ScotPHN report

A review of suicides in Polish people living in Scotland (2012-2016)

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The study was facilitated by the Crown Office and Procurator Fiscal Service which, following data release protocols being completed, efficiently provided the records for review and offered accommodation to the study team.

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We are indebted to Prof Steve Platt who commented on drafts of this report.

Preface

This report is a result of cooperation between the Polish Consulate General of Poland in Edinburgh and Scottish institutions involved in health and social interventions, including suicides.

Article 37 of the Polish Constitution 1997 guarantees the right to consular help to the Polish citizen abroad. It says that “A Polish citizen has a right to care and support from the Republic of Poland”. It is repeated in the Consular Law Act of 25 June 2015. One of the functions of the Polish Consulate General of Poland in Edinburgh is to support the development of the Polish national minority and to protect the rights and freedoms of the members of that community. In cases where it learns that a Polish citizen is in a difficult life or financial situation, has had a serious accident, or that a Polish citizen has died, the Consul provides help.

Due to the growth of the Polish community in Scotland in the recent years, the Consulate has observed an increased number of deaths and deaths by suicide in particular. The fact that psychological distress was seen as a precursor to these suicides suggested that a deeper analysis of the situation could help to start taking preventive actions by local organisations cooperating with the Consulate.

The Consulate General of Poland in Edinburgh invited Feniks, Counselling Personal Development and Support Services Ltd., a charity providing psychological support to Polish citizens in Scotland, to organise a series of work meetings. The meetings discussed the causes of the problem, the scale of suicides in the context of particular social groups and their effects on social life. Scottish partners from NHS Lothian Mental Health Team, NHS Lothian Public Health, Police Scotland, Choose Life Edinburgh and Crown Office also participated in the meetings.

This study is a result of the cooperation, experience and information exchange as well as the thorough analysis of data acquired in cooperation with Scottish partners. It is hoped it will contribute to increasing public awareness, not only about the phenomenon of suicides but also the possibilities for its prevention.

The Consulate General of Poland would like to express gratitude to all who have engaged in realisation of this publication for taking part in numerous meetings, exchange of views, sharing experiences in this field, and providing literature on the subject.

Consul Jolanta Srebrakowska
Consulate General of the Republic of Poland in Edinburgh

1 Executive Summary

Suicide amongst Polish nationals living in Scotland has been identified as a cause for concern.[a]

We accessed records from 2012-2016 and:

1. ascertained the number of such deaths from National Records of Scotland (NRS) data; and
2. reviewed the Crown Office records relating to them.

1.1 National Records of Scotland Data Analysis

We identified 68 suicide deaths between 2012 and 2016, meaning that an average of over one Polish resident in Scotland dies due to suicide each month.

We estimated the European age standardised suicide rate (EASR) for Polish residents (male and female) in Scotland to be 21.6 / 100,000 (95% Confidence Interval 13.4 - 31.4) for 2012-16. This suggests that Polish migrants living in Scotland have a suicide rate consistent with Poland rather than Scotland. The male to female suicide ratio of 5.8:1 also mirrors that in Poland rather than Scotland's 3:1 ratio. The suicide rates of Polish and non-Polish women in Scotland are very similar (5.4 vs 7.3 / 100,000 respectively). Polish men have a significantly higher rate than Scottish men of 31.5 vs 19.4 / 100,000.

National comparisons show that the adult suicide rate in Poland is 20.8 / 100,000 EASR population (Eurostat Suicide and Undetermined combined 2012-15). This is significantly higher than the 2012-16 Scottish level of 14.1 / 100,000 (NRS).

1.2 Crown Office Record Analysis

While several specific issues emerge, a key finding is how similar the circumstances surrounding suicide deaths in both Polish and Scottish people are. In particular unemployment or irregular work, shift and manual work, relationship problems, and heavy use of alcohol are all commonly described in accounts of the circumstances surrounding these deaths.

For Polish people who have moved to Scotland the 'migrant experience' and the challenges and stresses resulting from moving to a new country are superimposed onto other life events or choices. Difficulties working in an English-speaking environment (and lacking the sophisticated language to discuss mental or emotional

[a] In the UK 'suicide' is conventionally taken to include ICD codes for both suicide and undetermined deaths intentional self-harm (ICD-9 codes E950-959; ICD-10 codes X60-X84 plus Y87.0, which is for sequelae of intentional self-harm). It also includes events of undetermined intent (ICD-9 codes E980-989; ICD-10 codes Y10-Y34 plus Y87.2, which is for sequelae of events of undetermined intent). WHO tends to restrict the definition to suicide alone.

health), being unfamiliar with Scotland and its culture, not knowing about the NHS or how to access public services more generally, and the lack of family and community networks to offer social support are all common.

2 Background

There is evidence that Polish migrants to the UK may be at increased risk of suicidal behaviour compared with the British population (1). In 2016, the Polish Consulate in Scotland established a group to investigate the number of Polish people who had completed suicide in Scotland. While it has a role in investigating deaths in Polish nationals in Scotland, the Consulate could not accurately assess the scale of the problem, as Police Scotland contacted them only when they had difficulty in identifying the deceased person's next of kin. There was anecdotal evidence and concern that the rate of suicide amongst the Polish population in Scotland was high and therefore needed investigation.

