanting to return to Poland left professionals with little that they could do to support Polish migrants in need.

We can't get people into detox for 10 days so they're sent away. They have no passport, no employment, the alternative is detox in Poland but they've created a life here and they don't want to go (P1)

'There is no hope if there's no access to public funds and they won't go home' (P2)



For many it was recognised that alcohol may just be one of many issues that they need support with and there was a responsibility on services to try to address these issues also. Difficulties within relationships, unemployment and homelessness were discussed as some of the most common issues that service users present with. Homelessness in particular was discussed as one of the biggest challenges in supporting someone to stop drinking as it is a feature of homeless living and it is often necessary to drink with others in order to provide yourself with some form of social support and protection.

A further factor that impacts on treatment providers is the shame and stigma that is attached to admitting to having problems with alcohol. Women in particular face challenges in this respect as there is still pressure on them to be 'good' mothers and look after their children. The phrase 'Matka Polka' refers to an idealised version of a woman/motherhood that still persists in Polish culture but may be starting to shift both in the UK and in Poland but there are still entrenched opinions about how a woman should behave. Isolation can also be felt more by migrant women compared to men leaving them without a sense of belonging if they cannot return to Poland and need to build their own lives in the UK.

Looking to the future

We asked participants if they thought that Brexit was currently, or would in the future, have an impact on their services and how those from Eastern European backgrounds would be affected. The general consensus was that Brexit had created uncertainty for Polish and other Eastern European people who had made their homes in the UK. Discussion focused on how funding cuts have impacted services already and the likelihood that these will continue for some time. It was thought that the ongoing move away from commissioning and funding residential treatment services for alcohol problems and towards more community-based treatments was likely to continue. It was suggested that there is a tendency to create new services in response to increasing numbers of people looking for support but that funding levels do not change so that services struggle to meet demand. Professionals felt that costly repeated hospital admissions, ambulance call outs and attendances at A and E departments could be reduced by supporting easier access to alcohol treatment services.

Responding to population changes

Shifts in local populations have been seen in recent times and we asked attendees if these have had an impact on their services or on the types of support they were able to provide. An increase in the number of people from Lithuania was noted and that they are presenting to services with similar needs to Polish people such as having wider and complex intervention needs. However, it was less likely that services would have a native Lithuanian speaker or access to an interpreter compared to Polish and this was creating problems in providing care. Hiring interpreters is expensive and services do not have the funds to provide these to all who need them which can mean that services are not available to some groups. This is especially problematic for those in need of residential treatment who may be denied access because those services do not have the resources to provide interpreters.

Also related to resourcing issues was a noted decrease in staffing levels across services. For example, it was reported that locally, waiting lists for medical detox have increased in recent years due to a reduction in the number of detox nurses from seven to just two.

Addressing the needs of women

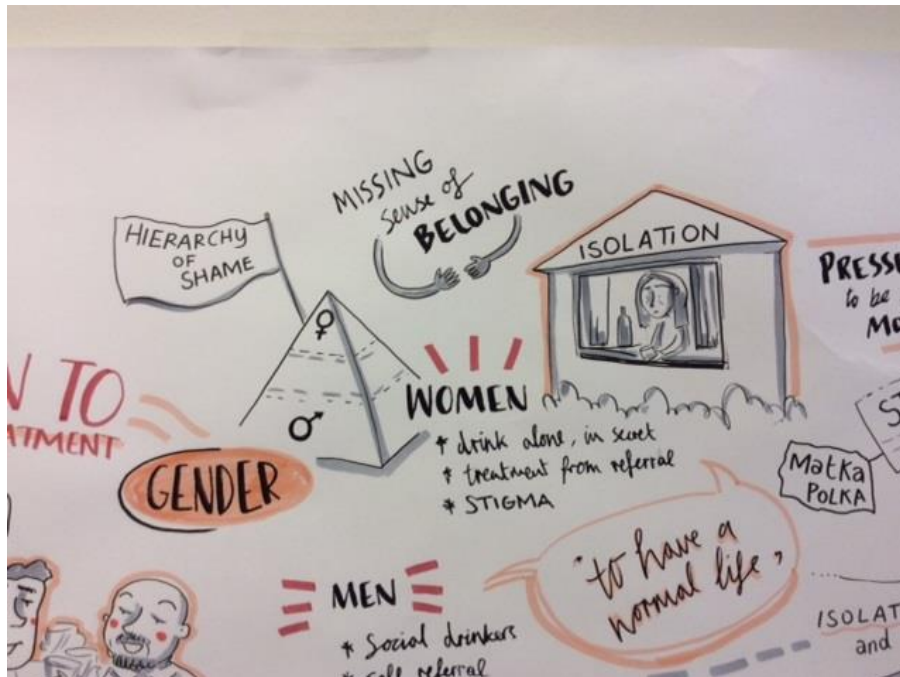
The potential for the need for different types of approaches to address the needs of women with problematic alcohol use was discussed by the group. One of the main factors that needed to be considered was that many Polish women with drinking problems were experiencing domestic violence and there is a need to address this in the first place. Many Polish women were dependent on their partners financially and socially and this creates difficulties for them if they wish to leave a relationship. It was suggested that some women used alcohol as a way of coping with these situations. It can take many attempts to leave an abusive relationship so services need to be open to women seeking help multiple times.