The group established was a partnership of local and national organisations with knowledge and expertise in data analysis, trends, and in the circumstances within the Polish communities and families who live in Scotland. The work was facilitated by Feniks, a charity working with the Central and Eastern European community in Edinburgh. The first meeting was in February 2016, and initially had representation from the Polish Consul, Police Scotland and Feniks. The group quickly realised that Police Scotland, the Crown Office and the Scottish Suicide Information Database (ScotSID*)* did not hold information about nationality. Some raw data was retrieved from the National Records Scotland at this time, but as they were not age standardised and the denominator populations unknown, the figures were difficult to interpret.

In July 2016 the partnership group was extended to include colleagues from NHS Lothian Public Health and Strategic Planning Directorates, NHS National Services Scotland's Information Services Division, and the City of Edinburgh Council Choose Life Coordinator. The group met over 2016 and 2017 and established a programme of work to:

1. determine the suicide rate in Polish people living in Scotland; and
2. describe the epidemiology and characterise the circumstances around these suicide deaths.

Ultimately, the aim of the work was to help inform the national suicide action plan regarding the perceived excess of suicides in Polish nationals.

Through NHS Lothian's data sharing arrangements, the Scottish Directors of Public Health Group and the Crown Office permission was gained to examine records held by the Crown Office (primarily police investigations of the deaths and any post-mortem

reports). This study of suicides in Polish people resident in Scotland was undertaken by a Public Health Consultant (Dermot Gorman), Feniks Development Manager (Magda Czarnecka), Consultant Psychiatrist (Wojtek Wojcik) and Senior Health Promotion Specialist Mental Health (Rachel King). They worked on behalf of the partnership, and with full support from the Consul, the Scottish Directors of Public Health, and the Scottish Public Health Network.

3 Comparing Suicide Statistics – Scotland and Poland

3.1 Methods

Deaths are registered with National Records of Scotland (NRS) and the details collected include nationality. Determining if a suspicious death is eventually classified as a suicide, undetermined or accidental death (the first two, in the United Kingdom at least, conventionally being combined to calculate the 'suicide rate') is an involved process. This is because police investigation, post-mortem reports and toxicology all require completion and consideration before death is finally attributed to one category. It may take some months for the Crown Office to advise NRS about the classification of a death. In turn NRS produces the final annual death tables for Scotland approximately nine months after the end of each calendar year. The summary death data is available at the NRS website (see: Table 1).

To disaggregate suicide and undetermined deaths we extracted data from NRS annual reports which detail numbers of deaths by suicide and undetermined methods separately (see: data for 2016).

For 2012-16 we classified suicide and undetermined deaths in Scotland by age-group and sex by Polish and all other nationalities to derive data on suicide and undetermined deaths separately and isolate deaths in Polish nationals from all other suicide and undetermined deaths in Scotland 2012-16.

To allow comparison with Polish figures we used the Eurostat database explorer to extract separate European age-standardised rates and numbers of deaths for intentional self harm (X60-X84 & Y870) and undetermined event (Y10-Y34 & Y872). These data are available here.

3.2 Suicide rate estimate for Polish people living in Scotland 2012-16

Calculating the suicide and undetermined death rate of Polish people living in Scotland requires both a numerator (the number of such deaths) and denominator (the Polish population living in Scotland). The numerator (suicides and undetermined deaths) is well-defined and precise, but the denominator is not. In interpreting these analysis, this limitation in the data should be recognised.

Occurring at approximately one a month, the annual number of suicides by Polish people in Scotland is small. To give more reliable results we combined five calendar

years (2012-16) which gave a numerator of 68 deaths (59 suicides and 9 undetermined deaths) of 58 men and 10 women.

There is no system of registering migrants or foreign nationals in Scotland and the size of Scotland's Polish population is uncertain. The Office for National Statistics makes annual estimates and, as Table 1 below shows over 2012-16 there was an average of 76,000 Polish born people were living in Scotland.

Table 1: Polish-born population of Scotland (1,000s) and recorded suicide and undetermined deaths (NRS data 2012-2016)

Year	Polish Population in Scotland[b]	CIs +/-	Deaths in Polish Men		Deaths in Polish Women	
			Suicide	Undetermined	Suicide	Undetermined
2012	56,000	8	5	1	0	0
2013	74,000	10	12	1	2	0
2014	71,000	9	10	2	1	1
2015	76,000	10	12	2	4	0
2016	91,000	12	12	1	1	1
Total			51	7	8	2

Source: population figures, see footnote; mortality data from National Records of Scotland (NRS) data

3.3 Death data from National Records of Scotland

We calculated the suicide and undetermined death rate for Polish nationals in Scotland using the Scottish Public Health Observatory method of age-standardisation using the European standard population (see Table 2). This allows direct comparison of rates based on populations with different age distributions. This calculation was undertaken using the 2015 estimate of 76,000 Polish people in Scotland who were distributed proportionately into 5 year age bands consistent with the 2011 census (2).

[b] These population figures are taken from Source: Table 1.4: Overseas-born population in the United Kingdom, excluding some residents in communal establishments, by country of birth Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/internationalmigration/datasets/populationoftheunitedkingdombycountryofbirthandnationality

Table 2: EASR Standardised suicide and undetermined rate Polish born people living in Scotland (2012-16, n=68)

	EASR / 100,000	Lower 95% CI	Upper 95% CI
Male	37.7	21.9	56.9
Female	5.4	2.1	10.9
Combined (M+F)	21.6	13.4	31.4

Source: Calculated from Eurostat and NRS data

This shows an age-standardised suicide rate for Polish nationals between 2012 and 2016 to be 21.6 / 100,000 (95% Confidence Interval 13.4 -31.4). That for males was 37.7 / 100,000, (95% CI 21.9 – 56.9) and for females 5.4 / 100,000 (95% CI 2.1 – 10.9).

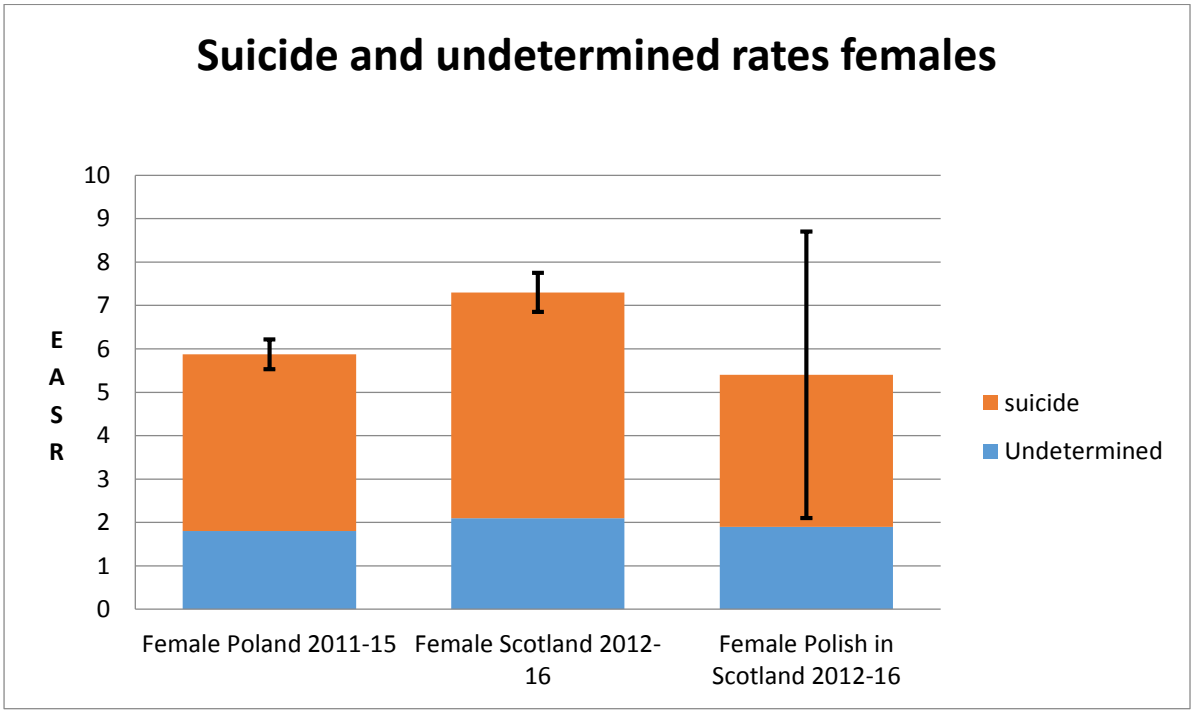
Table 3 is derived from Eurostat data for suicides and undetermined deaths expressed as European standardised rates, Scottish data is from NRS. These data have been combined in Graphs 1 and 2. Taken overall, these show that whilst rates for suicides amongst Polish females are comparable between Poland and Scotland, rates for Scottish females seems higher. Rates for males are much higher amongst Polish men living in either Scotland or Poland. As the confidence limits shows, this is significantly higher than the rate for Scottish makes.

Table 3: EASR Standardised Suicide and Undetermined death rates – Poland and Scotland: male and female (2012-16).