The second issue that affects women to a greater extent than men was if they had children and were afraid to admit to problematic drinking because they did not want social services to be alerted. Not only might their perception of their role as a good mother be compromised but there was risk of a decline in their mental health.

There's an acceptance among some women that you can't be a good mum while your kids are in social care. These are the consequences of your drinking. It's a hard process to get women to accept this (P3)

It can be a trigger to go downhill because of the loss of the children and can lead to depression. For some it's an engagement to go into treatment (P4)

However, for some women having their children taken into care due to their problematic drinking could also act as a trigger for them to look for help and as a motivating factor in stopping. Previous services offered child and family intervention which could help to address these needs but many of these are no longer available.



The aims of alcohol treatment

Analysis of the interview data collected for this research study suggested that Polish people seeking help with their drinking were inclined to aim towards total abstinence rather than a harm reduction or reduced drinking outcome. We asked our workshop attendees if this was reflective of their experiences of working with Eastern European migrants in the context of alcohol treatment service provision.

All professionals stated that the goal for this group was likely to be abstinence as this was how alcohol treatment is generally approached in Poland (and potentially other Eastern European countries also). The 'medical model' of treatment was discussed as being the predominant approach within Poland and most migrants would anticipate a similar approach to treatment in the UK based on their own experiences and understandings.

Interview participants talked about wanting to have a 'normal' life again as their main aim of alcohol treatment. This idea of what a normal life means was discussed by workshop attendees. The main features of this were suggested as having work, a family and occasional, or at least not problematic, drinking. Abstinence within Polish culture is not considered normal and most social occasions centre around drinking in some way. It was noted that people can become isolated when they stop drinking as they may try to avoid mixing with friends they previously drank with, but that meeting English people through work can make this easier as people are more likely to assimilate and create new social groups.

Key facilitators in getting people into treatment

We asked professionals what initiatives they used to help to encourage more people into alcohol treatment services and the things they felt were important to have in place to facilitate this. For most professionals having a Polish worker was seen to be important both so that language does not become a barrier but also so that there is someone who has the same cultural understanding as the service user. Alternatively, having an

interpreter available was seen as a necessary service provision for anyone without sufficient English to engage in services.

Informing people of the options available to them was also raised as being important to encouraging those with problematic alcohol use into some form of intervention or treatment. As shown from the interview data analysis in this report, different people tend to have a preference for different approaches to treatment and our workshop attendees stated that people need to know they have choices. Some may have had negative experiences with one service, or one type of approach and should be informed of their alternative options so they can access the help and support they need. Being able to signpost individuals to services is therefore a factor in ensuring people move into treatment when they are ready.

A third factor discussed by attendees was being able to provide individuals with practical activities or work to give them a reason to not drink. PEEC gave an example of a project they previously ran that involved people volunteering to build office furniture as a meaningful way of using both their time and skills. This made people feel valued and offered them something else to do with their time that did not involve drinking. The importance of work as a motivating factor to stop drinking was discussed as being especially relevant to Polish people.



The ideal service and best practice

For the next group discussion we asked attendees to think about what their ideal service would look like and to give any examples of best practice they have either implemented themselves or would like to see in their services.