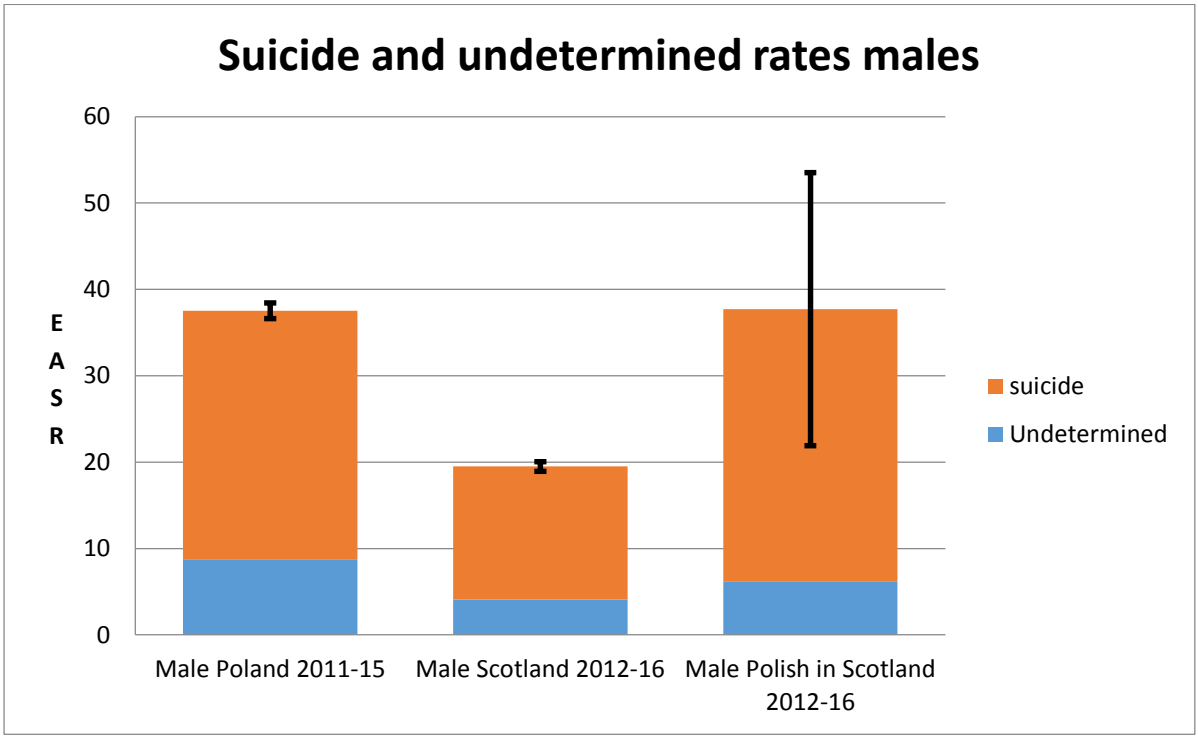
	Male Poland	Male Scotland	Female Poland	Female Scotland	M+F Poland	M+F Scotland
2012	39.4	23.6	6.2	7.4	21.8	15.8
2013	39.4	23.7	6.2	6.4	21.8	15.2
2014	36.8	19.3	6	6.9	20.5	13.3
2015	33.8	18.5	5.2	6.9	18.6	12.8
2016		19.7		7.2		13.6

Source: Calculated from Eurostat and NRS data

Graph 1: EASR Standardised Suicide and Undetermined death rates and 95% CI – Polish Females (2011-15), Scottish Females (2012-16) and Polish Females in Scotland (2012-16)



Graph 2: EASR Standardised Suicide and Undetermined death rates and 95% CI – Polish Males (2011-15), Scottish Males (2012-16) and Polish Males in Scotland (2012-16)



3.4 Commentary

Suicide in Poland is strongly associated with gender with a 5.6:1 male: female ratio about twice the male proportion as in Scotland (3:1). Men choose more violent (and therefore more certain) methods, contributing to the suicide rate among Polish men being amongst the highest in the EU. Polish women tend to use less violent methods (3). In Poland, 80-90% of suicides are by hanging and 5-10% by poisoning, much different to Scotland where 46.5% of suicides are hanging and 31.6% by poisoning (3, 4).

The gender differences have been related to the crisis in the traditional patriarchal family system observed since the beginning of the millennium. Researchers identify reasons for the phenomena as being different for men and women. Firstly, men are not able to cope with the challenges and pressures of society and expectations to perform in times of financial instability, high unemployment, etc. Men are often reluctant to admit defeat and hold the belief that they need to deal with problems by themselves, hence they do not seek any form of help. The need to reinstate the sense of control can then lead to violence directed towards their families (seen also as a reason for an increasing rate of domestic abuse amongst Polish immigrants in Scotland) or auto-aggression: alcohol and/or drug abuse, and suicide in extreme circumstances (5). What is more, research found a positive correlation between male suicide and increasing divorce rate in European post-Soviet republics, which is related to the social changes (i.e. change of the family dynamics) in the transition nations (6).

Interestingly, the same changes seem to have been less negative for Polish women and indeed, the female suicide rate in the Eastern European countries that entered EU in 2004 has significantly fallen since the accession (6). Polish Women seem to be keener to seek help and confide in others, which is seen as one explanation for lower level of suicide rates.

Alcohol is a well-known risk factor and nearly a quarter of suicide attempts in Poland take place following alcohol use, with 16.3% resulting in death (5). One fifth of those attempting or completing suicide regularly misused alcohol and 5.5% were had undergone treatment for alcoholism (7).

4 Review of Crown Office Records

4.1 Methods

NRS provided a list of deaths due to suicide or undetermined cause for Polish nationals for 2012-2016 to form our sample. The Crown Office gave permission and provided their paper records about these deaths for our review. We completed this in the secure surroundings of the Crown Office in Edinburgh.

These records consisted of the structured report of the police investigation and any post-mortem reports (including toxicology). The four authors reviewed these manually and the information therein is the source of our data. Variables were recorded on a spreadsheet held on an encrypted computer and fields related to sex, age, marital status, employment, length of time in Scotland, medical history, drug and alcohol issues, cause of death, circumstances of death, post-mortem report and any toxicology results. These were used to explore common factors amongst those who died.

It must be recognised that these reports are historical and the level of detail is entirely dependent on the investigative resources deployed by Police. In several cases there is reference to difficulty locating and interviewing next of kin, friends or flatmates with language difficulties noted as an impediment. This limitation has been taken into account in interpreting the data.

4.2 Method of Suicide

The most common method of suicide by Polish nationals was hanging and then poisoning, 63% and 21% respectively (Table 4). This is strikingly different to Scotland as a whole where the figures are 46.5% for hanging and 31.6% for poisoning. (3, 4) There were no drowning or firearms deaths in the Polish population in Scotland with the 'other' including four deliberate cutting incidents and one self-immolation.

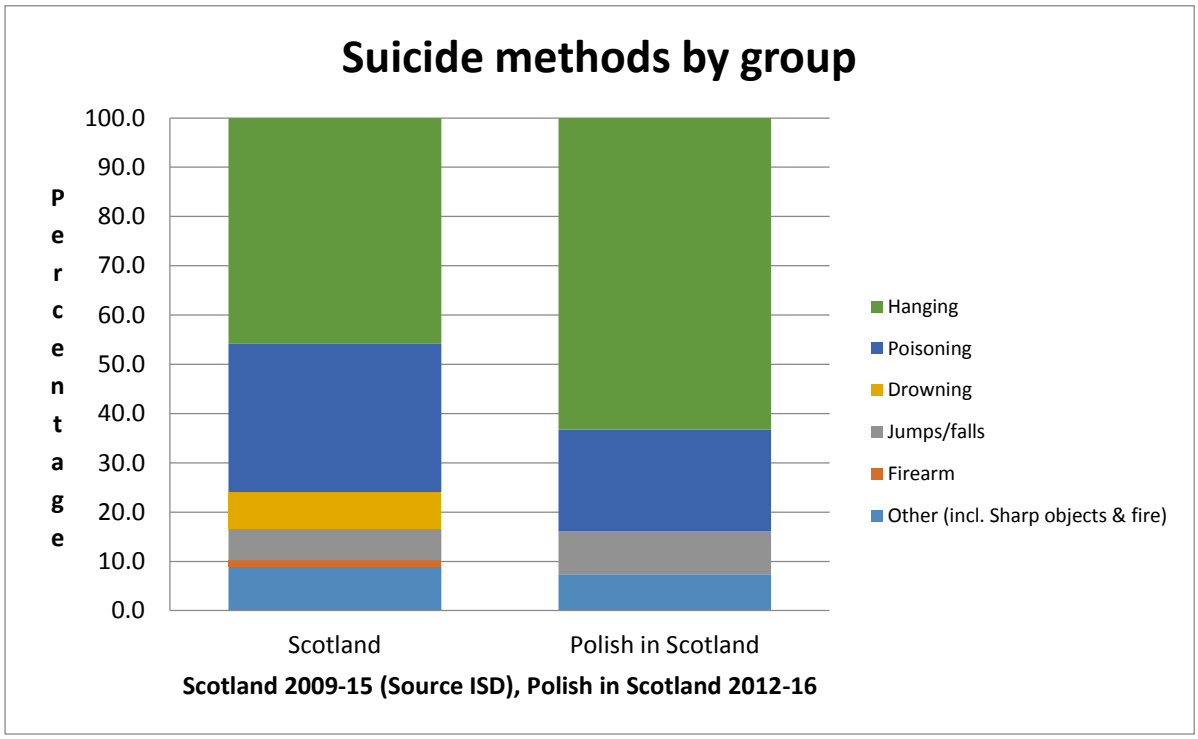
Table 4: Method of Suicide – Polish nationals in Scotland: Males and Females (2012-16)

Method	Female	Male
Hanging	4	37
Poisoning – *Opiate*	*1*	*5*
Poisoning – *Insulin*	*0*	*2*
Poisoning – *Other*	*4*	*1*
Fall / jump	0	5
Cutting	o	4
Plastic bag asphyxia	0	3
Self-immolation / burns	1	0
Step into path of vehicle	0	1
Total	10	58

Source: NRS data

Graph 3 compares the method of suicide for Scottish and Polish nationals in Scotland, using data taken from the ScotSID analyses. Whilst the time base is slightly different, the predominance of suicides by hanging is greater for Polish people in Scotland. In Poland 80-90% of suicides are by hanging and 5-10% by poisoning.

Graph 3: Method of Suicide for Scottish (2009-15) and Polish Nationals in Scotland (2012-16)



Hanging is more common in men and a prevalent method of suicide in Northern European countries, and an indicator of a cultural trend towards using more violent methods (8). It is a highly effective method of suicide with a high probability of death unlike self-poisoning, where many people survive and recover. In several of these hanging cases, the individual had practised, or shown people close to them what materials they would use to hang themselves. Some had asked close friends or family what they would do if they found them hanging.

There often were clear warnings, messages and/or signs of suicidality noticed by those close to the deceased. However, police reports show that they did not know how to seek help, and often friends, colleagues and family expressed that while they had knowledge about potential self-harm, they did not know where to take their concerns.

Other deaths in Polish people were either by suffocation, falls or self-laceration.

4.3 Sex, Age, and Marital Status

Of the 68 suicides, 10 were female giving a 6.8:1 male: female ratio. This is similar to Poland (6.7:1) (8), typical of northern Europe and much higher than Scotland's 3:1 ratio (9).

The mean age of women at death was 32.8 years (range 20-45) and men 37.0 years (range 16-61). The group had generally lived in Scotland for some time – a mean of 4.8 years in women and 5.1 years in men.