From these group discussions the main feature proposed as an ideal service was to create a multi-agency hub that would be able to provide holistic support to people across all of the varied needs they present with. It is important to understand the whole picture for each individual. Having relationships with multiple agencies offering different services (e.g. housing, benefits, education, therapeutic interventions, medical care) and being able to work together would ensure a more person-centred approach and would reduce the burden on service users to search out information from each agency individually. This would also mean that each individual could be assessed just once for all services and have a central place to go to for further information or signposting if needed. Aftercare support could also be provided through this central hub and a means of bringing people back into services if the need arose.

A second feature discussed was the need to be able to provide realistic goals to people so they have something to aim for when they stop drinking. The importance of work and the strong work ethic among Polish migrants was raised as being a key motivating factor in people's decisions to stop drinking. If services were able to offer routes into employment for people as an outcome to completing treatment it could be a strong motivator to engage with the service and maintain abstinence.

Finally, the groups highlighted the importance of having culturally competent staff, either by including Polish key workers or through ongoing staff training. It was noted that this required more than just providing interpreters to overcome language barriers but that this should be available at a minimum. Having skills necessary to gain a person's trust were key; especially so when supporting women into treatment who are dealing with the cultural stigma and shame attached to their drinking.

It's getting people into treatment support, structure, putting together someone's life and you need to gain their trust. It's about dealing with stigma. No one makes a conscious choice to mess up their lives (P5)



Discussion

Whilst there are indications that the number of Polish people living in the UK has declined recently as a result of uncertainty generated by the UK's decision to leave the EU, with almost a million Polish nationals living in the UK (ONS 2018b) they remain a significant minority group.

Most participants in our study sought help for their problematic drinking only after a series of negative life events had occurred (e.g. losing a job, becoming homeless, relationship breakdown etc.) or because of serious physical illness due to problematic alcohol use. Medicated detox was often their entry point into treatment. Denial of problematic drinking and delayed help-seeking has been highlighted in earlier research. Both participants and professionals linked late presentation to treatment services with aspects of Polish culture; alcohol is integral to social life for men who were mostly drinking visibly with others in public spaces or within their homes. They are likely to be supported in their decision to seek help to stop drinking by others in their social spheres. For women, the idealised version of a woman/mother, encapsulated in 'Matka Polka', a familiar term still persistent in Polish culture, creates stigma and shame for a woman who drinks. Women are more likely to be seen as personally responsible for failing in their role by their social circle. This was thought to contribute to women drinking more secretly and mostly in isolation and be a factor in their reluctance to seek help.

Key facilitators to getting people into treatment services were discussed at the workshop and centred around having a Polish worker available both for overcoming language barriers and cultural sensitivity and understanding. Interpreters were seen to be increasingly difficult to have within services, due in large part to reduced funding, and it was noted that for many other Eastern European service users there were restrictions on the types of treatment they could access because there were no interpretation services available to them. Cultural competence of staff was seen to be important from the perspective of professionals to help people feel understood and welcomed at services and gaining their trust was paramount. Discussion of this is notably absent from the research literature on alcohol treatment interventions for Polish migrants.

Gender differences were apparent throughout the pathways for men and women seen within this study and highlighted by professionals and participants themselves. These differences are not fully addressed in the literature. Men tended to present to treatment via self-referral, having made the decision to seek help without involving professionals. Women, in contrast, presented via services, primarily GPs but also social services and probation. Women often revealed unmet needs relating to domestic violence, dependency on male partners for financial support, impact of children being taken into care etc, which could affect their capacity to engage with alcohol treatment services. Professionals emphasised the importance of gaining women's trust to facilitate disclosure so that professionals could consider how best to support them, including referral to appropriate services. As an issue this has not been discussed fully in the literature but seems to be important in terms of how people come to services and the other factors that need to be considered throughout treatment (e.g. domestic violence/financial dependence on men).

The goal of treatment for Polish men and women is abstinence which reflects both Polish cultural expectations and alcohol treatment provision in Poland. The concept of harm reduction was unfamiliar to service users. Their cultural expectations of treatment could be seen not only to affect the point at which Polish people enter treatment but what they anticipate will be required of them during its course and how they perceive and

understand their goals beyond treatment. Some evidence from Poland supports this assessment where a majority of addiction therapists reported they would not be in favour of advocating reduced risk drinking as a goal but may find it acceptable as an intermediate goal when working towards abstinence (Klingemann, 2016). Understanding these expectations of Polish migrants when they come to alcohol treatment services was discussed in the context of having a shared cultural understanding by workshop participants highlighting the need to think beyond just language as a barrier or facilitator to engagement with services.