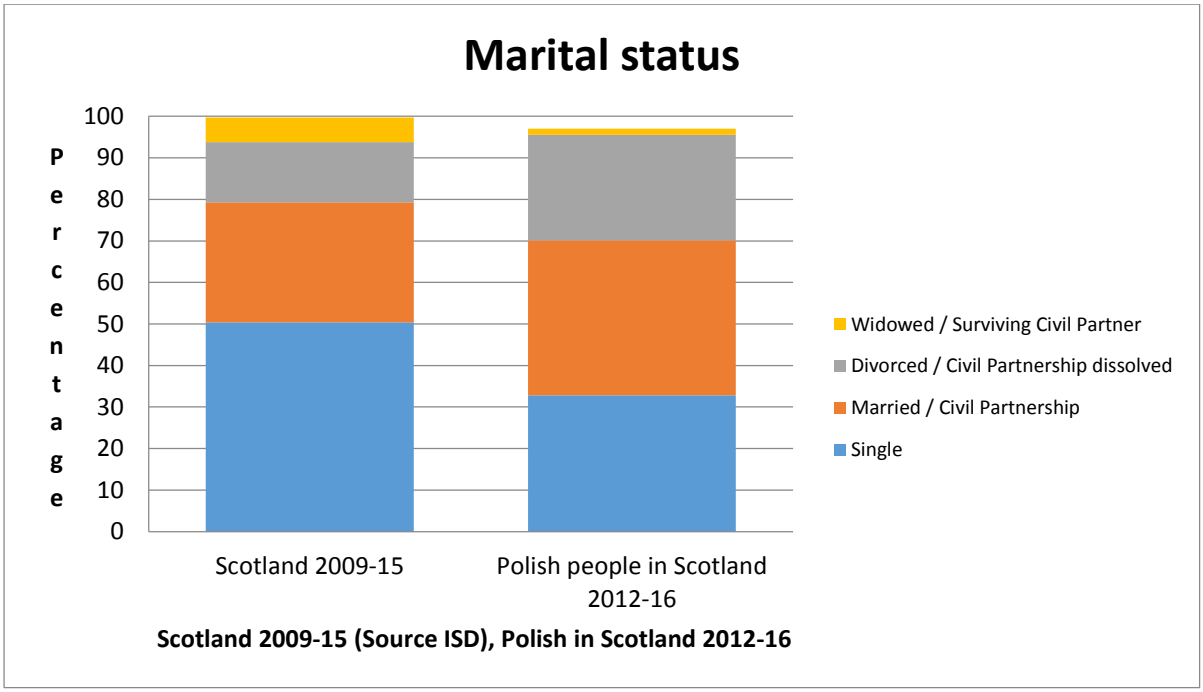
The marital status of those who completed suicide is shown in Table 5. Comparative data for Scotland is shown in Graph 4.

Table 5: Relationship status of Polish Nationals in Scotland at the time of Suicide (2012-16)

Status described	Number	Comment
Divorced	4	2 recently divorced
Married	14	Of whom one man had a wife who was living in Poland
Living with partner	11	
Separated – split under one month	4	
Separated – split 1 month – 1 year	5	
Separated	6	3 couples living together long term despite separation for family / practical reasons
Single	22	One in homeless hostel One of school age
Widower	1	
Unknown	1	
Total	**68**	

Source: Crown Office data

Graph 4: Relationship Status for Scottish (2009-15) and Polish Nationals in Scotland (2012-16) at the time of Suicide



A feature of this Polish sample is recent failed relationships prior to the suicide. Relationship challenges and couples who had separated were also mentioned in reports – options regarding housing and relationship counselling are likely to be less accessible to migrants than the Scottish population.

4.4 Employment status

The employment status of the Polish nationals who died are shown in Table 6.

Many individuals had no job, or had recently been made redundant, illustrating one stress many of the individuals were facing. Unemployment is linked with poor health outcomes and a risk factor for suicide. It is significant that such a high proportion of the deaths were in the unemployed (10).

Within Polish culture, it is the norm to adopt a strong work ethic and to be unemployed brings not only a reduced income but a loss of identity and status (11). This effect may be exaggerated in migrants who feel the need to succeed keenly.

Table 6: Employment Status of Polish Nationals in Scotland at the time of Suicide (2012-16)

Employment Status	Number	Comment
Unemployed	24	6 recent job loss noted, 1 recent benefits cut highlighted
Driver (Bus, HGV etc.)	5	
Catering / restaurant	6	
Food production	2	
Farm labour	4	
Carer	2	
School	1	
Building / construction trades	8	
Cleaning job / recycling plant	5	
Company executive	1	
Housewife	3	
Retired	1	
Unknown	6	
Total	**68**	

Source: Crown Office data

Of the 44 individuals working, 32 were employed in shift, seasonal, or manual work. Shift work in particular is becoming more associated with poor mental health, depression and suicide (12).

Some individuals were employed in more than one job simultaneously, with one report noting that the deceased had worked seven days per week. Several of the reports about individuals mention injury or illness, which can be particularly challenging for those employed in manual labour.

4.5 Financial status

Unemployment or unstable employment often results in financial problems and can hinder the ability to make future plans. Several people had money and financial worries, with gambling, debt, and lending money from Polish friends and family as particular features. A lack of social contact and being unable to afford visits to family or friends in Poland was a source of regret and distress for those affected.

In addition, for those who were unemployed or experiencing poor health, the impact of benefits cuts, changes or losses was a source of extreme concern and distress. In several instances a loss of benefits and ensuing debt were cited by informants in police reports as contributing to the suicide.

4.6 Healthcare access and well-being

There are important themes in the experience of Polish individuals and their use of the National Health Service (NHS). While the police enquiry always asked about General Practice and other health care contacts, the information was often unknown or incomplete. Using services in both Poland and Scotland is well-recognised to be common in the Polish community (13 -15, 17).

Of the 68 people reviewed, 10 had no information about General Practitioner (GP) registration status. Established GP registration was much more common in women (9 out of 10) than men (37 of 58). Twelve people were definitely not registered with a GP in Scotland (one had a doctor in Poland mentioned and another was reported as getting antidepressant medication from Poland).

Of the 46 who were definitely registered with a GP in Scotland, six were recorded as never having attended their doctor. There was information suggesting that 11 people had been seen in their last month alive by their GP; seven between two and six months before death; and nine had not been seen for over six months. There was no information about the last GP contact for 41 cases.

The police collect information about the deceased from people who have varying degrees of knowledge about the deceased – ranging from husbands/wives/partners to hostel wardens. Therefore, detail about GP and other healthcare contacts cannot be completely and consistently recorded. Nonetheless, the lack of clear information about links to, or attendance at health services or medical history, was striking. Where health information was available, there is not a clear picture about how, when or for what individuals accessed treatment or support from health services. This group are probably not very visible within primary care, meaning that their health needs may not be noticed and opportunities for early intervention not offered, as they may be for more frequent users of services. Examining this retrospectively, as we have done, is straightforward to do, but completeness of information is difficult to establish. Investigating such deaths prospectively could yield more comprehensive data.

About one third of reports say that individuals were seen by health services, mostly seeing their GP. The presentation was rarely recorded as being for mental health, instead problems with skin, stomach complaints, back or other pain featured commonly. A few of the cases mention ongoing difficulties such as epilepsy, diabetes or other long-term conditions.

Perhaps predictably, as police may be searching for mental health ‘reasons’ for suicide, mental health was reported as the second most common service accessed. There was specific mention in three cases of a mental health assessment service and two reports of in patient care.

While there is awareness within the Polish community about where and how to access health services, anecdotal evidence from within the Polish community in Scotland suggests that there is cultural reluctance to seek treatment or support for those experiencing mental health issues. As well as potentially explaining emotions in a foreign language, obtaining and getting to appointments could be hard if working nights or antisocial shift patterns or being unemployed. There is also fear about discussing poor mental health and potential stigma within the Polish community, and a worry that mental illness could have consequences for working and living in Scotland.

The information about NHS medication prescriptions is scarce and only available for 10% of cases. Where mentioned, the medications are usually for a mental health condition such as a psychosis or depression. Previous methadone prescription following issues with substance misuse is mentioned in two people. This collection of information by the police is retrospective and potentially incomplete. However, the low number of declared prescriptions may again suggest that individuals were either reluctant or unable to access treatment or support from local NHS services.

There are several other cases where medication or medical input from Poland is noted. In at least five instances people were having support from a Polish practitioner in Poland, or having Polish medication delivered (including anti-depressant medication commenced just before death and seemingly unsupervised in Scotland) to them in Scotland.

The Polish health service offers direct access to specialists and primary care has yet to be fully developed in Poland. Polish patients in Scotland can find the British primary care model confusing and find access to medications (e.g. antibiotics and pain relief) more controlled and restricted than they are used to. They are unfamiliar with staff groups and roles in the NHS and social care which can, quite understandably, result in what NHS staff can describe as ‘inappropriate’ use of services. NHS staff are often unfamiliar with the expectations of migrant patients and the healthcare cultures in their countries of origin. This is a particular issue in terms of supporting people’s mental health and wellbeing while they are living in a place where utilising NHS services feels unachievable. This may be especially true if someone is feeling depressed.

4.7 Alcohol and Substance Misuse

Information about alcohol use was found in 30 sets of notes (44%) and 20 (29%) of the 68 people who completed suicide had a label of ‘alcoholic’ or some variation of ‘heavy drinker’ associated with them. A further five were described as being drunk at the time of death (three of these were described as social drinkers, one as non-drinker and one had previously had a drunk-driving ban).

This level of alcohol and substance use is notable for several reasons. Firstly, the impact that alcohol has on mental and emotional health, ability to function and to gain or maintain employment or relationships is well known. Some of the cases illustrated the impact that alcohol had on people's lives; for example, losing jobs or employment, breakdown of relationships, lack of social contact, and low mood.

Secondly, disinhibition due to drinking can lead to risk-taking or suicidal behaviours. This is particularly relevant when linked to the method most chosen for suicides which was hanging. As this is a very effective method for suicide, understanding the impact that drinking alcohol and resultant disinhibition can have on this behaviour is key.

As in Scotland, alcohol use is a cultural norm for the Polish community. It is important to understand how and where individuals are using alcohol. In the Polish context, the location and outlets where they are purchasing and drinking it may be particular to them. Polish people in Scotland may be reluctant to pay 'pub prices' and outdoor drinking by groups of Polish men is often reported.