Earlier literature suggests that many Polish migrants in the UK returned to Poland for healthcare if they could afford it, usually explained as arising from a lack of trust or faith in the UK system. This is routinely offered to migrants who have No Recourse to Public Funds (NRPF) but there is resistance from Polish migrants with many choosing to stay on the streets and/or keep drinking rather than return. Reasons for wanting to stay were discussed by interviewees and workshop participants as being related to experiences of past trauma in Poland, having lost contact with family or not having good relationships with them and fears that they would also be homeless in Poland where they felt it was more difficult to survive compared to the UK.

Many of our interview participants spoke about a desire to achieve a 'normal' life as their goal for alcohol treatment. For these participants this meant being in work, earning money, having a stable place to live and either being in a relationship or being part of a family. In the workshop, participants were at first unfamiliar with the idea of the 'normal' life as described in our interviews but through discussion they seemed to have a similar understanding of the key elements of this concept. There are elements of cultural influence in this image of normal living, it has strong links to the Polish work ethic and reflects cultural assumptions about the responsibilities of men and ideas of masculinity. Alongside the ideal of the normal life, some interview participants talked explicitly about wanting to be 'strong' again through alcohol treatment, a reflection that socially, problematic drinking is viewed as a sign of weakness.

Within this study, people were facing an array of complex and often inter-related problems (e.g. homelessness, mental health issues, lack of work, debt etc), which required input from a variety of agencies and both interviewees and professionals highlighted the importance of this broad range of support in enabling alcohol problems to be addressed. Evident in earlier literature and in both professional and participants' accounts is that full engagement with alcohol treatment is particularly challenging when the housing and employment needs of service users cannot be addressed. Crucially, ineligibility to secure public funds restricts the services that can be accessed by people and serves to exacerbate existing problems such as homelessness and lack of employment.

There is some evidence from the literature that there have been changes to patterns of alcohol use amongst Polish migrants from the early years of A8 accession to the present, but it has yet to be fully investigated. In our interviews with professionals, there was a suggestion that changing attitudes to drinking and increased restrictions in the workplace (primarily on construction sites) have led to some reduction in drinking at least during the working week. Our search for research literature revealed a larger body of literature published in the years immediately after Poland joined the EU, (which largely focused on economic or employment issues), and some quite recent literature (on more varied issues), with very little published research on any aspect relating to this group in the intervening years.

Conclusion

This study, as in previous research, highlights the importance of providing services that are culturally sensitive and in the Polish language, not just for those with no/limited English but also for those who would prefer to use Polish when accessing alcohol treatment and therapeutic services. Such provision facilitates access, engagement and progression through treatment.

Denial of problem drinking and delay in help seeking was evident for both men and women and this impacts on individuals, families, communities and services. Whilst there are potential opportunities for professionals across settings (e.g. primary care, A&E, workplace, housing) to identify and intervene and/or refer at an earlier stage, cultural sensitivities and understanding need to be taken into account which requires knowledge of Polish culture which could be met by training and awareness raising. In addition, to signposting and supporting individuals and their families, Polish community organisations are well placed to work towards shifting cultural attitudes to drinking and also to help seeking. Public health policy needs to consider prevention approaches in consultation with the Polish community and a broad range of professionals.

On the whole, problematic drinking is only one of a myriad of problems experienced by Polish drinkers and this necessitates a person centred and multi-agency approach as currently offered by HAGA-Blenheim. Moreover, service users and professionals noted that steps need to be taken to address other needs, for example, mental health as well as practical needs (e.g. housing, money) *before* individuals are able to engage effectively with alcohol treatment. The desire for a 'normal life', underpinned by a strong work ethic seems to provide a foundation for recovery. Work is valued and routes into employment and other meaningful occupation (e.g. voluntary work, study) should be an integral part of treatment.

Gender differences were apparent throughout this study. There were different drinking patterns and pathways into treatment for men and women. In addition, there were significant unmet needs for women, particularly concerning domestic violence and having children in their care. These differences have implications for identification, signposting and supporting individuals and their families which need to be considered when commissioning and delivering services.

Professionals raised significant concerns about the limited help available for those with NRPF, most of whom were reluctant to return to Poland and without appropriate treatment were likely to experience a deterioration in health and even die. This presents a profound challenge not only for practitioners and service providers, but also needs to be a policy consideration for society more broadly.

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