4.8 Relationships

Social isolation and relationships are strongly connected to wellbeing. It was clear from the cases that the breakdown of a significant relationship was considered by respondents to be precipitating factor for many of the suicides. This included sibling disagreements or disputes, or the end to a marriage or partnership.

There was no or little information collected in police interviews about the lives of the deceased in several cases. This lack of personal information shows that finding next of kin was difficult, and thus, police descriptions cannot know or include detail about their lives and relationships. It certainly implies that some individuals were not connected with a community or part of a family.

Sometimes, it was noted that the wife lived in Poland or abroad, that relationships were violent or abusive, or that partners were alcoholics and the relationship was tense. Many individuals were separated or divorced. In terms of separation, cases noted that several had split up months, weeks or just a few days before death. The impact on the individual of a relationship breakdown was very clear. Often individuals had talked to their ex-partners about their intention or thoughts about taking their own lives. Although sometimes these ex-partners had informed services, there was not a clear outcome from doing this and in several cases families had not known how to seek help from public services in Scotland. As this is almost a third of all the cases, it is significant in terms of considering how this can be part of work locally and nationally. Understanding the significance of relationships, family structure and gender role for men as part of the family is key to supporting individuals to seek help when relationships breakdown.

Twenty-three individuals were described as single. This may be due to a previous relationship ending, or that since being in Scotland no significant relationship had been formed. The lack of social ties was obvious in several cases where the police could find no one, or only one friend or contact, for the deceased to interview about the circumstances. Coupled with unstable, seasonal or shift work, this adds to a sense of individuals not being situated within families or communities.

Social isolation is linked to poor mood and higher rates of suicide (16). Bringing the picture together of social isolation, alcohol use, relationship breakdown and money worries, it is clear that the aspects of inequalities that affect Scottish born individuals are also present within Polish communities now living in Scotland. These elements are further indicated by the lack of description about hobbies, interests or social groups that individuals were part of. This may be due to not having this information, or it not being sought, but also seems that in many cases the social links were not possible or available.

4.9 Police and legal involvement

Several cases mention legal or police involvement with the family or individual. The reasons for this are varied and often refer to domestic violence, controlling behaviour or stalking of current or former partner. There were also a small number of cases where police had been called to fights or disputes among family members. A third reason for court involvement is debt and money concerns.

The stress and distress caused by being involved with the police or courts is part of the description of the current situation for several of the individuals. Even when there was nothing known about the deceased's links to other services they may have been known to police. Understanding police involvement as a risk factor in terms of suicidality may be significant in creating better information and services for Polish individuals.

5 Conclusions and recommendations

Whilst not seeking to over interpret the data considered in this review, there are clear themes which emerge about the cases of Polish nationals who died by suicide or as an undetermined death within Scotland over the four years 2012- 2016.

The picture is a group of males, often in unsteady or no employment and with concerns about money and finances. Individuals often had experience of relationship breakdown, high use of alcohol and lack of opportunities to form or maintain social bonds and relationships.

The impact of this lack of connectedness, coupled with the reality of structural and economic inequalities, means that individuals were not receiving relevant advice help or support in a timely way.

This in turn exacerbated the risk factors for low mood, suicidal feelings and thoughts, and risk taking behaviours.

There is a higher level of suicide in Poland than in Scotland, and the data from these cases suggests that for Polish people in Scotland the rate is higher than for Scottish born individuals.

In making recommendations for work across Scotland to prevent suicide amongst the Polish population, the review group consider the following would be helpful:

1. **National approaches:**

- ensure that national suicide prevention approaches in Scotland recognise the importance of the migrant experience, particularly in relation to the Polish population in Scotland;
- commission additional national campaigns to signpost those sections of the Polish population in Scotland least likely to engage services and their families and friends to seek help;
- such campaigns should recognise the potential for cultural resistance in seeking help from the NHS and wider support services, especially in relation to the role and expertise of the GP and primary care team;

2. **In the Health Sector:**

- support existing and develop new primary care based Link Worker / Navigator schemes to be sensitive to the needs of vulnerable migrant families and provide culturally appropriate assistance;
- improve existing alcohol services by making them more inclusive (e.g. employ a Polish speaking worker) and culturally sensitive;
- training for NHS staff:

i. improve and extend cultural competency training for all staff to include more focus on health seeking behaviour and expectations in different cultures;
ii. provide training on working with interpreters and developing the cultural mediator role, especially in the context of the recent move of interpreting services to be 'in house', offer opportunities for training of interpreter staff;

3. In the Employment sector:

- engage with large and small and medium-sized enterprise (SME) employers and agencies to raise awareness about access to and support from health services as part of Health Working Lives schemes;
- engage with large and SME employers of Polish nationals to raise awareness of key messages around suicide prevention, mental health first-aid schemes, and how to seek help;
- facilitate capacity in employment agencies, centres and benefits centres to provide benefits advice and increase ability to practically support individuals in distress;

4. In the Community:

- encourage local work with Polish shops and other key community assets to raise awareness of suicide prevention and where and how to seek help; and
- work with libraries, women's and children's groups to raise awareness among Polish women about mental health and suicide prevention.

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